DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Melisa Byrd
Senior Deputy Director and Medicaid Director
Department of Health Care Finance
One Judiciary Square
441 4th Street NW
Suite 900 South
Washington, DC 20001

Dear Director Byrd:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Behavioral Health Transformation (Project Number 11-W-00331/3) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is

updating the cadence for this demonstration to annual monitoring reporting (see also section 1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Behavioral Health Transformation demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on June 29, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 47, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Some of the metrics currently required for Substance Use Disorder (SUD) and Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstrations will no longer be required.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to the SUD or SMI/SED. Removal of the Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

Demonstration Monitoring Calls

As STC 51 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the District," and the calls are intended "to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Behavioral Health Transformation section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Taneka Rivera, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11-W-00331/3**

TITLE: **BEHAVIORAL HEALTH TRANSFORMATION**

AWARDEE: **DISTRICT OF COLUMBIA**

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by the District of Columbia ("the District") for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 1, 2020 through December 31, 2024, unless otherwise specified, be regarded as expenditures under the District's title XIX plan.

The Secretary of Health and Human Services has determined that the Behavioral Health Transformation demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the District to operate this section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder and Serious Mental Illness.** Expenditures for Medicaid state plan services—furnished to eligible individuals who are primarily receiving short-term treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) in facilities that meet the definition of an IMD.

2. **Temporary SMI/SED and/or SUD Non-State Plan Services.** Expenditures for additional SMI/(serious emotional disturbance (SED) and/or SUD services furnished during a stay in an IMD to eligible individuals who are primarily receiving treatment for the conditions described in Expenditure Authority #1 above. These services, which are not currently Medicaid state plan-approved, are authorized from January 1, 2020 through December 31, 2021 (see STC 66 for exclusions).

3. **Temporary SMI/SED and/or SUD Non-IMD Services.** Expenditures for additional SMI/SED and/or SUD or behavioral services furnished outside of an IMD setting to eligible individuals who are receiving treatment or who are assessed as needing treatment or recovery support services for the conditions described in Expenditure Authority #1 above and other behavioral health conditions as specified in STCs 20 through 35. These additional services, which are not currently Medicaid state plan-approved, are authorized from January 1, 2020 through December 31, 2021 (see STC 66 for exclusions).

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: **11-W-00331/3**

TITLE: **BEHAVIORAL HEALTH TRANSFORMATION**

AWARDEE: **DISTRICT OF COLUMBIA**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration.

The following waivers shall enable the District to implement the approved STC for the Behavioral Health Transformation (BHT) section 1115(a) demonstration beginning January 1, 2020 and ending December 31, 2024.

1. Amount, Duration & Scope **Section 1902(a)(10)(B)**

To enable the District to exempt beneficiaries receiving SUD treatment under this demonstration from $1 pharmacy co-payments when they are also receiving prescriptions associated with medication assisted therapy (MAT).

2. Comparability **Section 1902(a)(10), Section 1902(a)(17)**

To allow the District to apply different pharmacy cost sharing requirements for individuals described in Expenditure Authority #1 above.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00331/3

TITLE: BEHAVIORAL HEALTH TRANSFORMATION

AWARDEE: DISTRICT OF COLUMBIA

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Behavioral Health Transformation" section 1115(a) Medicaid demonstration (hereinafter "demonstration" or "BHT"), to enable the District of Columbia (hereinafter "the District") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act ("the Act"), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the District's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan populations affected by the demonstration are effective from January 1, 2020 through December 31, 2024 unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Demonstration Programs and Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. Monitoring
X. Evaluation of the Demonstration
XI. General Financial Requirements Under Title XIX
XII. Monitoring Budget Neutrality for the Demonstration
XIII. Schedule of Deliverables for the Demonstration Extension Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Reserved for SMI/SED Implementation Plan (includes Financing Plan)
Attachment D: Reserved for SUD Implementation Plan
Attachment E: Reserved for SMI/SED and SUD Monitoring Protocol(s)
Attachment F: Reserved for SMI/SED and SUD Evaluation Design(s)

II. PROGRAM DESCRIPTION AND OBJECTIVES

The goal of this demonstration is for the District to maintain and enhance access to mental health services, opioid use disorder (OUD), and other substance use disorder (SUD) services; and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED), and/or SUD (hereafter collectively "SMI/SED and/or SUD"). This demonstration authorizes the District to receive federal financial participation (FFP) for delivering high-quality, clinically appropriate treatment to beneficiaries diagnosed with SMI and/or SUD and receiving treatment while they are short-term residents in settings that qualify as Institutions for Mental Diseases (IMD). This demonstration also complements the District's efforts to implement models of care that are focused on increasing supports for individuals outside of institutions, in home and community-based settings (HCBS) to improve their access to SMI/SED and/or SUD services at varied levels of intensity, and to combat OUD and other SUDs among District residents.

During the demonstration period, the District seeks to achieve the following goals:

SMI/SED Goals:

1. Reduced utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care and specialty hospitals and residential settings;
3. Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the District;
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

SUD Goals:

1. Increased rates of identification, initiation, and engagement in treatment for SUD;
2. Increased adherence to and retention in treatment;

3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of hospital emergency departments and inpatient hospital settings for 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 the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries with SUD.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The District must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The District must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the District to submit an amendment to the demonstration under STC 7. CMS will notify the District 30 business days in advance of the expected approval date of the amended STCs to allow the District to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The District must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the District must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the District may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require District legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such District legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments**. The District will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The District must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the District to submit required elements of a complete amendment request as described in this STC, and failure by the District to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the District, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the District in the final amendment request submitted to CMS;
   b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
   c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;
e. The District must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the District in accordance with the requirements of 42 CFR§431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The District may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The District must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The District must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the District must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the District must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the District must provide a summary of the issues raised by the public during the comment period and how the District considered the comments received when developing the revised transition and phase-out plan.
b. Transition and Phase-out Plan Requirements: The District must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the District will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the District will undertake to notify affected beneficiaries, including community resources that are available.
c. Transition and Phase-out Plan Approval. The District must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
d. Transition and Phase-out Procedures: The District must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the District must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the District must maintain benefits as required in 42 CFR 431.230. In addition, the District must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP

eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the District must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the District elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the District's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the District, FFP must limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the District in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the District an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The District will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The District must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the District must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The District must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The District must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the District's

approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the District.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The District must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards and methodologies for eligibility remain set forth under the state plan and are subject to all applicable Medicaid laws and regulations.

V. DEMONSTRATION PROGRAMS AND BENEFITS

17. **SMI/SED and/or SUD Program Benefits.** Under this demonstration, beneficiaries will have access to high quality, evidence-based SMI/SED and/or SUD treatment and withdrawal management services. These services will range in intensity from medically supervised withdrawal management for SUDs and short-term acute care in inpatient settings for SMI to ongoing chronic care for these conditions in cost-effective community-based settings. The District will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The District must achieve a statewide average length of stay of no more than 30 days in residential and inpatient treatment settings, to be monitored pursuant to the SMI/SED and SUD Monitoring Plans as outlined in STCs 36 – 38 below.

    The coverage of SMI and/or SUD treatment services during short term residential and inpatient stays in IMDs will expand the District's current SMI and/or SUD benefit package

available to all the District's Medicaid beneficiaries as outlined in Table 1 (except where prohibited in these STCs).

The District attests that the services indicated in Table 1 as being either already covered under the Medicaid state plan authority or being authorized under the terms of this demonstration.

Table 1. SMI/SED and/or SUD Benefits Coverage Authorized with Expenditure Authority

Benefit	Type	Medicaid Authority	Expenditure Authority
Outpatient services	SMI/SED and/or SUD	State plan (Individual services covered)	N/A
Intensive outpatient services	SMI/SED and/or SUD	State plan[1] (Individual services covered)	N/A
Inpatient services	SMI/SED and/or SUD	State plan (Individual services covered)	Services provided to individuals in IMDs
Residential treatment services	SMI and/or SUD	Section 1115 demonstration	Services provided to individuals residing in IMDs
Medically Supervised Withdrawal Management	SUD	State plan (Individual services covered)	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	SUD	State plan (individual services covered)	Services provided to individuals in IMDs
Comprehensive Psychiatric Emergency Program	SMI and/or SUD	Section 1115 demonstration	N/A
Mobile Crisis Intervention and Outreach Services	SMI/SED and/or SUD	Section 1115 demonstration	N/A
Psychiatric Residential Crisis Stabilization Services	SMI/SED	Section 1115 demonstration	Services provided to individuals in IMDs

[11] The District State Plan provides coverage for a broad array of intensive outpatient services, including assessment and diagnostic, clinical care coordination, crisis intervention, counseling, medication management, and MAT. Under the demonstration, the District is planning to more fully implement intensive outpatient services, consistent with the Implementation Plan.

Table 1. SMI/SED and/or SUD Benefits Coverage Authorized with Expenditure Authority			
Benefit	**Type**	**Medicaid Authority**	**Expenditure Authority**
Recovery Support Services	SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Psychosocial Rehabilitative Services	SMI	Section 1115 demonstration	N/A
Trauma-Informed Service: Trauma Recovery and Empowerment Model (TREM)	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Trauma-Informed Service: Trauma Systems Therapy (TST)	SED	Section 1115 demonstration	N/A
Services of a Licensed Behavioral Health Practitioner	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Transition Planning Services	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Supported Employment	SMI	Section 1115 demonstration	N/A
Supported Employment	SUD	Section 1115 demonstration	N/A

18. Residential SUD Treatment Services. Treatment services delivered to residents of a residential care setting, including facilities that meet the definition of an IMD, are provided to the District's Medicaid recipients with a SUD diagnosis when determined to be medically necessary and in accordance with an individualized plan of care.

a. Residential treatment services are services provided to an individual residing in a District-certified facility that has been enrolled as a Medicaid provider and assessed as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.
b. Residential treatment services can be provided in settings of any size.
c. The implementation date for residential treatment services is January 1, 2020.

d. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
e. Covered services include:

i. Assessment/Diagnostic and Plan of Care Development: Includes assessment and diagnosis of the client and the development of the plan of care.
ii. Clinical Care Coordination: The initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a client's care needs.
iii. Case Management: Facilitation of 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 includes coordination of linkages to vocational, housing, child care, and social services.
iv. Crisis Intervention: An 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.
v. SUD Counseling/Therapy: Individual, family, or group counseling; includes group-psychoeducation counseling.
vi. Drug Screening: Toxicology sample collection and breathalyzer and urine testing to determine and detect the use of alcohol and other drugs.
vii. Medication Management: Coordination and evaluation of medications consumed by clients, monitoring potential side effects, drug interactions, compliance with doses, and efficacy of medications.
viii. Medication Assisted Treatment: Use of pharmacotherapy and other psychosocial supports for the treatment of opioid or other substance use disorders.
ix. Withdrawal management: Treatment of acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol or other drugs.

19. Psychiatric Residential Treatment Services: Psychiatric Residential Treatment Services are intensive services offered in a non-hospital setting for individuals over the age of 21 who have been diagnosed with an SMI. All services are provided under the direction of a psychiatrist. The goal of these services is to stabilize or improve a psychiatric condition until an individual's symptoms can be managed in a community setting. The District will provide services for a targeted statewide average length of stay of thirty (30) days in inpatient and residential treatment settings, to be monitored pursuant to the SMI Implementation Plan as outlined in STCs 36 below. Reimbursement for long-term residential or inpatient stays (longer than sixty (60) days) and forensic IMD stays will not be provided under this demonstration. Total length of stay will be determined by medical necessity and reviewed by the District or its assignee for clinical appropriateness.

a. Residential treatment services are services provided to an individual residing in a District-certified facility that has been enrolled as a Medicaid provider. Residential

treatment facilities that qualify as an IMD must also be accredited in accordance with STC 36(c)(i)(B).

b. Residential treatment services can be provided in settings of any size.
c. The implementation date for residential treatment services is January 1, 2020.
d. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
e. The components of Psychiatric Residential Treatment Services include:
    i. Assessments of the individual's social, emotional, and medical needs;
    ii. Therapeutic interventions
    iii. Psychiatric interventions
    iv. Non-hospital care in a structured 24-hour monitored environment for individuals whose mental health needs cannot be met in an outpatient setting,
    v. Comprehensive Transitional Care Coordination.
f. Provider Qualifications: Out-of-District provider psychiatric residential treatment services may be provided by a psychiatrist, APRN, physician's assistant, RN, LPN, LPC, LICSW, LMFT, psychologist, psychology associates, LGPC, LGSW, LCSW and other qualified practitioners that are authorized and licensed to provide services under District law and regulations and the state in which services are offered. For in-District providers, services must be furnished by a District-certified Psychiatric Residential Treatment Service provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations operating within scope of their license, including psychiatrists, psychologists, advanced practice registered nurses (APRN), and other qualified practitioners authorized under District regulations.

20. Temporary SMI/SED and/or SUD Services. Under this demonstration, the District may also receive federal financial participation (FFP) from January 1, 2020 through December 31, 2021 for providing additional services that are detailed in Expenditure Authorities #2 and #3.

a. For the services identified in Expenditure Authorities # 2 and 3 above, the District must submit all necessary SPAs and/or 1915(i) SPA application(s) to implement these title XIX services prior to the conclusion of DY1.
b. If the District fails to submit all necessary SPAs/applications prior to commencing DY2, this expenditure authority will be withdrawn effective January 1, 2021.
    i. If the District submits a justifiable reason (via memorandum) prior to withdrawal of this expenditure authority – and contingent upon CMS approval of the submission – CMS may allow the District additional time to complete the SPA/application submission processes.
c. If CMS withdraws Expenditure Authority #2, it will notify the District, in writing, of its determination and the reasons for the withdrawal.
    i. Once received, the District may request reconsideration of CMS's decision within 30 calendar days.
d. For temporary 1915-like HCBS authorized under this demonstration and listed in Tables 2 and 3, see STCs 29-32 for additional considerations.

Temporary 1905(a) State Plan-Approvable Services STCs 21-28

21. **Comprehensive Psychiatric Emergency Program (CPEP).** CPEP provides 24 hours, 7 days a week emergency psychiatric assessment and treatment to individuals who present on involuntary and voluntary status through an in person, on site, multidisciplinary team comprised of attending psychiatrists, nurses, certified peer specialists, licensed professional counselors, general medical staff, licensed social workers, and credentialed CPEP staffs. The duration of treatment for Psychiatric Emergency Services is up to 72 hours.

    a. Covered services include:

        i. **Brief Psychiatric Crisis/Emergency Visit.** Assessment and monitoring of an individual in crisis by a psychiatrist to determine the scope of emergency services required.

        ii. **Twenty-Three-Hour Psychiatric Crisis/Emergency Visit**. Assessment and monitoring of an individual in crisis by a psychiatrist and other clinical staff for up to twenty-three hours to ensure client safety when extended time is needed to assess treatment effectiveness and tolerance for crisis stabilization.

        iii**. Extended Observation Psychiatric Crisis/Emergency Visit.** Evaluation and monitoring of a patient by a psychiatrist and other clinical staff when a crisis has not sufficiently resolved for safe discharge to the community. This interaction includes a mental health diagnostic assessment, and, if necessary, treatment activities including prescribing or administering medication, and evaluation and monitoring for treatment effectiveness.

    b. Provider Qualifications. Services are furnished by any District-certified Comprehensive Psychiatric Emergency Program provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations operating within scope of their license, including psychiatrists, psychologists, advanced practice registered nurses (APRNs), and other qualified practitioners authorized under District regulations.

22. **Mobile Crisis Intervention and Outreach Services.** Clinical attention or treatment provided by mobile crisis intervention and outreach staff, in the community or via telephone, to an individual experiencing a behavioral health crisis. Services are provided with the immediate goals of preventing exacerbation of the underlying condition, limiting the risk of injury to the individual or others, and connecting the individual to clinically appropriate, ongoing care.

    a. The components of Mobile Crisis Intervention and Outreach Services are:
        i. Assessment and follow up;
        ii. Counseling;
        iii. Care coordination and case management.

    b. **Provider Qualifications.** Services are furnished by any District-certified Comprehensive Psychiatric Emergency Program provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations and operating within

the scope of their license, including psychiatrists, psychologists, advanced practice registered nurses (APRNs), and other qualified practitioners authorized under District regulations.

23. Psychiatric Residential Crisis Stabilization Services. A residential treatment alternative to psychiatric inpatient hospitalization for individuals in need of support to ameliorate psychiatric symptoms.

a. The components of Psychiatric Residential Crisis Stabilization Services include:

i. Psychiatric services, necessary to assess, treat, medicate and stabilize residents.
ii. Comprehensive nursing assessment within 24 hours of admission
iii. Monitoring of patients who pose a threat to themselves or others
iv. Stabilization and mental health services to address psychiatric, psychological, and behavioral needs
v. Development of treatment and discharge plans upon admission.
vi. Active treatment and mental health services for stabilization
vii. Individual, group counseling or other interventions as required to stabilize the person.

b. **Provider Qualifications.** Services are furnished by any District-certified psychiatric residential crisis stabilization provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations and operating within the scope of their license, including psychiatrists, psychiatric nurses, licensed independent clinical social workers (LICSWs), and other qualified practitioners authorized under District regulations.

24. Recovery Support Services. Non-clinical services and supports designed to support and maintain ongoing recovery from SUD. Recovery Support Services are available to individuals with a SUD who are currently in treatment or have moved into recovery from SUD use/abuse, and individuals who have self-identified with SUD, but are assessed as not needing treatment.

a. The components of Recovery Support Services include goal-setting, case management, coaching, counseling, and other services designed to assist individuals with SUD with successful implementation of their recovery plan in either individual or group settings.

b. **Provider Qualifications.** Services are furnished by any District-certified recovery support services provider. Qualified provider staff include certified recovery coaches, certified peer specialists, and other qualified practitioners authorized under District regulations.

25. Psychosocial Rehabilitative Services. Psychosocial rehabilitative services (PRS) that use behavioral, cognitive, or supportive interventions to assist individuals with SMI to develop social networking, independent living, budgeting, self-care, and other skills that will assist them to live in the community and to prepare for securing and retaining employment.

a. The components of PRS include:
    i. Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses;
    ii. Improvement in functional competence responding to a psychiatric crisis;
    iii. Improvement in functional competence in understanding the role psychotropic medication plays in the stabilization of the members' well-being;
    iv. Increase in independent living competencies;
    v. Strengthening social and interpersonal abilities;
    vi. Increasing personal adjustment abilities to reduce dependency on professional caregivers and to enhance independence;
    vii. Increasing cognitive and adult role competency;
    viii. Identification and development of organizational support; and
    ix. Identification and development of existing natural supports for addressing personal needs.
b. **Provider Qualifications.** Services are furnished by any District-certified PRS provider. Qualified provider staff must be credentialed and meet requirements under District laws and regulations.

26. Trauma-Informed Services:

a. Trauma Recovery Empowerment Model (TREM): Trauma Recovery Empowerment Model (TREM) is a structured group therapy intervention for individuals who have survived trauma and have substance use and/or mental health conditions. TREM draws on cognitive restructuring, skills training, and psychoeducational and peer support to address recovery and healing from sexual, physical, and emotional abuse. TREM requires at least two facilitators for each group. The component services of TREM include:

    a. Therapy sessions on empowerment, self-comfort, and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries.
    b. Therapy sessions on the trauma experience and its consequences. Therapy sessions on skills building, including emphases on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.
    c. **Provider Qualifications.** Services are furnished by any District-certified TREM provider. Qualified provider staff has completed District-approved TREM training and includes psychiatrists, psychologists, LICSWs, LPCs, and other qualified providers authorized under District law and regulations.

b. Trauma-Informed Service: Trauma Systems Therapy (TST) is a comprehensive, phase-based treatment program for children and adolescents who have experienced traumatic events and/or who live in environments with ongoing stress and/or traumatic reminders. TST is designed to address the complicated needs of a trauma system in which a traumatized youth who, when exposed to trauma reminders, has difficulty regulating their emotions and behavior, and their caregiver/system of care is not able to adequately protect the youth or help them manage this dysregulation. The three phases are Safety-

Focused, Regulation-Focused, and Beyond Trauma. The component services of TST include:

i. Psychotherapy,
ii. Home/community-based stabilization,
iii. Emotion regulation skills training, and
iv. Psychopharmacology.
v. **Provider Qualifications:** Services are furnished by any District-certified TST provider. Qualified provider staff has completed District-approved TST training. The multi-disciplinary treatment team includes psychiatrists, therapists, and credentialed staff practicing in accordance with District law and regulations. TST teams are supervised by licensed behavioral health practitioners, including psychiatrists, psychologists, LICSWs, or LPCs.

27. Services of a Licensed Behavioral Health Practitioner. Outpatient behavioral health services for individuals with SMI/SED or SUD, including assessment, counseling and other treatment services, provided by licensed Psychologist, licensed Independent Clinical Social Workers, licensed Professional Counselors, and licensed Marriage and Family Therapist. Services associated with screening or treatment of Autism Spectrum disorders is not included.

a. The component services include:
   i. Assessment, diagnostic, and screening services;
   ii. Counseling and psychotherapy;
   iii. Treatment planning and care coordination; and
   iv. Psychological Testing.

b. **Provider Qualifications.** Services are furnished by licensed behavioral health practitioners. A licensed behavioral health practitioner is an individual, practicing within the scope of their professional licensure and in accordance with District law, who is authorized to diagnose or treat SMI/SED or SUD. Licensed behavioral health professionals include the following providers practicing independently, in a group practice, or in a hospital setting:
   i. Psychologist;
   ii. Licensed Independent Clinical Social Workers;
   iii. Licensed Professional Counselors; and
   iv. Licensed Marriage and Family Therapist

28. Transition Planning Services. Discharge planning and facilitation of transitions of care for individuals leaving institutional treatment settings by providers of lower levels of care. Transition planning services consist of up to eight (8) hours per individual for services provided within thirty (30) days prior to an individual being discharged.

a. The components of Transition Planning Services include:
   i. Assessment.
   ii. Development of a service plan.

iii. Care coordination and case management

b. **Provider Qualifications.**
Services are furnished by any District-certified provider qualified to provide Mental Health Rehabilitative Services, Adult Substance Abuse Rehabilitative Services, or other behavioral health services allowable under the State Plan that are authorized under District law and rulemaking to provide transition services

Temporary 1915(i)-Approvable (Supported Employment) Services STCs 29-32

29. Supported Employment for Individuals with SMI. Services available to adults with SMI for whom competitive employment has not occurred, has been interrupted, or is intermittent as a result of SMI. Vocational supports help the individual prepare for, obtain, and maintain a part-time or full-time job in a competitive employment setting, earning at least minimum wage.

a. The components of Supported Employment services include:
   i. Intake and Assessment;
   ii. Individualized work plan development;
   iii. Benefits counseling
   iv. Coordination with the individual's treatment team;
   v. Initial job development; and
   vi. Follow-along supports after job placement such as problem-solving and job coaching for the beneficiary and helping the employer with making reasonable accommodations and effective supervision strategies.

b. **Needs-Based Functional Criteria:** The supported employment services are available to individuals who meet the following health needs-based criteria:

Individual is assessed to have a behavioral health need, which is defined as at least one of the following:

a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness; or

b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment; and

AND

Individual has at least one of the following risk factors:

1) Unable to sustain gainful employment for at least 90 consecutive days related to a history of a mental or substance use disorder;

2) An inability to obtain or maintain employment resulting from age or disability (physical or behavioral);

3) More than one instance of mental illness or substance use treatment in the past two years; or

4) At risk of deterioration of mental illness and/or substance use disorder, evidenced by one or more of the following:

a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness;

b) Care for mental illness and/or substance use disorder requiring multiple provider types, including behavioral health, primary care, long-term services and supports; or

c) A past psychiatric history with no significant functional improvement that can be maintained without treatment and supports.

a. **Provider Qualifications:** Services are furnished by any District-certified supported employment provider. Qualified provider staff include psychiatrists, psychologists, LICSWs, licensed professional counselors, and other qualified providers that are licensed and authorized in accordance with applicable District laws and regulations and operating within the scope of their license. These qualified practitioners supervise other staff that are supported employment managers and employment specialists trained in accordance with evidence-based supported employment principles and practices, consistent with District regulations.

30. Supported Employment for Individuals with SUD. Targets adults for whom competitive employment has not occurred, has been interrupted, or is intermittent as a result of SUD. Ongoing vocational and therapeutic supports help the individual prepare for, obtain, and maintain a part-time or full-time job in a competitive employment setting, earning at least minimum wage. Job options are diverse and permanent.

a. The components of Supported Employment SUD services, include:
    i. Intake and Assessment;
    ii. Individualized work plan development;
    iii. Care coordination;
    iv. Benefits counseling;
    v. Job development and coaching; and
    vi. Follow-along supports for the beneficiary and employer. For the beneficiary, vocational supports include problem-solving and job coaching; and therapeutic supports include helping the individual manage their illness and teach strategies to help prevent symptom exacerbation that affects their employment. Supports for

the employer help with making reasonable accommodations and effective supervision strategies.

b. **Needs-Based Functional Criteria:** The supported employment services are available to individuals who meet the following health needs-based criteria:

Individual is assessed to have a behavioral health need, which is defined as at least one of the following:

a) Mental health needs, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support), resulting from the presence of a mental illness; or

b) Substance use needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the individual meets at least ASAM level 1.0, indicating the need for outpatient Substance Use Disorder treatment. The ASAM is a multi-dimensional assessment approach for determining an individual's need for SUD treatment; and

AND

Individual has at least one of the following risk factors:

1) Unable to sustain gainful employment for at least 90 consecutive days related to a history of a mental or substance use disorder;

2) An inability to obtain or maintain employment resulting from age or disability (physical or behavioral);

3) More than one instance of mental illness or substance use treatment in the past two years; or

4) At risk of deterioration of mental illness and/or substance use disorder, evidenced by one or more of the following:

a) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness;

b) Care for mental illness and/or substance use disorder requiring multiple provider types, including behavioral health, primary care, long-term services and supports; or

c) A past psychiatric history with no significant functional improvement that can be maintained without treatment and supports.

c. **Provider Qualifications:** Services are furnished by any District-certified supported employment provider. Qualified practitioners are behavioral health practitioners,

including psychiatrists, psychologists, LICSWs, licensed professional counselors, and other qualified providers that are licensed and authorized in accordance with applicable District laws and regulations and operating within the scope of their license. These qualified practitioners supervise staff that are supported employment managers and employment specialists trained in accordance with evidence-based supported employment principles and practices, consistent with District regulations.

31. Quality Improvement Strategy for 1915(c) or 1915(i)-Approvable HCBS Services Provided Through Fee-for-Service (FFS) Delivery System. The District must have an approved Quality Improvement Strategy and is required to work with CMS to develop approvable performance measures within 90 days following approval of the 1115 for the following waiver assurances (see (a) through (g) below):

a. **Administrative Authority.** A performance measure must be developed and tracked for any authority that the District's Medicaid Agency delegates to another agency, unless already captured in another performance measure.
b. **Eligibility or Level of Care Requirements**. Performance measures are required for the following:
   i. Applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility.
   ii. The district-mandated processes for determining level of care or eligibility for HCBS are followed as documented in District materials. While performance measures for the actual provision of care or determinations of eligibility are not required to be reported, the District is expected to ensure that annual levels of care/eligibility are determined.
c. **Qualified Providers.** The District must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the District verifies that training is given to providers in accordance with the demonstration.
d. **Service Plan.** The District must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for 1) choice of waiver services and providers; 2) service plans address all assessed needs and personal goals; and 3) services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
e. **Health and Welfare.** The District must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. The District must have performance measures that track that on an ongoing basis it 1) identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; 2) an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that District policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the District establishes overall health care standards and monitors those standards based on the responsibility of the service provider as District in the approved demonstration.
f. **Financial Accountability.** For FFS, the District must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS

program. The District must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered, and that it provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle. For managed care, the District must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR Part 438.

g. **HCBS Settings Requirements**. The District must assure compliance with the characteristics of HCBS settings as described in the 1915(c) and 1915(i) regulations at 42 CFR 441.710 in accordance with implementation/effective dates as published in the Federal Register.

32. Quality Improvement Strategy for 1915(c) or 1915(i)-Approvable HCBS Services Provided Through Managed Care Delivery System. For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS District plan, the District's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in federal managed care rules at 42 CFR 438.330 and must also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the District's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.

33. HCBS Reporting. The District will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements set out in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers set forth in 42 CFR 441.301 and 441.302. This information could be captured in the 1115 Summary Report detailed in STC 47.

34. HCBS Monitoring and Evaluation. The District must report annually the deficiencies found during the monitoring and evaluation of the HCBS demonstration requirements, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not recur. The District must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. This information must be included in the annual reports submitted for 1115 waivers detailed in STC 47.

35. HCBS Beneficiary Protections. The District will demonstrate compliance with the following HCBS beneficiary protections.

a. **Person-Centered Planning**. The District assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2). The person-centered service plan is reviewed, and revised upon

reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

b. **Conflict of Interest.** The entity that authorizes the services must be external to the agency or agencies that provide the HCB supported employment services. Appropriate separation of assessment, treatment planning and service provision functions must be incorporated into the District's conflict of interest policies.

c. **Additional HCBS Beneficiary Protections**.

   i. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options. (for use in MLTSS programs with self-direction)

   ii. The District, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

   iii. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

36. SMI/SED Implementation Plan.

a. The District must submit the SMI/SED Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. The District must submit the revised SMI/SED Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The District may not claim FFP for services provided in IMDs to beneficiaries with a primary diagnosis of SMI/SED until CMS has approved the SMI/SED Implementation Plan and the SMI/SED Financing Plan described in STC 37(e). After approval of the applicable implementation plans required by this STCs, FFP will be available prospectively, not retrospectively.

b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the District and CMS will result in a funding deferral as described in STC 44.

c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

   i. **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.**

      A. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for

licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

B. Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
C. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet District licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
D. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
E. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and establishment of a District process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, the District must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.407, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
F. Implementation of a District requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. **Improving Care Coordination and Transitions to Community-Based Care.**

A. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts (e.g., by allowing initial services with a

community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);

B. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who are homeless or who have unsuitable or unstable housing with community providers that coordinate housing services, where available;
C. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider they were referred to;
D. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
E. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.**

A. Establishment of a process to annually assess the availability of mental health services throughout the District, particularly crisis stabilization services, and updates on steps taken to increase availability;
B. Commitment to implementation of the SMI/SED financing plan described in STC 36(e);
C. Implementation of strategies to improve the District's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
D. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. **Earlier Identification and Engagement in Treatment Including Through Increased Integration**

A. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

B. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
C. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. **SMI/SED Health IT Plan:** Implementation of the milestones and metrics as detailed in Attachment C.

e. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan referred to in STC 36(c), the District must submit, within 90 calendar days after approval of the demonstration, a financing plan that will be approved by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;
iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

37. SUD Implementation Plan.

a. The District must submit the SUD Implementation Plan within ninety (90) calendar days after approval of this demonstration for CMS review and comment. The District must submit the revised SUD Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The District may not claim FFP for services provided in IMDs to beneficiaries who are primarily receiving SUD treatment and withdrawal management services until CMS has approved the SUD Implementation Plan. Once approved, the SUD Implementation Plan will be incorporated into the STCs as Attachment D and, once incorporated, may be altered only with CMS approval. After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively.

b. Failure to submit a SUD Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the District and CMS will result in a funding deferral as described in STC 43.

c. At a minimum, the SUD Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

   i. **Access to Critical Levels of Care for SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of SUD demonstration approval;
   ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;
   iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;
   iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Chapter 63 (Mental Health) of Subtitle A of Title 22 (Health) of the District Code of Municipal Regulations (DCMR) and Certification Standards for Substance Use Disorder Treatment and Recovery Providers and related District rulemaking in the DCMR. The District must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that 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 within 12-24 months of demonstration approval;
   v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
   vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD:** An assessment of the availability of providers in the critical levels of care throughout the District, or in the regions of the District participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

x. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in Attachment D.

d. **SMI/SED and/or SUD Health Information Technology Plan ("Health IT Plan(s)").** The SMI/SED and/or SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type (SMI/SED and/or SUD).

The Health IT Plan(s) must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED and/or SUD goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan(s) must include implementation milestones and projected dates for achieving them (see Attachments C and D), and must be aligned with the District's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the District's Behavioral Health (BH) IT Health Plan.

i. The District must include in its Monitoring Protocol (see STC 38) an approach to monitoring its SMI/SED and/or SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The District must monitor progress, each DY, on the implementation of its SMI/SED and/or SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 47).

iii. As applicable, the District should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation

Specifications' (ISA)[2] in developing and implementing the District's SMI/SED and/or SUD Health IT policies and in all related applicable District procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the District- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the District should use the federally-recognized standards, barring another compelling District interest.

v. Where there are opportunities at the District- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the District should use the federally-recognized ISA standards, barring no other compelling District interest.

A. The SMI/SED Health IT Plan must describe the District's current and future capabilities to support providers implementing or expanding Health IT functionality for:
    1. Referrals,
    2. Electronic Care Plans and Medical Records.
    3. Consent.
    4. Interoperability in Assessment Data.
    5. Telehealth.
    6. Alerting/Analytics.
    7. Identity Management.

B. Components of the SUD Health IT Plan include:

    1. The SUD Health IT Plan must describe the District's goals, each DY, to enhance the District's prescription drug monitoring program (PDMP).[3]
    2. The SUD Health IT Plan must address how the District's PDMP will enhance ease of use for prescribers and other District and federal stakeholders.[4] This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the District will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
    3. The SUD Health IT Plan will, as applicable, describe the District's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health

[2] Available at: https://www.healthit.gov/isa/section-iii-standards-and-implementation-specifications-services

[3] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[4] *Ibid.*

IT Plan must describe current and future capabilities regarding PDMP queries—and the District's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The District will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

4. The SUD Health IT Plan will describe how the activities described in (1), (2) and (3) above will support broader District and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[5]
5. In developing the SUD Health IT Plan, states should use the following resources.

    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
    - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
    - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

38. SMI/SED and SUD Monitoring Protocol(s). The District must submit a Monitoring Protocol for the SMI/SED and SUD programs authorized by this demonstration within 150 calendar days after approval of the implementation plan. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit the revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments. Once approved, the SMI/SED and SUD Monitoring Protocol will be incorporated into the STCs, as Attachment E. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:

a. An assurance of the District's commitment and ability to report information relevant to each of the program implementation areas listed in STC 36(c) and STC 37(c), reporting relevant information to the District's SMI/SED financing plan described in Attachment

[5] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017; 66.

C, and reporting relevant information to the District's Health IT plans described in STC 37(d);

b. A description of the methods of data collection and timeframes for reporting on the District's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by District data, and targets will be benchmarked against performance in best practice settings.

39. Evaluation. The SMI/SED Evaluation and SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections VIII (General Reporting Requirements) and X (Evaluation of the Demonstration) of these STCs.

40. Availability of FFP for the SMI/SED Services. FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for stays up to 60 days as long as it shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Stays in IMDs that exceed 60 days are not eligible for FFP under this demonstration. If the District cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The District assures that it will provide coverage for stays that exceed 60 days—or 45 days, as relevant—with other sources of funding if it is determined that a longer length of stay is medically necessary for an individual beneficiary.

VI. COST SHARING

41. Cost Sharing. The demonstration removes $1 co-payment cost sharing requirements now in effect under the State Plan for individuals receiving services under the demonstration who are also using prescription medications associated with MAT. Otherwise, cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

42. Delivery System. The District's SMI/SED and/or SUD Medicaid delivery system is divided, with overlapping authority, primarily among the District and its Medicaid MCOs. The District has authority over Medicaid's reimbursement of clinic services, hospitals, and outpatient services. MCOs contract with a behavioral health provider network providing low-acuity behavioral health services. Services and supports for individuals with SMI/SED/SUD are carved out of MCO contracts and delivered through FFS by providers operating under the oversight of the District.

Medicaid MCOs manage their own network of behavioral health service providers who offer lower level, non-rehabilitative behavioral health services. MCOs also provide inpatient, emergency, pharmacy, and psychiatric residential treatment facility (PRTF) services. MCOs

are subject to State Plan requirements and accountable to the District through the MCO contract and oversight.

For the District's residents with a diagnosis of SMI/SED, the Medicaid program (via Mental Health Rehabilitation services) provides an array of mental health services and supports. In 2011, Medicaid-covered SUD services administered by the District expanded with the implementation of the ASARS program. The District contracts with 57 providers of mental health services, 33 providers of substance use services, and 10 providers of both mental health and substance use services. The District also operates adult and child clinics that provide urgent care and crisis emergency services and provides homeless outreach and treatment services.

Under the demonstration, the Behavioral Health Transformation will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) demonstration and section 1115(a) demonstrations.

VIII. GENERAL REPORTING REQUIREMENTS

43. Deferral of FFP for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The District does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the District materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the District has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the District in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the District providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
b. For each deliverable, the District may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the District's anticipated date of submission. Should CMS agree to the District's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the District as an interim step before applying the deferral, if the District proposes a corrective action plan in the District's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the District fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the District.
d. If the CMS deferral process has been initiated for District non-compliance with the terms of this agreement with respect to required deliverable(s), and the District submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a District's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

44. Deferral of FFP for Insufficient Progress toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the District is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Plan agreed upon by the District and CMS. Once CMS determines the District has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The District is expected to meet the milestones by the end of the first two years of the SMI/SED demonstration.

45. Submission of Post-Approval Deliverables. The District must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

46. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the District will work with CMS to:
a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the District; and
c. Submit deliverables to the appropriate system as directed by CMS.

IX. MONITORING

47. Monitoring Reports. The District must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring

Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the District's SMI/SED financing plan and maintenance of effort described in STC 36(e); legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
b. Performance Metrics. The performance metrics will provide data to demonstrate how the District is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The District must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the District must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the District shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
e. SMI Health IT and/or SUD Health IT. The District will include a summary of progress made in regards to SMI/SED and/or SUD Health IT requirements outlined in STC 37(d).
f. SMI/SED Financing Plan Updates. The District will include an update on its SMI/SED Financing plan as outlined in STC 36(e).

48. SMI/SED and/or SUD Mid-Point Assessment. The District must conduct an independent mid-point assessment by January 1, 2022. In the design, planning and conduction of the mid-point assessment, the District must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCO), SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners.

The District must require that the assessor provide a report to the District that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The District must provide a copy of the report to CMS no later than 60 days after January 1, 2022. The District must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the District must submit to CMS modifications to the SMI/SED Implementation Plan and/or the SUD Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol and/or SUD Monitoring Plan for ameliorating these risks. Modifications to the applicable Implementation, Financing, and Monitoring Protocol are subject to CMS approval.

Elements of the mid-point assessment include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED and/or the SUD Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol and/or SUD Monitoring Protocol;
b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the District's SMI/SED or SUD Implementation Plans or SMI/SED Financing Plan or to pertinent factors that the District can influence that will support improvement; and
e. An assessment of whether the District is on track to meet the budget neutrality requirements.

49. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the District to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

50. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the District must submit a Draft Close-Out Report to CMS for comments.

a. The draft close-out report must comply with the most current guidance from CMS.

b. The District will present to and participate in a discussion with CMS on the close-out report.
c. The District must take into consideration CMS' comments for incorporation into the final close-out report.
d. The final close-out report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the close-out report may subject the District to penalties described in STC 43.

51. Monitoring Calls. CMS will convene periodic conference calls with the District.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The District and CMS will jointly develop the agenda for the calls.

52. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the District must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the District must publish the date, time and location of the forum in a prominent location on its website. The District must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the District must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

53. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the District must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The District must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The District may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 43.

54. Independent Evaluator. Upon approval of the demonstration, the District must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The District must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the District may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

55. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs.

The District must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable Evaluation Design guidance, including guidance about SMI/SED and SUD. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to) the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs).
b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

56. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

57. Evaluation Design Approval and Updates. The District must submit the revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the District will publish the approved Evaluation Design to the District's website within thirty (30) calendar days of CMS approval.

The District must implement the evaluation designs and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation designs, if the District wishes to make changes, the District must submit a revised evaluation design to CMS for approval.

58. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the District intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

59. Interim Evaluation Report. The District must submit an Interim Evaluation Report for each evaluation design, as applicable, and for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Reports should be posted to the District's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the District is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the District made changes to the demonstration in its application for renewal, the research questions and hypotheses and a description of how the design was adapted should be included. If the District is not requesting a renewal for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The District must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the District's website.
e. The Interim Evaluation Report must comply with Attachment B of these STCs.

60. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The District must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the

end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the District must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the District's Medicaid website within thirty (30) calendar days of approval by CMS.

61. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the District to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the District's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

62. District Presentations for CMS. CMS reserves the right to request that the District present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

63. Public Access. The District shall post the final documents (e.g., Monitoring Reports, Close-out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the District's website within thirty (30) calendar days of approval by CMS.

64. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the District, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to District or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

65. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[6]

[6] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

66. Unallowable Expenditures. In addition to the other unallowable costs and caveats already outlined in these STCs, the District may not receive FFP under any expenditure authority approved under this demonstration for any of the following: Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

a. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
b. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
c. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

67. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The District will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The District will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and District and local administration costs (ADM). CMS shall make federal funds available based upon the District's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the District shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the District, and include the reconciling adjustment in the finalization of the grant award to the District.

68. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XI:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

69. Sources of Non-Federal Share. The District certifies that its match for the non-federal share of funds for this demonstration are District/local monies. The District further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The District acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The District agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. The District acknowledges that any amendments that impact the financial status of the demonstration must require the District to provide information to CMS regarding all sources of the non-federal share of funding.

70. Certification of Funding Conditions. The District must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that District or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the District utilizes certified public expenditures (CPE) as the funding mechanism for the District share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the District would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the District utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the District the amount of such District or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the District share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the District's claim for federal match.
d. The District may use intergovernmental transfers (IGT) to the extent that such funds are derived from District or local monies and are transferred by units of government within the District. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and District and/or local government to return and/or redirect to the District any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care

provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

71. Program Integrity. The District must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The District must also ensure that the District and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

72. Medicaid Eligibility Groups. Medicaid Eligibility Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 4. Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD IMD Services MCO	Hypo 1	X		X	Medicaid beneficiaries diagnosed with an SUD in managed care.
SUD IMD Services FFS	Hypo 1	X		X	Medicaid beneficiaries diagnosed with an SUD in fee-for-service.
SMI IMD Services MCO	Hypo 1	X		X	Medicaid beneficiaries diagnosed with an SMI in managed care
SMI IMD Services FFS	Hypo 1	X		X	Medicaid beneficiaries diagnosed with an SMI in fee-for-service.
Non-State Plan Services MEG	Hypo 2	X		X	Temporary authority for services detailed in Expenditure Authority #2.
Non-IMD Services MEG	Hypo 3	X		X	Temporary authority for services detailed in Expenditure Authority #3.

73. Reporting Expenditures and Member Months. The District must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00331/3). Separate

reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the District also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The District will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the District. The District will report any premium contributions collected by the District from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the District's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The District will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The District will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section IX, the District must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member

months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The District must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The District will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the District will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the District's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the District compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
SUD IMD Services MCO	Medicaid beneficiaries diagnosed with an SUD in managed care.	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24
SUD IMD Services FFS	Medicaid beneficiaries diagnosed with an SUD in fee-for-service.	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24
SMI IMD Services MCO	Medicaid beneficiaries diagnosed with an SMI/SED in managed care	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24
SMI IMD Services FFS	Medicaid beneficiaries diagnosed with an SMI/SED in fee-for-service.	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24

Table 5. MEG Detail for Expenditure and Member Month Reporting								
Non-State Plan Services MEG	Temporary authority for services described in Expenditure Authority #2.	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24
Non-IMD Services MEG	Temporary authority for services described in Expenditure Authority #.	See STC 66	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	1/1/20	12/31/24

74. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 6 Demonstration Years		
Demonstration Year 1	January 1, 2020 to December 31, 2020	12 months
Demonstration Year 2	January 1, 2021 to December 31, 2021	12 months
Demonstration Year 3	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 4	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 5	January 1, 2024 to December 31, 2024	12 months

75. Budget Neutrality Monitoring Tool. The District must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XII. CMS will provide technical assistance, upon request.[7]

[7] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

76. Claiming Period. The District will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the District made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the District will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

77. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the District must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The District agrees that if mandated changes in the federal law require District legislation, the changes shall take effect on the day such District legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
c. The District certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the District's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, District, and local statutes, regulations, and policies, and that the data are correct to the best of the District's knowledge and belief. The data supplied by the District to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

78. Limit on Title XIX Funding. The District will be subject to limits on the amount of federal Medicaid funding the District may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the District would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the District's compliance with these tests

will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the District on the CMS-64 that pertain to the demonstration.

79. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the District is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the District at risk for changing economic conditions; however, by placing the District at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the District accepts risk for both enrollment and per capita costs.

80. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the District may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

81. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

82. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the District could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS' current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality

Tests, which subject hypothetical expenditures to pre-determined limits to which the District and CMS agree, and that CMS approves, as a part of this demonstration approval. If the District's WW hypothetical spending exceeds the supplemental test's expenditure limit, the District agrees (as a condition of CMS approval) to offset that excess spending by refunding the FFP to CMS.

a. **Hypothetical Budget Neutrality Test 1: SMI/SED and/or SUD Services (see Expenditure Authority #1).** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

b. **Hypothetical Budget Neutrality Test 2: SMI/SED and/or SUD Non-State Plan Services (see Expenditure Authority #2).** The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

c. **Hypothetical Budget Neutrality Test 3: SMI/SED and/or SUD Non-IMD Services (see Expenditure Authority #3).** The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7. Hypothetical Budget Neutrality Tests

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR [2018]	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
SUD IMD	PC	Both	$1,605	4.3%	$1,728	$1,802	$1,880	$1,961	$2,045

Services MCO									
SUD IMD Services FFS	PC	Both	$2,331	4.3%	$2,510	$2,618	$2,730	$2,848	$2,970
SMI IMD Services MCO	PC	Both	$10,226	4.3%	$11,008	$11,481	$11,975	$12,490	$13,027
SMI IMD Services FFS	PC	Both	$7,719	4.3%	$8,309	$8,666	$9,039	$9,427	$9,833
Non-State Plan Services MEG	PC	Both	$480.06	4.3%	$517	$539	$562	$586	$612
Non-IMD Services MEG	PC	Both	$215	4.3%	$231	$241	$252	$262	$274

83. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the District on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

84. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 1, 2020 to December 31, 2024. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

85. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the District to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 8. Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	**Percentage**
DY1	Cumulative budget neutrality limit plus:	2.0 percent
DY1 through DY2	Cumulative budget neutrality limit plus:	1.5 percent
DY1 through DY3	Cumulative budget neutrality limit plus:	1.0 percent
DY1 through DY4	Cumulative budget neutrality limit plus:	0.5 percent
DY1 through DY5	Cumulative budget neutrality limit plus:	0.0 percent

Table 9. Schedule of Deliverables		
Date	**Deliverable**	**STC**
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after SUD program approval date	SUD Implementation Plan	STC 37(c)
60 calendar days after receiving CMS feedback	Draft SUD Implementation Plan	STC 37(c)
150 calendar days after SUD implementation plan approval date	Draft SUD Monitoring Protocol	STC 37
60 calendar days after receiving CMS feedback	Revised SUD Monitoring Protocol	STC 37
180 calendar days after demonstration approval date	Draft Evaluation Design	STC 55
60 Calendar days after receiving CMS feedback	Revised Evaluation Design	STC 55
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website	STC 55
June 30, 2023, or with renewal application	Draft Interim Evaluation Report	STC 59(c)
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 59(d)
Within 18 months after June 30, 2024	Draft Summative Evaluation Report	STC 60
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 60(a)-(b)
Monthly Deliverables	Monitoring Call	STC 51
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter, beginning November 2019.	Quarterly Monitoring Reports, including implementation updates	STC 47
	Quarterly Expenditure Reports	STC 47(c)
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Reports	STC 47

ATTACHMENT A
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both District and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

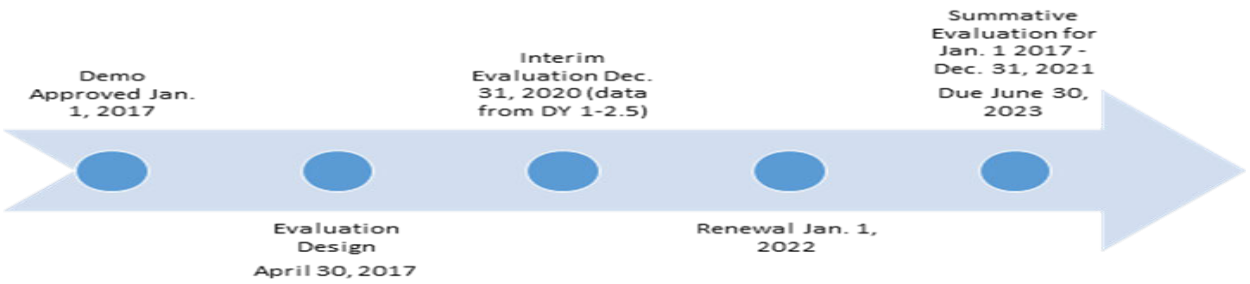
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the District's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the District should be aware that section 1115 evaluation documents are public records. The District is required to publish the Evaluation Design to the District's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the District's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the District should include basic information about the demonstration, such as:

1. The issue/s that the District is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the District selected this course of action to address the issue/s (e.g., a narrative on why the District submitted an 1115 demonstration proposal).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.

4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the District should:

1. Describe how the District's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

3. Identify the District's hypotheses about the outcomes of the demonstration.

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the District is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. Evaluation Design – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2. Target and Comparison Populations – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. Evaluation Period – Describe the time periods for which data will be included.

4. Evaluation Measures – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and District standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the District for improving quality of care and health outcomes, and controlling cost of care.

5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6. Analytic Methods – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the District might want to articulate the analytic methods for each research question and measure.
    b. Explain how the District will isolate the effects of the demonstration (from other initiatives occurring in the District at the same time) through the use of comparison groups.
    c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
    d. The application of sensitivity analyses, as appropriate, should be considered.

7. Other Additions – The District may provide any other information pertinent to the Evaluation

Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The District should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the District would like CMS to take into consideration in its review. For example:

1. When the District demonstration is:

    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No District issues with CMS-64 reporting or budget neutrality; and

d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1. Independent Evaluator. This includes a discussion of the District's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the District will assure no conflict of interest. Explain how the District will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(2)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both District and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single District or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the District's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

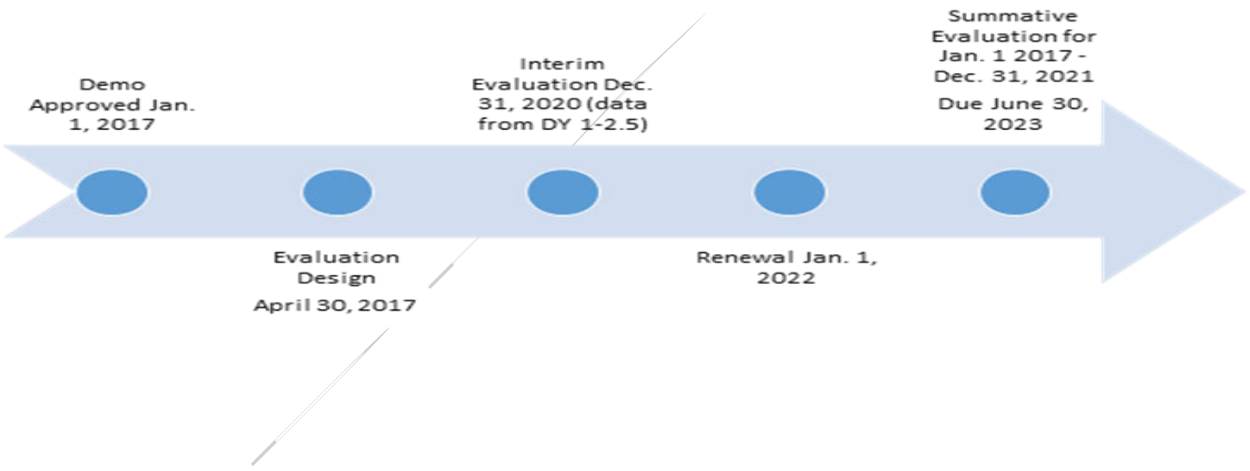
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the District's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other District Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the District's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the District should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the District is required to publish to the District's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS, pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports
The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the District's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the District would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the District's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the District should include basic information about the demonstration, such as:

1. The issues that the District is trying to address with its section 1115 demonstration and/or expenditure authorities, how the District became aware of the issue, the potential magnitude of the issue, and why the District selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the District and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5. Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the District should:

1. Describe how the District's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2. Identify the District's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and

c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the District is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.
The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions – The District may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the District presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the District will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the District did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other District Initiatives – In this section, the District will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the District's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the District with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the District and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design

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:
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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	
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

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	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	
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

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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

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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

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	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

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	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

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	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;

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	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.

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	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.

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	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

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	• 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.

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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

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	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.

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	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)

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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

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.

Current State:

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:

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[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:

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Section III – Relevant Documents

Not Applicable.

Attachment A – SUD Health Information Technology (IT) Plan

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

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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.

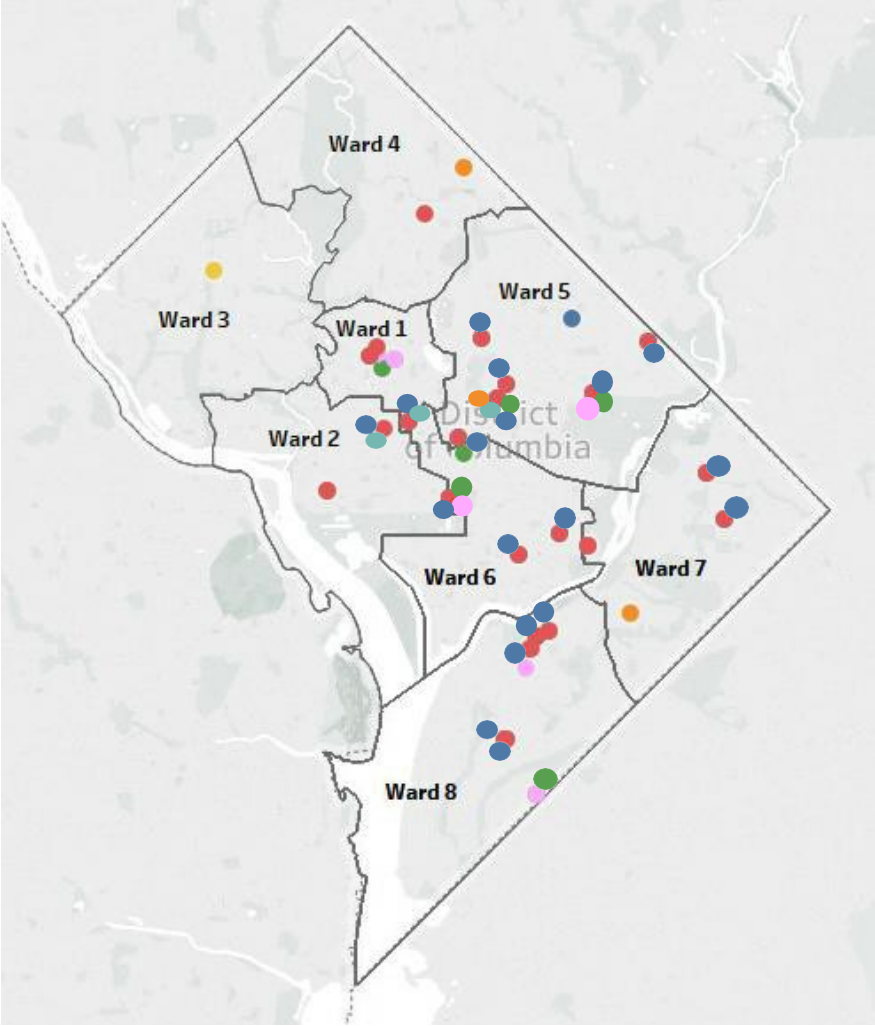
Appendix III – Certified SUD Providers by ASAM Level of Care Enrolled in Medicaid[1]

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.

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

State	District of Columbia
Demonstration name	Behavioral Health Transformation
Approval date for demonstration	11/06/2019
Approval period for SUD	01/01/2020 – 12/31/2024
Approval date for SUD, if different from above	
Implementation date of SUD, if different from above	
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	The goal of the demonstration is for the District to maintain and enhance access to opioid use disorder (OUD) and other substance use disorder (SUD) services; and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SUD. This demonstration authorizes the District to receive federal financial participation (FFP) for delivering high-quality, clinically appropriate treatment to beneficiaries diagnosed with SUD and receiving treatment while they are short-term residents in settings that qualify as Institutions for Mental Diseases (IMD). This demonstration also complements the District's efforts to implement models of care that are focused on increasing supports for individuals outside of institutions, in home and community-based settings (HCBS) to improve their access to SUD services at varied levels of intensity, and to combat OUD and other SUDs among District residents.

2. Proposed Modifications to SUD Narrative Information on Implementation, by Milestone or Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SUD Health Information Technology (Health IT)		

Summary of proposed modification	Related metric (if any)	Justification for modification
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-related Metrics		
Please see notes in columns P and U of the monitoring workbook for additional information on metric issues.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Other Demonstration Reporting		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
Provide a brief description of any changes or modifications the state expects to make in its narrative reporting, relative to the expectations described in the SUD Monitoring Report Template (Narrative Information on Implementation)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting-

☒ The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

If a state's monitoring protocol is approved after its first quarterly monitoring report submission date, the state should report data to CMS retrospectively for any prior quarters of SUD demonstration implementation. States are expected to submit retrospective metrics data in the state's second monitoring report submission after monitoring protocol approval, or propose an alternative plan for reporting retrospectively on its SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the state's demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Table 3: Narrative Information on Implementation, by Milestone and Reporting Topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data (for example, unlike other monitoring report submissions, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for states to provide context for its retrospective metrics data, to support CMS's review and interpretation. For example, consider a state that submits data showing an increase in the number of medication assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its report (under Milestone 4) by briefly summarizing the trend and providing context that during this period, the state implemented a grant that supported training for new MAT providers throughout the state.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval:

5. Reporting SUD Demonstration Metrics and Narrative Information

The state should review the guidance in Appendix A of the instructions document in order to attest it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its SUD demonstration approval period.

☒ The state has completed the table below according to the guidance in Appendix A of the instructions document and attests to reporting metrics and narrative information in its quarterly and annual reports according as described.

☐ The state has reviewed Appendix A of the instructions document and completed the table below with the following deviations: .

Table A. District of Columbia reporting in quarterly and annual monitoring reports

Dates of reporting quarter	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
January 1, 2020 – March 31, 2020	DY1 Q1	7/31/2020	• Narrative information: SUD DY1 Q1 • Other monthly and quarterly metrics: None • Annual metrics that are established quality measures: None • Other annual metrics: None
April 1, 2020 – June 30, 2020	DY1 Q2	8/29/2020	• Narrative information: SUD DY1 Q2 • Grievances and appeals (no critical incidents): SUD DY1 Q2 • Other monthly and quarterly metrics: SUD DY1 Q1 • Annual metrics that are established quality measures: None • Other annual metrics: None
July 1, 2020 – September 30, 2020	DY1 Q3	11/29/2020	• Narrative information: SUD DY1 Q3 • Grievances and appeals (no critical incidents): SUD DY1 Q3 • Other monthly and quarterly metrics: SUD DY1 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2020 – December 31, 2020	DY1 Q4	3/30/2021	• Narrative information: SUD DY1 Q4 • Grievances and appeals: SUD DY1 Q4 • Other monthly and quarterly metrics: SUD DY1 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2021 – March 31, 2021	DY2 Q1	5/30/2021	• Narrative information: SUD DY2 Q1 • Grievances and appeals: SUD DY2 Q1 • Other monthly and quarterly metrics: SUD DY1 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SUD DY1 (calculated for DY1)

Dates of reporting quarter	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
April 1, 2021 – June 30, 2021	DY2 Q2	8/29/2021	• Narrative information: SUD DY2 Q2 • Grievances and appeals: SUD DY2 Q2 • Other monthly and quarterly metrics: SUD DY2 Q1 • Annual metrics that are established quality measures: SUD DY1 (calculated for CY 2020) • Other annual metrics: None
July 1, 2021 – September 30, 2021	DY2 Q3	11/29/2021	• Narrative information: SUD DY2 Q3 • Grievances and appeals: SUD DY2 Q3 • Other monthly and quarterly metrics: SUD DY2 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2021 – December 31, 2021	DY2 Q4	3/30/2022	• Narrative information: SUD DY2 Q4 • Grievances and appeals: SUD DY2 Q4 • Other monthly and quarterly metrics: SUD DY2 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2022 – March 31, 2022	DY3 Q1	5/30/2022	• Narrative information: SUD DY3 Q1 • Grievances and appeals: SUD DY3 Q1 • Other monthly and quarterly metrics: SUD DY2 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SUD DY2 (calculated for DY2)
April 1, 2022 – June 30, 2022	DY3 Q2	8/29/2022	• Narrative information: SUD DY3 Q2 • Grievances and appeals: SUD DY3 Q2 • Other monthly and quarterly metrics: SUD DY3 Q1 • Annual metrics that are established quality measures: SUD DY2 (calculated for CY 2021) • Other annual metrics: None
July 1, 2022 – September 30, 2022	DY3 Q3	11/29/2022	• Narrative information: SUD DY3 Q3 • Grievances and appeals: SUD DY3 Q3 • Other monthly and quarterly metrics: SUD DY3 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None

Dates of reporting quarter	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
October 1, 2022 – December 31, 2022	DY3 Q4	3/30/2023	• Narrative information: SUD DY3 Q4 • Grievances and appeals: SUD DY3 Q4 • Other monthly and quarterly metrics: SUD DY3 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2023 – March 31, 2023	DY4 Q1	5/30/2023	• Narrative information: SUD DY4 Q1 • Grievances and appeals: SUD DY4 Q1 • Other monthly and quarterly metrics: SUD DY3 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SUD DY3 (calculated for DY3)
April 1, 2023 – June 30, 2023	DY4 Q2	8/29/2023	• Narrative information: SUD DY4 Q2 • Grievances and appeals: SUD DY4 Q2 • Other monthly and quarterly metrics: SUD DY4 Q1 • Annual metrics that are established quality measures: SUD DY3 (calculated for CY 2022) • Other annual metrics: None
July 1, 2023 – September 30, 2023	DY4 Q3	11/29/2023	• Narrative information: SUD DY4 Q3 • Grievances and appeals: SUD DY4 Q3 • Other monthly and quarterly metrics: SUD DY4 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2023 – December 31, 2023	DY4 Q4	3/30/2024	• Narrative information: SUD DY4 Q4 • Grievances and appeals: SUD DY4 Q4 • Other monthly and quarterly metrics: SUD DY4 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2024 – March 31, 2024	DY5 Q1	5/30/2024	• Narrative information: SUD DY5 Q1 • Grievances and appeals: SUD DY5 Q1 • Other monthly and quarterly metrics: SUD DY4 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SUD DY4 (calculated for DY4)

Dates of reporting quarter	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
April 1, 2024 – June 30, 2024	DY5 Q2	8/29/2024	• Narrative information: SUD DY5 Q2 • Grievances and appeals: SUD DY5 Q2 • Other monthly and quarterly metrics: SUD DY5 Q1 • Annual metrics that are established quality measures: SUD DY4 (calculated for CY 2023) • Other annual metrics: None
July 1, 2024 – September 30, 2024	DY5 Q3	11/29/2024	• Narrative information: SUD DY5 Q3 • Grievances and appeals: SUD DY5 Q3 • Other monthly and quarterly metrics: SUD DY5 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2024 – December 31, 2024	DY5 Q4	3/30/2025	• Narrative information: SUD DY5 Q4 • Grievances and appeals: SUD DY5 Q4 • Other monthly and quarterly metrics: SUD DY5 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None

Medicaid Section 1115 SUD Demonstration Monitoring Protocol - Planned metrics
State: District of Columbia
Demonstration Name: Behavioral Health Transformation
Submitted on: 11/02/2020

#	Metric name	Metric description	Standard information on CMS-provided metrics: Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline, annual goals, and demonstration target: Period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Alignment with CMS-provided technical specifications: reporting matches the CMS-provided	specifications (different data source, definition, codes, target population, etc.)	Initial reporting date: measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	metric will be submitted (Format: DIY1 Q3 report)	which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Medical record review or claims	Month	Quarterly	Recommended	N										
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Recommended	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	Y	
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	Y	
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	Y	
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopulatio	1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD during the measurement period	Milestone 1	CMS-constructed	Other annual metric	Claims; State-specific IMD database	Year	Annually	Required	Y	1/1/2020-12/31/2020	no more than 30 days	no more than 30 days	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries with a new episode of alcohol or other drug (AOD)ADD abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	increase	N	DHCF does not currently have access to suspended, pending and denied cla	1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	The percentage of individuals≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	The percentage of individuals≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission; NQF #1664]	SUB-3 rate: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a rate: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.[3]	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Medical record review or claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure][4]	Percentage of ED visits for beneficiaries who have a principal diagnosis of AOD abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	DHCF does not currently have access to suspended, pending and denied cla	1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure][4]	Percentage of ED visits for beneficiaries who have a principal diagnosis of mental illness and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	DHCF does not currently have access to suspended, pending and denied cla	1/1/2020-12/31/2020	DIY2 Q2 report	08/29/2021	N	
Q1	Number of active DC HIE behavioral health provider users	Number of active DC HIE behavioral health provider users	Health IT	State-identified	HIT	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	State-identified metric, no CMS-provided specifications	01/01/2020-01/31/2020	DIY1 Q2 report	08/29/2020	N	
S1	Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE	Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE	Health IT	State-identified	HIT	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	State-identified metric, no CMS-provided specifications	01/01/2020-01/31/2020	DIY1 Q2 report	08/29/2020	N	
S2	Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE	Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE	Health IT	State-identified	HIT	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	State-identified metric, no CMS-provided specifications	01/01/2020-01/31/2020	DIY1 Q2 report	08/29/2020	N	
Q2	Number of behavioral health providers managed in provider directory	Number of behavioral health providers managed in provider directory	Health IT	State-identified	HIT	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	State-identified metric, no CMS-provided specifications	01/01/2020-01/31/2020	DIY1 Q2 report	08/29/2020	N	
Q3	Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days	Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days	Health IT	State-identified	HIT	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	State-identified metric, no CMS-provided specifications	01/01/2020-01/31/2020	DIY1 Q2 report	08/29/2020	N	
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-1/31/2020	DIY1 Q2 report	08/29/2020	N	
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	quarter	Annually	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause o overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	Y	DHCF will start reporting this data once it enters into the proper data sharing agreements with agencies with overdose death data and expects to begin reporting by Q1 of CY 2021.
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	Y	DHCF will start reporting this data once it enters into the proper data sharing agreements with agencies with overdose death data and expects to begin reporting by Q1 of CY 2021.
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
29	SUD Spending Within IMDs	Total Medicaid SUD spending on residential or inpatient treatment within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DIY2 Q1 report	05/30/2021	N	

Medicaid Section 1115 SUD Demonstration Monitoring Protocol - Planned metrics

State	District of Columbia
Demonstration Name	Behavioral Health Transformation
Submitted on	11/02/2020

			Standard information on CMS-provided metrics								Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications		Initial reporting date		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	reporting matches the CMS-provided	specifications (different data source, definition, codes, target population, etc.)	measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	metric will be submitted (Format: DY1 Q3 report)	which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied cla	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	Y	01/01/2020 - 02/28/2021	decrease	decrease	N	The District's waiver reporting will report grievances related to services for SUD delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report grievances related to SUD that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021. DHCF revised the MCO grievances reporting template to enable identification of grievances related to SMI treatment. DHCF will work with the MCOs to make any necessary changes in their system to enable grievance reporting based on the new reporting requirements, which will go into effect on October 1, 2020.	04/01/2020-6/30/2020	DY1 Q2 report	08/31/2020	Y	The District's waiver reporting will report grievances related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report grievances related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021.
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	Y	01/01/2020 - 02/28/2021	decrease	decrease	N	The District's waiver reporting will report appeals related to services for SUD delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report appeals related to SUD that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021. DHCF revised the MCO appeals reporting template to enable identification of grievances related to SUD treatment. DHCF will work with the MCOs to make any necessary changes in their system to enable appeals reporting based on the new reporting requirements, which will go into effect on October 1, 2020.	04/1/2020-06/30/2020	DY1 Q2 report	08/31/2020	Y	The District's waiver reporting will report appeals related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report appeals related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021.
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	Y	10/01/2020 - 09/30/2021	decrease	decrease	N	The District will be able to report critical incidents related to SUD starting in Q4 of CY 2020. The Department of Behavioral Health has a system for reporting Major and Unusual Incidents in the Behavioral Health system. Critical Incidents include all incidents reported in this policy here (https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/480.1AA2021-224_1.pdf), excluding categories 20b, 20c, and 23. Please note that the style of reporting does not contain information on all individuals' insurance type. We think the data will still be useful and worth reporting because Medicaid beneficiaries are an overwhelming amount of those in the behavioral health system and all facilities in the behavioral health system serve Medicaid clients. Also, many critical incidents (such as a fire) at a facility would affect many individuals at once regardless of insurance type. We believe a critical incident involving a facility may also provide an indicator of facility quality that is relevant to Medicaid beneficiaries even if the specific incident affected someone with another insurance type. However, the current tracking system for Major and Unusual Incidents does not currently allow for separating out incidents related to SMI/SED and SUD. The tracking system will be able to do so starting in Q4 of CY 2020, so reporting will be unavailable for Q1, Q2, and Q3 of CY 2020.	10/1/2020-12/31/2020	DY1 Q4 report	02/01/2021	Y	The current tracking system for Major and Unusual Incidents does not currently allow for separating out incidents related to SMI/SED and SUD. The tracking system will be able to do so starting in Q4 of CY 2020, so reporting will be unavailable for Q1, Q2, and Q3 of CY 2020.

*There are no CMS-provided metrics related to milestone 2 or milestone 3.
^ Rates 1 and 2 reported for metric 17(1) correspond to rates 2 and 3 for metric 17 from 1115 SUD Technical Specifications for Monitoring Metrics Version 1.1 Manual
^ Rates 1 and 2 reported for metric 17(2) correspond to rates 1 and 2 for metric 17 from 1115 SUD Technical Specifications for Monitoring Metrics Version 1.1 Manual

The SUD Monitoring Protocol Workbook (Part A) is also available in spreadsheet format on Medicaid.gov

1. Title Page for the State's SMI/SED Demonstration or SMI/SED Components of Broader Demonstration

State	District of Columbia
Demonstration name	Behavioral Health Transformation
Approval date for demonstration	11/06/2019
Approval period for SMI/SED	01/01/2020 – 12/31/2024
Approval date for SMI/SED, if different from above	Click here to enter text.
Implementation date of SMI/SED, if different from above	Click here to enter text.
SMI/SED (or if broader demonstration, then SMI/SED -related) demonstration goals and objectives	The goal of this demonstration is for the District to maintain and enhance access to mental health services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with serious mental illness (SMI) and serious emotional disturbance (SED). This demonstration authorizes the District to receive federal financial participation (FFP) for delivering high-quality, clinically appropriate treatment to beneficiaries diagnosed with SMI and receiving treatment while they are short-term residents in settings that qualify as Institutions for Mental Diseases (IMD). This demonstration also complements the District's efforts to implement models of care that are focused on increasing supports for individuals outside of institutions, in home and community-based settings (HCBS) to improve their access to SMI/SED services at varied levels of intensity.

2. Proposed Modifications to SMI/SED Narrative Information on Implementation, by Milestone or Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Increasing Access to Continuum of Care, Including Crisis Stabilization Services (Milestone 3)		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. SMI/SED Health Information Technology (Health IT)		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Other SMI/SED-related Metrics		
Please see notes in columns P and U of the monitoring workbook for additional information on metric issues.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Annual Assessment of the Availability of Mental Health Providers		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SMI/SED Financing Plan		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Budget Neutrality		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. SMI/SED-Related Demonstration Operations and Policy		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SMI/SED Demonstration Evaluation Update		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

Summary of proposed modification	Related metric (if any)	Justification for modification
12. Other Demonstration Reporting		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Notable State Achievements and/or Innovations		
☐ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SMI/SED Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Annual Assessment of the Availability of Mental Health Providers Reporting

☒ The state will use the following time period for reporting of its Annual Assessment of the Availability of Mental Health Providers**:**

The state will use data as of December 31 to conduct its Annual Assessment of Availability of Mental Health Providers.

4. Acknowledgement of Budget Neutrality Reporting

☒ The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

5. Retrospective reporting

If a state's monitoring protocol is approved after its first quarterly monitoring report submission date, the state should report data to CMS retrospectively for any prior quarters of SMI/SED demonstration implementation. States are expected to submit retrospective metrics data in the state's second monitoring report submission after monitoring protocol approval, or propose an alternative plan for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the state's demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Table 3: Narrative Information on Implementation, by Milestone and Reporting Topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data (for example, unlike other monitoring report submissions, the state is not required to describe all metrics changes (+ or) greater than 2 percent). Rather, the assessment is an opportunity for states to provide context for its retrospective metrics data, to support CMS's review and interpretation. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (metric #15) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its report (under Milestone 3) by briefly summarizing the trend and providing context that during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission after approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval:

6. Reporting SMI Demonstration Metrics and Narrative Information

The state should review the guidance in Appendix A of the instructions document in order to attest it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its SMI/SED demonstration approval period.

☒ The state has completed the table below according to the guidance in Appendix A of the instructions document and attests to reporting metrics and narrative information in its quarterly and annual reports as described.

☐ The state has reviewed Appendix A of the instructions document and completed the table below with the following deviations:

Table A. District of Columbia reporting in quarterly and annual monitoring reports

Dates of reporting quarter	SMI/SED DY	Report due (per STCs schedule)	Measurement period associated with SMI/SED information in report, by reporting category
January 1, 2020 – March 31, 2020	DY1 Q1	7/31/2020	• Narrative information: SMI/SED DY1 Q1 • Other monthly and quarterly metrics: None • Annual metrics that are established quality measures: None • Other annual metrics: None
April 1, 2020 – June 30, 2020	DY1 Q2	8/29/2020	• Narrative information: SMI/SED DY1 Q2 • Grievances and appeals (no critical incidents): SMI/SED DY1 Q2 • Other monthly and quarterly metrics: SMI/SED DY1 Q1 • Annual metrics that are established quality measures: None • Other annual metrics: None
July 1, 2020 – September 30, 2020	DY1 Q3	11/29/2020	• Narrative information: SMI/SED DY1 Q3 • Grievances and appeals (no critical incidents): SMI/SED DY1 Q3 • Other monthly and quarterly metrics: SMI/SED DY1 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2020 – December 31, 2020	DY1 Q4	3/30/2021	• Narrative information: SMI/SED DY1 Q4 • Grievances and appeals: SMI/SED DY1 Q4 • Other monthly and quarterly metrics: SMI/SED DY1 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2021 – March 31, 2021	DY2 Q1	5/30/2021	• Narrative information: SMI/SED DY2 Q1 • Grievances and appeals: SMI/SED DY2 Q1 • Other monthly and quarterly metrics: SMI/SED DY1 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SMI/SED DY1 (calculated for DY1)

Dates of reporting quarter	SMI/SED DY	Report due (per STCs schedule)	Measurement period associated with SMI/SED information in report, by reporting category
April 1, 2021 – June 30, 2021	DY2 Q2	8/29/2021	• Narrative information: SMI/SED DY2 Q2 • Grievances and appeals: SMI/SED DY2 Q2 • Other monthly and quarterly metrics: SMI/SED DY2 Q1 • Annual metrics that are established quality measures: SMI/SED DY1 (calculated for CY 2020) • Other annual metrics: None
July 1, 2021 – September 30, 2021	DY2 Q3	11/29/2021	• Narrative information: SMI/SED DY2 Q3 • Grievances and appeals: SMI/SED DY2 Q3 • Other monthly and quarterly metrics: SMI/SED DY2 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2021 – December 31, 2021	DY2 Q4	3/30/2022	• Narrative information: SMI/SED DY2 Q4 • Grievances and appeals: SMI/SED DY2 Q4 • Other monthly and quarterly metrics: SMI/SED DY2 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2022 – March 31, 2022	DY3 Q1	5/30/2022	• Narrative information: SMI/SED DY3 Q1 • Grievances and appeals: SMI/SED DY3 Q1 • Other monthly and quarterly metrics: SMI/SED DY2 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SMI/SED DY2 (calculated for DY2)
April 1, 2022 – June 30, 2022	DY3 Q2	8/29/2022	• Narrative information: SMI/SED DY3 Q2 • Grievances and appeals: SMI/SED DY3 Q2 • Other monthly and quarterly metrics: SMI/SED DY3 Q1 • Annual metrics that are established quality measures: SMI/SED DY2 (calculated for CY 2021) • Other annual metrics: None

Dates of reporting quarter	SMI/SED DY	Report due (per STCs schedule)	Measurement period associated with SMI/SED information in report, by reporting category
July 1, 2022 – September 30, 2022	DY3 Q3	11/29/2022	• Narrative information: SMI/SED DY3 Q3 • Grievances and appeals: SMI/SED DY3 Q3 • Other monthly and quarterly metrics: SMI/SED DY3 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2022 – December 31, 2022	DY3 Q4	3/30/2023	• Narrative information: SMI/SED DY3 Q4 • Grievances and appeals: SMI/SED DY3 Q4 • Other monthly and quarterly metrics: SMI/SED DY3 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2023 – March 31, 2023	DY4 Q1	5/30/2023	• Narrative information: SMI/SED DY4 Q1 • Grievances and appeals: SMI/SED DY4 Q1 • Other monthly and quarterly metrics: SMI/SED DY3 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SMI/SED DY3 (calculated for DY3)
April 1, 2023 – June 30, 2023	DY4 Q2	8/29/2023	• Narrative information: SMI/SED DY4 Q2 • Grievances and appeals: SMI/SED DY4 Q2 • Other monthly and quarterly metrics: SMI/SED DY4 Q1 • Annual metrics that are established quality measures: SMI/SED DY3 (calculated for CY 2022) • Other annual metrics: None
July 1, 2023 – September 30, 2023	DY4 Q3	11/29/2023	• Narrative information: SMI/SED DY4 Q3 • Grievances and appeals: SMI/SED DY4 Q3 • Other monthly and quarterly metrics: SMI/SED DY4 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2023 –	DY4 Q4	3/30/2024	• Narrative information: SMI/SED DY4 Q4 • Grievances and appeals: SMI/SED DY4 Q4

Dates of reporting quarter	SMI/SED DY	Report due (per STCs schedule)	Measurement period associated with SMI/SED information in report, by reporting category
December 31, 2023			• Other monthly and quarterly metrics: SMI/SED DY4 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None
January 1, 2024 – March 31, 2024	DY5 Q1	5/30/2024	• Narrative information: SMI/SED DY5 Q1 • Grievances and appeals: SMI/SED DY5 Q1 • Other monthly and quarterly metrics: SMI/SED DY4 Q4 • Annual metrics that are established quality measures: None • Other annual metrics: SMI/SED DY4 (calculated for DY4)
April 1, 2024 – June 30, 2024	DY5 Q2	8/29/2024	• Narrative information: SMI/SED DY5 Q2 • Grievances and appeals: SMI/SED DY5 Q2 • Other monthly and quarterly metrics: SMI/SED DY5 Q1 • Annual metrics that are established quality measures: SMI/SED DY4 (calculated for CY 2023) • Other annual metrics: None
July 1, 2024 – September 30, 2024	DY5 Q3	11/29/2024	• Narrative information: SMI/SED DY5 Q3 • Grievances and appeals: SMI/SED DY5 Q3 • Other monthly and quarterly metrics: SMI/SED DY5 Q2 • Annual metrics that are established quality measures: None • Other annual metrics: None
October 1, 2024 – December 31, 2024	DY5 Q4	3/30/2025	• Narrative information: SMI/SED DY5 Q4 • Grievances and appeals: SMI/SED DY5 Q4 • Other monthly and quarterly metrics: SMI/SED DY5 Q3 • Annual metrics that are established quality measures: None • Other annual metrics: None

Medicaid Section 1115 SMI/SED Demonstration Protocol - Planned metrics	
State	District of Columbia
Demonstration Name	Behavioral Health Transformation
Demonstration Year (DY)	[Enter Demonstration Year] (Format: DY1, DY2, DY3, etc.)
Calendar Dates for DY	[Enter Calendar Dates for Demonstration Year] (Format: MM/DD/YYYY - MM/DD/YYYY)
Reporting Period	[Enter Reporting Period] (Format: Q1, Q2, Q3, Q4)
Calendar Dates for Reporting Period	[Enter Calendar Dates for Reporting Period (Format: MM/DD/YYYY - MM/DD/YYYY)
Submitted on	11/02/2020

	Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications		Initial reporting date			
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY–MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications (different data source, definition, codes, top-out punctation, etc.)	Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	Name of first report in which the metric will be submitted (Format: DY1 Q3 report)	Submission date of first report in which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	Two rates will be reported for this measure. 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUB-2a: Patients who received the brief intervention during the hospital stay.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N									
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	DHCF does not currently have access to suspended, pending and denied claims from MCOs. However, DHCF is currently revising its data collection process from MCOs to include this information in our Medicaid Data Warehouse and may be able to begin including these types of claims in our analyses in early 2021.	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission rate for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
5	Medication Reconciliation Upon Admission	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended	N									
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied claims from MCOs. However, DHCF is currently revising its data collection process from MCOs to include this information in our Medicaid Data Warehouse and may be able to begin including these types of claims in our analyses in early 2021.	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied claims from MCOs. However, DHCF is currently revising its data collection process from MCOs to include this information in our Medicaid Data Warehouse and may be able to begin including these types of claims in our analyses in early 2021.	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	Y	DHCF will start reporting this data once it enters into the proper data sharing agreements with agencies with suicide death data and expects to begin reporting by Q1 of CY 2021.
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	decrease	decrease	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	Y	DHCF will start reporting this data once it enters into the proper data sharing agreements with agencies with suicide death data and expects to begin reporting by Q1 of CY 2021.
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration or with SMI/SED who use inpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration or with SMI/SED who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration or with SMI/SED who used outpatient services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration or with SMI/SED who use emergency department services for mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	decrease	decrease	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration or with SMI/SED who used telehealth services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration or with SMI/SED who used any services related to mental health during the measurement period.	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	1/1/2020-12/31/2020	no more than 30 days	no more than 30 days	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	1/1/2020-12/31/2020	no more than 30 days	no more than 30 days	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries with SMI/SED who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
21	Count of Beneficiaries With SMI/SED (monthly)	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims have sufficient qualifying facility, or provider claims to qualify as having SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N	
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration (with a diagnosis and service history indicating SMI/SED) during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	Criminal justice status will be based on ever qualifying for this subpopul	1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCH-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement yea is >9.0%.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	Per CMS communication in 5/8/20 email, DHCF plans to deviate from th	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N									
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive a follow-up plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N									
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
27	Tobacco Use Screening and Follow-up for People with SMI or Alcohol or Other Drug Dependence	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported: • Percentage of adults with SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user • Percentage of adults with AOD who received a screening for tobacco use and follow-up for those identified as a current tobacco user	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N									
28	Alcohol Screening and Follow-up for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1-17 years of age with ongoing antipsychotic medication use who had metabolic testing during the year.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	Y		1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have received a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	N	DHCF does not currently have access to suspended, pending and denied	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
31	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	consistent	consistent	N	DHCF does not currently have access to suspended, pending and denied	1/1/2020-12/31/2020	DY2 Q2 report	08/29/2021	N	
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Total Medicaid costs for non-inpatient or residential services for mental health, among beneficiaries in the demonstration or with SMI/SED during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Total Medicaid costs for inpatient or residential services for mental health among beneficiaries with SMI/SED during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries with SMI/SED during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for not inpatient or residential services for mental health, among beneficiaries with SMI/SED during the measurement period.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N	
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	03/01/2020-02/28/2021	decrease	decrease	N	The District's waiver reporting will report grievances related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report grievances related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021. DHCF revised the MCO grievances reporting template to enable identification of grievances related to SMI treatment. DHCF will work with the MCOs to make any necessary changes in their system to enable grievance reporting based on the new reporting requirements, which will go into effect on October 1, 2020.	04/01/2020-06/30/2020	DY1 Q2 report	08/31/2020	Y	The District's waiver reporting will report grievances related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report grievances related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021.

37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	03/01/2020 - 02/28/2021	decrease	decrease	N	The District's waiver reporting will report appeals related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report appeals related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021. DHCF revised the MCO appeals reporting template to enable identification of grievances related to SMI treatment. DHCF will work with the MCOs to make any necessary changes in their system to enable appeals reporting based on the new reporting requirements, which will go into effect on October 1, 2020.	04/01/2020-06/30/2020	DY1 Q2 report	08/31/2020	Y	The District's waiver reporting will report appeals related to services for SMI/SED delivered to Medicaid beneficiaries that were made to the Department of Behavioral Health and the Office of the Health Care Ombudsman in DC starting in Q2 of 2020. The District's waiver reporting will report appeals related to SMI/SED that were made to Medicaid managed care organizations starting in either Q4 of CY 2020 or Q1 of CY 2021.
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	10/01/2020 - 09/30/2021	decrease	decrease	N	The District will be able to report critical incidents related to SMI/SED starting in Q4 of CY 2020. The Department of Behavioral Health has a system for reporting Major and Unusual Incidents in the Behavioral Health system. Critical Incidents include all incidents reported in this policy here (https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/ABS.1A%2075-.134_1.pdf), excluding categories 20b, 20c, and 23. Please note that the style of reporting does not contain information on all individuals' insurance type. We think the data will still be useful and worth reporting because Medicaid beneficiaries are an overwhelming amount of those in the behavioral health system and all facilities in the behavioral health system serve Medicaid clients. Also, many critical incidents (such as a fire) at a facility would affect many individuals at once regardless of insurance type. We believe a critical incident involving a facility may also provide an indicator of facility quality that is relevant to Medicaid beneficiaries even if the specific incident affected someone with another insurance type. However, the current tracking system for Major and Unusual Incidents does not currently allow for separating out incidents related to SMI/SED and SUD. The tracking system will be able to do so starting in Q4 of CY 2020, so reporting will be unavailable for Q1, Q2, and Q3 of CY 2020.	10/01/20-12/31/20	DY1 Q4 report	02/01/2021	Y	The current tracking system for Major and Unusual Incidents does not currently allow for separating out incidents related to SMI/SED and SUD. The tracking system will be able to do so starting in Q4 of CY 2020, so reporting will be unavailable for Q1, Q2, and Q3 of CY 2020.
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries with SMI/SED who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N						
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries with SMI/SED who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2020-12/31/2020	increase	increase	Y		1/1/2020-12/31/2020	DY2 Q1 report	05/30/2021	N						
Q1	*Number of active DC HIE behavioral health provider users*	*Number of active DC HIE behavioral health provider users*	Health IT	State-identified	*Other monthly and quarte*	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase			1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N						
Q1	*Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE*	*Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE*	Health IT	State-identified	*Other monthly and quarte*	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase			1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N						
Q2	*Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE*	*Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE*	Health IT	State-identified	*Other monthly and quarte*	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase			1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N						
Q2	*Number of behavioral health providers managed in provider directory*	*Number of behavioral health providers managed in provider directory*	Health IT	State-identified	*Other monthly and quarte*	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase			1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N						
Q3	*Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days*	*Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days*	Health IT	State-identified	*Other monthly and quarte*	DC HIE	Month	Quarterly	Required	Y	1/1/2020-12/31/2020	increase	increase			1/1/2020-1/31/2020	DY1 Q2 report	08/29/2020	N						

The SMI/SED Monitoring Protocol Workbook (Part A) is also available in spreadsheet format on Medicaid.gov

Medicaid Behavioral Health Transformation Demonstration

Final Evaluation Design

District of Columbia

Department of Health Care Finance

November 25, 2020

IMPAQ INTERNATIONAL LLC

SUBMITTED TO

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1115 Waiver Evaluation

TASK & DELIVERABLE

Task 3
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Table of Abbreviations

AHL	Access Help Line
AOD	Alcohol or Other Drug
APRN	Advanced Practice Registered Nurse
ARC	Assessment and Referral Center
ARIMA	Autoregressive Integrated Moving Average
ASAM	American Society of Addiction Medicine
ASARS	Adult Substance Abuse Rehabilitative Services
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHIP	Children's Health Insurance Plan
COO	Chief Operating Officer
CMO	Chief Medical Officer
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CNO	Chief Nursing Officer
COI	Conflicts of Interest
CPEP	Comprehensive Psychiatric Emergency Program
CRISP	Chesapeake Regional Information System for our Patients
CRT	DBH Community Response Team
DATA/WITS	District's Automated Treatment Accounting (System)
DAST	Drug Abuse Screening Test
DBH	Department of Behavioral Health
Demonstration	Behavioral Health Transformation Demonstration
DHCF	Department of Health Care Finance
DID	Difference-in-Differences
District	District of Columbia
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUA	Data Use Agreement
DY	Demonstration Year
ED	Emergency Department
EHR	Electronic Health Records
EUA	Enterprise User Administration
FDA	Federal Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FISMA	Federal Information Security Management Act of 2002

FMAP	Federal Medical Assistance Percentage
FQHCs	Federally Qualified Health Centers
FTP	File Transfer Protocol
FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness
FY	Fiscal Year
HCBS	Home- and Community-Based Settings
HEDIS	Health Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HWR	Hospital-Wide Readmission
iCAMS	DC Department of Behavioral Health's electronic health records
IDR	Integrated Data Repository (CMS)
IFE	IMPAQ FISMA Enclave
IMD	Institution for Mental Disease
IPF	Inpatient Psychiatric Facility
IP	Inpatient
IPFQR	Inpatient Psychiatric Facility Quality Reporting
IT	Information Technology
ITS	Interrupted Time Series
LT	Long-term care
LOS	Length of Stay
MAT	Medication-Assisted Treatment
MCAC	Medical Care Advisory Committee (DC)
MCO	Managed Care Organization
MDW	Medicaid Data Warehouse
MHRS	Mental Health Rehabilitation Services
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NHIS	National Health Interview Survey
NQF	National Quality Forum
NSDUH	National Survey on Drug Use and Health
NSSATS	National Survey of Substance Abuse Treatment Services
OCME	Office of the Chief Medical Examiner
OCP	Office of Contracting and Procurement
OUD	Opioid Use Disorder
OT	Outpatient
PDMP	Prescription Drug Monitoring Program
PIW	Psychiatric Institute of Washington
QAP	Quality Assurance Plan
RSS	Recovery Support Services
RX	Pharmacy
SAMHSA	Substance Abuse and Mental Health Services Administration
SE	Supported Employment

SED	Serious Emotional Disturbance
SFTP	SSH [Secure Shell] File Transfer Protocol
SMI	Serious Mental Illness
SOR	State Opioid Response
SOW	Statement of Work
SSH	Secure Shell
STCs	Special Terms and Conditions
SUD	Substance Use Disorder
SUPPORT	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
T-MSIS	Transformed Medicaid Statistical Information System
TREM	Trauma Recovery and Empowerment Model
TST	Trauma Systems Therapy
USCIS	United States Customs and Immigration Services
WM	Withdrawal Management

A. GENERAL BACKGOUND INFORMATION

The District of Columbia (District) received approval from the Centers for Medicare & Medicaid Services (CMS) for a Section 1115(a) demonstration entitled Behavioral Health Transformation Demonstration (Demonstration) on November 6, 2019. The Demonstration has three overarching aims that include expanding the continuum of Medicaid behavioral health services and supports in the District, advancing the District's goals to improve outcomes for individuals with opioid use disorder (OUD) and other substance use disorders (SUDs), and supporting a more person-centered, integrated, and coordinated system of physical and behavioral health care for Medicaid beneficiaries.

The Demonstration will enable the District to receive federal financial participation (FFP) for inpatient, residential, and other services provided to eligible Medicaid beneficiaries while residing in Institutions for Mental Diseases (IMDs) for treatment of SUD, serious mental illness (SMI), and/or serious emotional disturbance (SED). In addition, the Demonstration will:

- Provide community-based services designed to improve behavioral health care for beneficiaries with SUD and/or SMI/SED.
- Provide temporary authority for crisis intervention, recovery support services, transition planning, supported employment services, and other related benefit changes.
- Eliminate the current $1 copayment requirement for certain prescriptions associated with medication assisted treatment (MAT).

Under the special terms and conditions (STCs) outlined in CMS's approval letter, the District's Department of Health Care Finance (DHCF), which operates the District's Medicaid program, must contract with an independent third party to evaluate the Demonstration.[1] DHCF contracted with IMPAQ International, LLC (IMPAQ) to conduct the independent evaluation of the Demonstration. The IMPAQ Team includes IMPAQ, its subcontractor, L&M Policy Research, LLC and SUD and SMI/SED consultant, Dr. Victor Capoccia. This Evaluation Design Report provides an overview of the IMPAQ Team's evaluation design for assessing the effects of the Demonstration. This document follows CMS's recommended structure for evaluation designs, as outlined below.

A. **General Background Information.** This section describes the District's behavioral health challenges that served as the impetus for the Demonstration, the Demonstration's goals and time period, and the evaluation time period.

B. **Evaluation Questions and Hypotheses.** This section includes a driver diagram that links the goals of the Demonstration to primary and secondary interventions and policy changes that will drive expected outcomes. The section also articulates the hypotheses behind each Demonstration goal and provides research questions that we will use to test the hypotheses.

C. **Methodology.** This section outlines the evaluation design and describes the key elements of the approach, including target and comparison populations, the evaluation

[1] CMS Administrator Verma, Seema. Received by Senior Deputy Director and State Medicaid Director at the District of Columbia Department of Health Care Finance Melisa Byrd. (2019 Nov 5). Retrieved from: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20SMI-SUD_STCs%20for%201115%20Waiver%20110619.pdf

period, data sources (such as claims data, beneficiary surveys, and interviews), measures, and quantitative and qualitative analytic methods.

D. **Methodological Limitations.** This section discusses the limitations and confounding factors that could affect the results of the evaluation, along with proposed mitigation strategies that we will employ.

E. **Attachments.** The Evaluation Design Report includes attachments provided by DHCF that address the selection of the independent evaluator, the evaluation budget, and the timeline and major milestones related to the evaluation.

A.1 DEMONSTRATION CONTEXT

The District's Medicaid behavioral health delivery system is complex, with services financed by Medicaid (administered either through managed care organizations [MCOs] or fee-for-service [FFS] arrangements) and provided by a network of private- and public-sector providers. Many of the behavioral health community-based providers are contractually supported by the District's Department of Behavioral Health (DBH) for services not covered by Medicaid or other insurance. Due to the multiple overlapping delivery systems as well as differing administrative and financing roles of DHCF and DBH, Medicaid providers and beneficiaries are often ill-informed about available benefits and coverage requirements.

Over the past five years, the District has experienced an increased need for SUD treatment, and OUD treatment in particular, as the number of drug-overdose deaths spiked by 236 percent between 2014 and 2017 (from 83 to 279) mirroring trends in other states.[2] The District is facing a need for increased capacity for appropriate levels of care, particularly critical levels of care, and is seeking to address the under-utilization of MAT. Historically, Medicaid did not allow FFP for care provided to individuals age 21-64 during stays in IMDs—hospitals, nursing facilities, or other institutions with more than 16 beds. This IMD exclusion limited the Medicaid supports available for individuals needing services in facilities that specialize in the treatment of psychiatric disorders and SUD.

Prior to waiver implementation, residential treatment for SUDs and short-term, medically monitored withdrawal-management (WM) services delivered in an IMD were provided with local-only funding through DBH. In addition, although Medicaid expansion has helped to reduce the unmet treatment needs of childless adult beneficiaries, the District still faces shortages in appropriate levels of care and evidence-based and specialized practices for youth with SED. This is particularly problematic for the District, where in Fiscal Year (FY) 2019 nearly 44 percent of its 72,959 Medicaid FFS beneficiaries had a behavioral health diagnosis, and an estimated 32 percent had an SMI/SED or SUD diagnosis.

A major barrier to addressing SUD is a lack of availability of critical levels of care for people with SMI/SED and SUD. Beneficiaries with co-occurring SMI and SUD face structural barriers, namely lack of treatment options but also difficulty navigating complex systems and entry points into treatment.[3] Individuals with SMI may require stabilization in an intensive setting before

[2] District of Columbia, Department of Behavioral Health. (2019 Mar). *LIVE.LONG.DC.: Washington, DC's Strategic plan to reduce opioid use, misuse and related deaths*. Retrieved from: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf

[3] Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016 Feb). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *J Subst Abuse Treat*., 61, 47–59. doi:10.1016/j.jsat.2015.09.006

moving to less intensive levels of care. People with co-occurring disorders require a specialized environment, with trained professionals and a combination of medication and counseling.[4] Culturally competent care is also an important facilitator to effective behavioral health treatment.[5] Co-occurring SMI and SUD are associated with difficulties engaging in and adhering to treatment.[6] Prior heroin use and homelessness are also associated with a lower likelihood of treatment completion.[7] Further, older heroin users, such as those more prevalent in the District, tend to have co-occurring mental health co-morbidities and face issues of marginalization that impact treatment seeking and treatment retention.[8]

Additionally, the demographic profile of OUD-related deaths in the District differs from that in some other states. Eighty percent of the non-elderly population in the District's Medicaid program is non-Hispanic African American, in part reflecting significant income disparities that contribute to a higher than national-average number of residents living in poverty.[9,10] These demographics, in addition to the service landscape, are driving factors in the rate of opioid-related deaths in the District, which were initially concentrated among older, African-American men who are long-term heroin users, rather than among younger white adults who first became addicted to opioids through prescription drug use.[11] As DHCF notes in its waiver proposal, there was also a disparity in the services available between Medicaid FFS and managed care because care in an IMD was allowable as an "in lieu of" service for MCO beneficiaries under certain circumstances.[12] Additionally, the fragmentation of the managed care-FFS landscape results in coordination challenges, confusion about entry points to care, and gaps in services (particularly for FFS beneficiaries).

[4] Substance Abuse and Mental Health Services Administration (SAMHSA). (2019 Jan). *Behavioral health treatments and services*. Retrieved from: https://www.samhsa.gov/find-help/treatment

[5] SAMHSA. (first printed in 2014). Tip 59. Improving cultural competence. Retrieved from: https://store.samhsa.gov/system/files/sma14-4849.pdf

[6] Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *J Subst Abuse Treat*, 61, 47–59. doi:10.1016/j.jsat.2015.09.006

[7] Sanchez, J., Sahker, E., & Arndt, S. (2020 Mar). The Assessment of Recovery Capital (ARC) predicts substance abuse treatment completion. *Addict Behav*, 102. doi:10.1016/j.addbeh.2019.106189

[8] Rosen, D., Hunsaker, A., Albert, S. M., Cornelius, J. R., Reynolds, C. F., 3rd. (2011). Characteristics and consequences of heroin use among older adults in the United States: A review of the literature, treatment implications, and recommendations for further research. *Addict Behav*, 36(4), 279–285. doi:10.1016/j.addbeh.2010.12.012

[9] Kaiser Family Foundation. (2018). *Distribution of the nonelderly with Medicaid by race/ethnicity*. Retrieved from: https://www.kff.org/medicaid/state-indicator/distribution-by-raceethnicity-4/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[10] Government of the District of Columbia, Department of Health. (2018) *Health equity report: District of Columbia 2018*. Retrieved from: https://app.box.com/s/yspij8v81cxqyebl7gj3uifjumb7ufsw

[11] District of Columbia, Department of Behavioral Health. (2019 Mar). *LIVE. LONG. DC.: Washington, DC's Strategic plan to reduce opioid use, misuse and related deaths.* Retrieved from: https://livelong.dc.gov/sites/default/files/dc/sites/opioid/page_content/attachments/LIVE-LONG-DC-WashingtonDCsOpioidStrategicPlan-MarchRevision.pdf

[12] District of Columbia. (2019). *District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program*. Retrieved from: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/1115%20Final%20Demonstration%20Application%206.3.19%20.pdf

Nationally, health outcome disparities have been linked to racial disparities in access to care.[13] Increased use of managed care may help decrease under-utilization of care by groups with health disparities.[14] To address these issues at the local level and improve care coordination, the District recently announced plans to move toward a fully managed Medicaid program over the next five years, starting in 2020. In October 2020, DHCF transitioned approximately 17,000 beneficiaries from FFS to the Medicaid managed care program.[15] As the District goes through a transition to managed care, it is important that evaluators understand this transition and its impacts on the composition of the remaining FFS population and other interactive effects.

The District has been implementing SUD, including OUD-specific, treatment reforms for several years and many of these initiatives will continue into the evaluation period. These reforms include locally funded initiatives and Medicaid policy reforms that focus on preventing substance use disorder by changing prescribing behavior, increasing the availability of overdose-reversal drugs, increasing the use of data to monitor and address changes in OUD trends, and direct outreach for overdose survivors. The development and implementation of *Live. Long. DC*., the District's strategic plan to address OUD and opioid-related mortality, has been supported by more than 40 stakeholder groups, District government, and federal agencies since 2017. The District received a Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grant, which has funded a variety of activities including education on the benefits of naloxone, placed clinical-care coordinators and peer-recovery specialists in DBH-contracted methadone clinics and a primary care–physician practice group providing buprenorphine, and trained recovery coaches to use MAT and OUD competency.[16] The District has focused on discharge-planning and care-coordination requirements and currently operates two Health Home programs. It has also implemented intake and assessment sites using evidence-based criteria to determine appropriate level of care and services. To improve SUD treatment, infrastructure, and care coordination, the District kicked off a demonstration project in 2019 that is funded by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Section 1003. The grant funds education and technical assistance to build Medicaid provider capacity to treat individuals with SUD in community settings.[17]

The COVID-19 public health emergency has coincided with the launch of the Demonstration. It is uncertain what effects the resulting economic downturn might have on the number of uninsured individuals in the District and the Medicaid population. An increase in Medicaid enrollment would lead to an increase in the Demonstration population and potentially affect the metrics in the early years of the Demonstration. In addition, it is plausible that the pandemic will directly impact metrics used to evaluate the Demonstration. For example, the District could see an increase in overdose deaths and demand for mental health care to cope with pandemic stressors. The District may also experience a reduction in utilization of Demonstration

[13] Cook, B. L. (2007). Effect of Medicaid Managed Care on racial disparities in health care access. *Health Serv Res*, *42*(1 Pt 1), 124–145. doi:10.1111/j.1475-6773.2006.00611.x

[14] Marton, J., Yelowitz, A., Shores, M., & Talbert, J. C. (2016). Does Medicaid Managed Care help equalize racial and ethnic disparities in utilization? *Health Serv Res, 51*(3), 872–891. doi:10.1111/1475-6773.12396

[15] District of Columbia, Department of Health Care Finance. (2019 Sep). DHCF *Announces Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts*. Retrieved from: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts

[16] District of Columbia, Department of Behavioral Health (2019 Mar). *Our work.* Retrieved from: https://livelong.dc.gov/page/our-work

[17] District of Columbia, Department of Health Care Finance. (n.d.). *Demonstration Project to Increase Substance Use Provider Capacity.* Retrieved from: https://dhcf.dc.gov/page/demonstration-project-increase-substance-use-provider-capacity

community-based services due to COVID-19 stay at home orders and concerns about the safety of congregate settings of care.

To assist SUD providers who are experiencing a reduction in service volume and therefore revenue, DHCF is seeking approval of an emergency state plan amendment that would provide a 20 percent increase in reimbursement rates for certain SUD providers. At this time, DHCF is not implementing a reimbursement increase specific to SMI/SED providers, some of which have been able to use telehealth as a method of service delivery. However, certain pandemic-related payment enhancements (e.g., for federally qualified health centers) may benefit providers that serve individuals with SMI/SED. IMPAQ and DHCF will work together to account for changes in policy, provider and beneficiary behavior, and outcomes related to the pandemic that could affect the Demonstration, following evaluation best practices and CMS guidance.

A.2 BEHAVIORAL HEALTH TRANSFORMATION DEMONSTRATION

Demonstration and Evaluation Periods

The approval period for the District's Behavioral Health Transformation Demonstration is January 1, 2020 – December 31, 2024.[18] The evaluation period for the Demonstration is from January 1, 2020 – December 31, 2024. The Interim Evaluation Report will cover Demonstration activities between January 1, 2020, and June 30, 2022 (Demonstration Year [DY] 1-2.5). The Summative Evaluation Report, which will be the final evaluation deliverable to CMS, will cover Demonstration activities from January 1, 2020 – December 31, 2024 and will include quantitative data through the first quarter of DY 5 and qualitative observations for the remainder of the DY.[19] As outlined in Demonstration STCs, the summative evaluation report is due to CMS within 18 months of June 30, 2024 (i.e., by December 31, 2025). Should CMS require changes to the evaluation, the IMPAQ Team will work with the District to make the necessary revisions. This evaluation design is for the Demonstration as approved on November 6, 2019. It does not apply to an amendment, extension, renewal, or expansion of the Demonstration. The evaluation design follows CMS guidance and is organized around the District's and CMS's goals for the Demonstration and the evaluation.

Goals of the Demonstration

The Demonstration has three overarching aims:

- Ensuring that the District's Medicaid program provides a broader continuum of behavioral health services and supports for individuals with SMI/SED, SUD, or other behavioral health needs.
- Advancing the District's goals in the Opioid Strategic Plan*, Live. Long. DC*., to improve outcomes for individuals with OUD and other SUDs.
- Supporting movement towards a more person-centered system of physical and behavioral health care for Medicaid beneficiaries that facilitates coordinated treatment.

[18] The District received 24-month approval for certain additional waiver authorities. CMS Administrator Verma, Seema. Received by Senior Deputy Director and State Medicaid Director at DHCF Melisa Byrd. (2019 Nov 5). Retrieved from: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20SMI-SUD_STCs%20for%201115%20Waiver%20110619.pdf

[19] Ibid.

The Demonstration has SUD and SMI/SED components as well as components that impact both populations and those with co-occurring mental health and substance use disorders. The primary objectives of the SUD components are for the District to maintain and enhance access to OUD and other SUD services and to continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SUD. The primary objectives of the SMI/SED components are for the District to maintain and enhance access to mental health services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SMI and SED. The Demonstration authorizes the District to receive FFP for delivering high-quality, clinically appropriate treatment to beneficiaries who are diagnosed with SUD/SMI/SED, self-identify with SUD, or experience a behavioral health crisis and those who are receiving treatment while short-term residents in settings that qualify as IMDs. This Demonstration also complements the District's efforts to implement models of care that are focused on increasing supports for individuals outside of institutions, in home- and community-based settings (HCBS), to improve their access to SUD/SMI/SED services at varied levels of intensity and to combat OUD and other SUDs among District residents.

There are 11 specific goals (Exhibit A) that inform the evaluation's research questions and the measures we will use to evaluate the effects of the Demonstration.

Exhibit A: Goals of the Behavioral Health Transformation Demonstration

Goal 1: Increased rates of identification, initiation, and engagement in treatment for SUD. (SUD-1 in STCs)
Goal 2: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care. (SMI/SED-4 in STCs)
Goal 3: Increased adherence to and retention in treatment. (SUD-2 in STCs)
Goal 4: Reduced utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings. (SMI/SED-1 in STCs)
Goal 5: Reduced utilization of hospital emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services. (SUD-4 in STCs)
Goal 6. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. (SMI/SED-5 in STCs)
Goal 7: Reduced preventable readmissions to acute care and specialty hospitals and residential settings. (SMI/SED-2 in STCs)
Goal 8: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. (SUD-5 in STCs)
Goal 9: Improved access to care for physical health conditions among beneficiaries with SUD. (SUD-6 in STCs)
Goal 10: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the District. (SMI/SED-3 in STCs)
Goal 11: Reductions in overdose death, particularly those due to opioids. (SUD-3 in STCs)

Note: Parentheses in the table indicate whether the goal applies to SUD or SMI/SED and the number of the goal as written in the CMS Special Terms and Conditions for the Demonstration.[20]

Demonstration Activities

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 SUD initiatives aim to improve access to MAT and support services at all levels in the continuum of care recommended by the American Society of Addiction Medicine (ASAM). The SMI/SED initiatives improve critical care access, as well as screening, standards of care, and care coordination. Demonstration initiatives are outlined in the District's SUD and SMI/SED implementation plans. Medicaid waiver authority was effective immediately, while several of the other initiatives will take one to two years to implement. Altogether, the Demonstration includes the initiatives listed below.

- 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.
- Ensuring all residential treatment facilities provide or facilitate access to beneficiaries for whom MAT is an appropriate treatment option.
- Medicaid waiver and expenditure authority to exempt medications for MAT (beyond methadone, which was already exempt) from the $1 co-payment otherwise associated with outpatient prescription medications.
- Increased entry points and access to SUD and dual SUD/mental health treatment.
- Medicaid reimbursement for transition planning services for individuals with SMI/SED and/or SUD being discharged from residential, inpatient, and other institutional facilities.
- FFP for treatment provided to Medicaid recipients in IMDs. The Demonstration will cover short-term (up to 60 days) stays for SMI acute care.
- New reimbursement methodology for Comprehensive Psychiatric Emergency Program (CPEP), youth mobile crisis intervention, and adult mobile crisis and behavioral health outreach services to appropriately account for and value them.
- Establishment of a new service, Psychiatric Crisis Stabilization, as a treatment alternative to psychiatric inpatient hospitalization.
- Medicaid reimbursement for SUD-related Recovery Support Services (RSS), vocational and therapeutic Supported Employment (SE) services for individuals with SUD, vocational SE services for individuals with SMI, and Psychosocial Rehabilitative Clubhouse Services (Clubhouse).
- New reimbursement methodologies and service definitions for the trauma-targeted services Trauma Systems Therapy (TST) and Trauma Recovery and Empowerment Model (TREM).

[20] CMS Administrator Verma, Seema. Received by Senior Deputy Director and State Medicaid Director at the District of Columbia Department of Health Care Finance Melisa Byrd. (2019 Nov 5). Retrieved from: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20SMI-SUD_STCs%20for%201115%20Waiver%20110619.pdf

- An assessment 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.
- Updates to the District's needs-assessment methods.
- Collaboration with stakeholders to improve health information technology adoption, use, and interoperability.

Population Groups Impacted by the Demonstration

The populations targeted and likely to be most impacted by the Demonstration are beneficiaries with SUD and/or SMI/SED who are in need of critical levels of care and short-term residential or inpatient stabilization. Beneficiaries with OUD and other SUDs who could be stabilized and/or undergo detox with the follow-up use of MAT could also benefit from expanded access to and utilization of MAT. These populations are often particularly vulnerable and, if the Demonstration is successfully implemented, many of the District's SUD and/or SMI/SED beneficiaries could be helped with increased support for care transitions and linkages to social support services. As opioid-overdose mortality has disproportionately impacted older African-American heroin users in the District, this population may benefit from increased access to treatment. Increased access to SUD services will increase SUD and mental health treatment utilization, while the use of evidence-based standards for such treatment will improve the quality of care and health outcomes for beneficiaries receiving treatment.

B. EVALUATION QUESTIONS AND HYPOTHESES

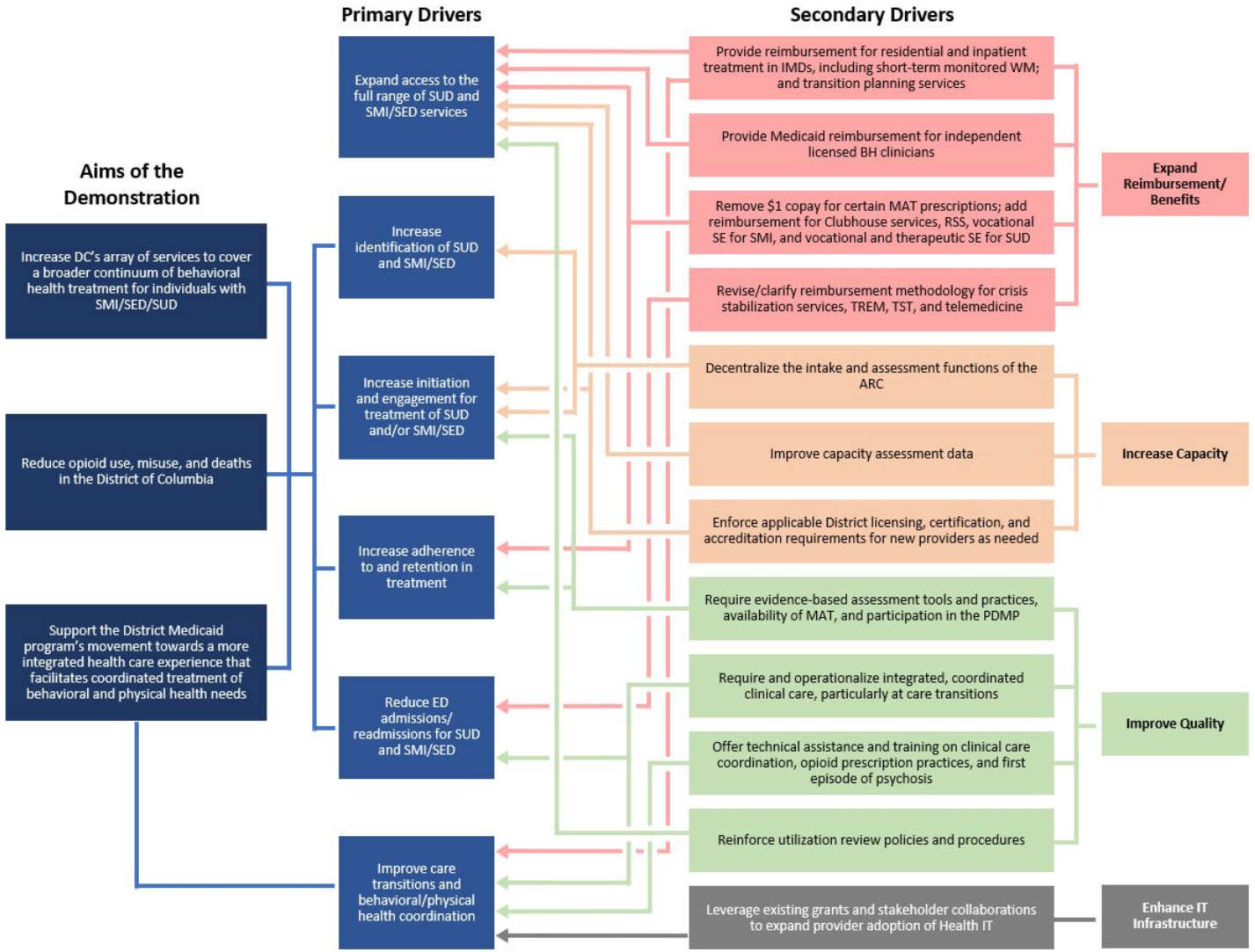
B.1 DRIVER DIAGRAM

The waiver goals and initiatives in Section A articulate DHCF's vision for the Demonstration. The driver diagrams (Exhibits B–F) illustrate how the goals, implementation milestones, and initiatives from the District's SUD and SMI/SED Implementation Plans work together to drive change and advance the three overarching aims of the Demonstration. The District's interventions under the waiver are presented as secondary drivers. These secondary drivers are grouped into four domains: Expand Reimbursement/Benefits, Increase Capacity, Improve Quality, and Enhance IT Infrastructure, and map to the goals of the Demonstration (summarized here as primary drivers). Exhibits C, D, E and F break down the overall driver diagram (Exhibit B) to show how the interventions in each domain map to the goals of the Demonstration. For example, one of the Demonstration's key interventions—reimbursement of intensive services delivered in an IMD setting—supports the District's goal of expanding access to the full range of SUD and SMI/SED services. Similarly, within the Improve Quality domain, the District's provision of technical assistance on care coordination supports the goal of improving care transitions and behavioral and physical health coordination.

As these driver diagrams show, the District will achieve the Demonstration aims through expanded reimbursement, increased capacity, quality improvements, and enhanced information technology (IT) infrastructure in SUD and SMI/SED services. The expansion of coverage for intensive inpatient and outpatient treatment, crisis care, MAT, and recovery supports will increase access to the full continuum of care, improve retention and completion of treatment, and reduce reliance on emergency departments (EDs) and avoidable hospitalizations. The Demonstration also increases provider capacity, which supports access to services, improves identification and engagement in treatment, and seeks to decrease preventable or medically inappropriate ED/hospital service use. Quality improvements such as care-transition services, evidence-based assessment, care coordination, technical assistance, and utilization review will further improve identification of SUD and SMI/SED, increase access to treatment and adherence, and align beneficiaries' physical and behavioral health care. Finally, the District will use existing grants and stakeholder collaborations to expand the use of health IT among SUD and mental health providers to improve care coordination and transitions between levels of care.

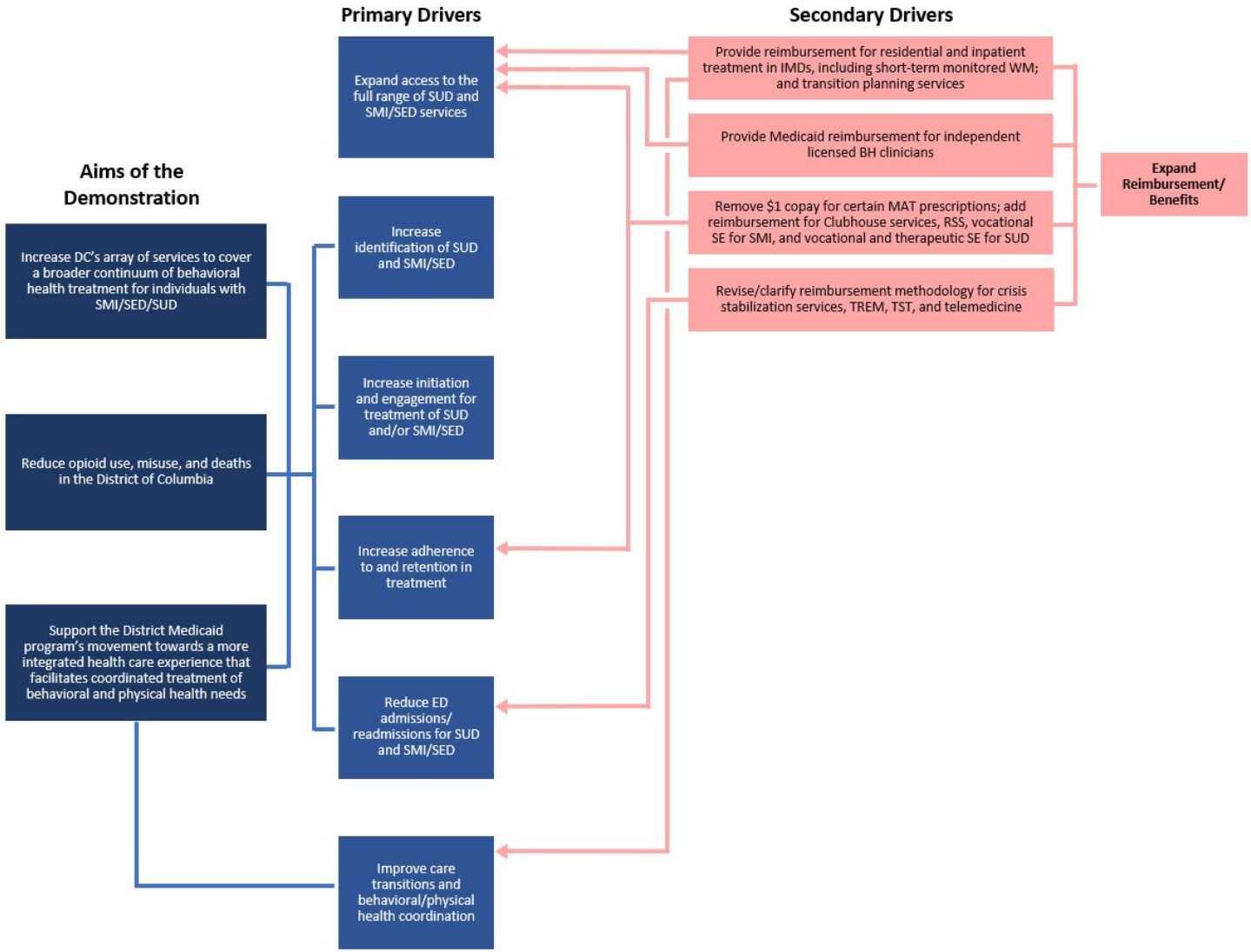
The primary and secondary drivers in Exhibits B–F are reflected in the hypotheses and research questions (Section B.2) and the proposed evaluation measures (Exhibit G).

Exhibit B: Behavioral Health Transformation Demonstration Driver Diagram



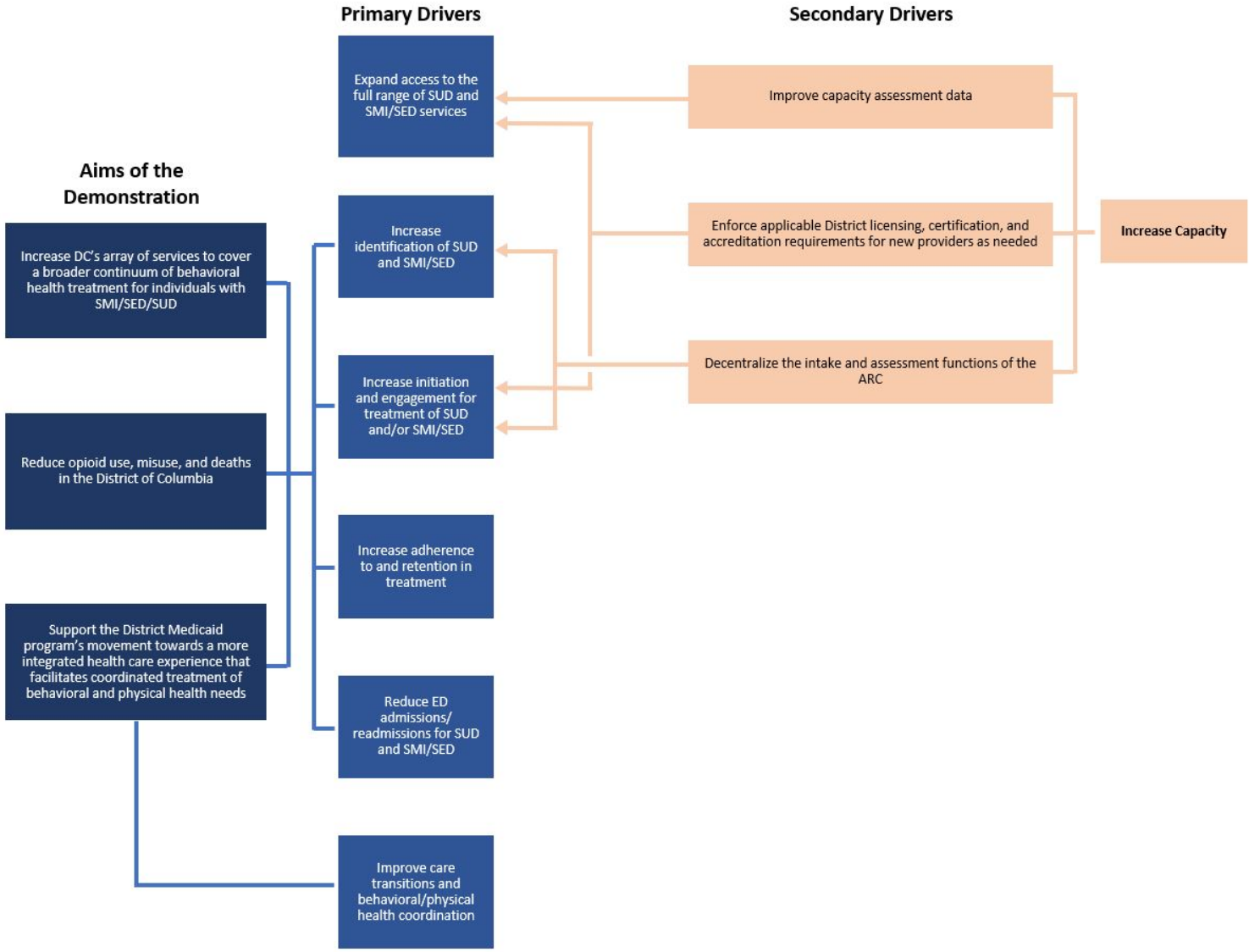
ARC=Assessment and Referral Center; BH=behavioral health; ED=emergency department; IMD=Institutions of Mental Disease; IT=information technology; MAT=medication assisted treatment; PDMP=prescription drug monitoring program; RSS=Recovery Support Services; SE=Supported Employment; SED=serious emotional disturbance; SMI=serious mental illness; SUD=substance use disorder; TREM=Trauma Recovery and Empowerment Model; TST=Trauma Systems Therapy; WM=withdrawal management

Exhibit C: Behavioral Health Transformation Demonstration Driver Diagram – *Expand Reimbursement/Benefits Domain*



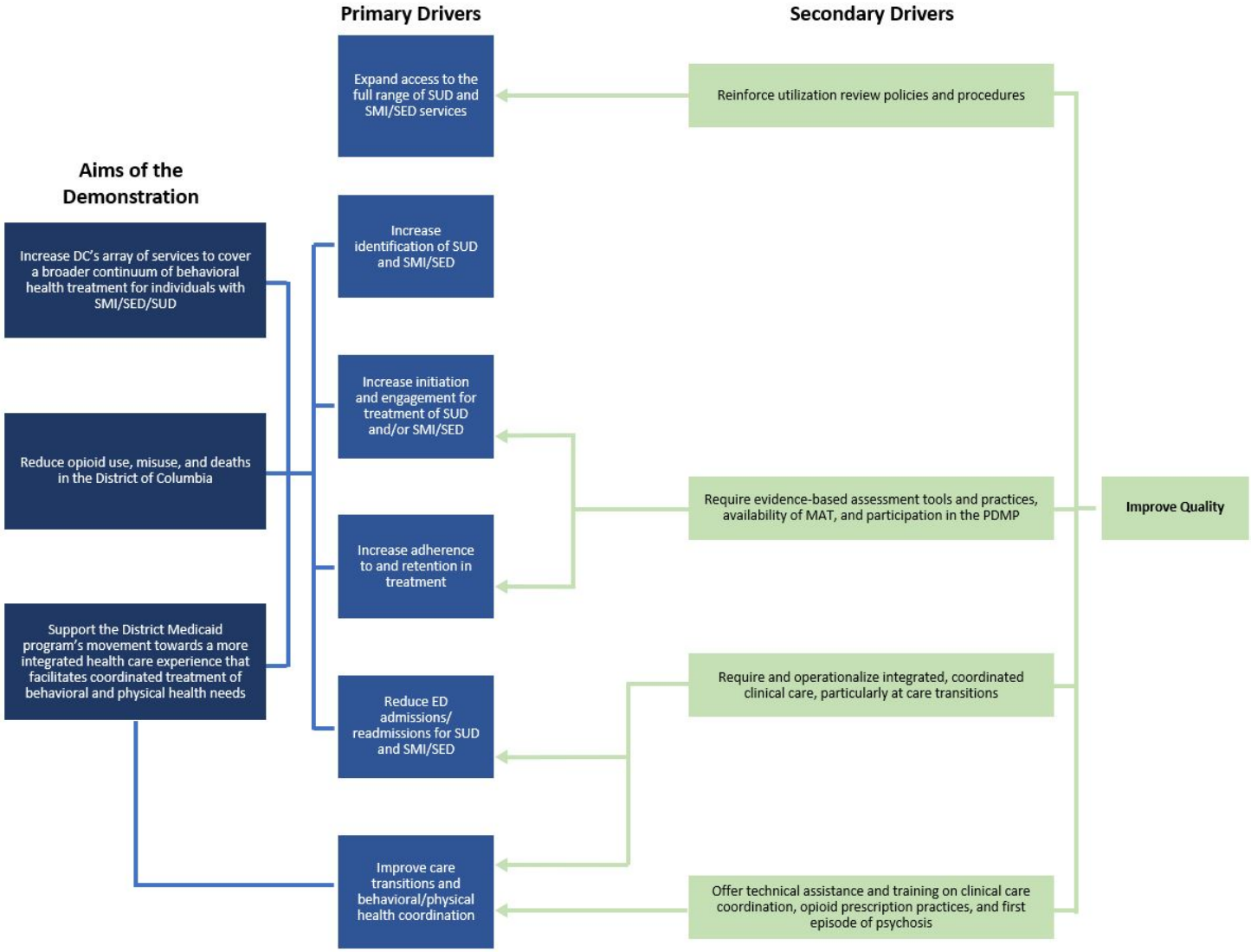
BH=behavioral health; ED=emergency department; IMD=Institutions of Mental Disease; MAT=medication assisted treatment; RSS=Recovery Support Services; SE=supported employment; SED=serious emotional disturbance; SMI=serious mental illness; SUD=substance use disorder; TREM=Trauma Recovery and Empowerment Model; TST=Trauma Systems Therapy; WM=withdrawal management.

Exhibit D: Behavioral Health Transformation Demonstration Driver Diagram – *Increase Capacity Domain*



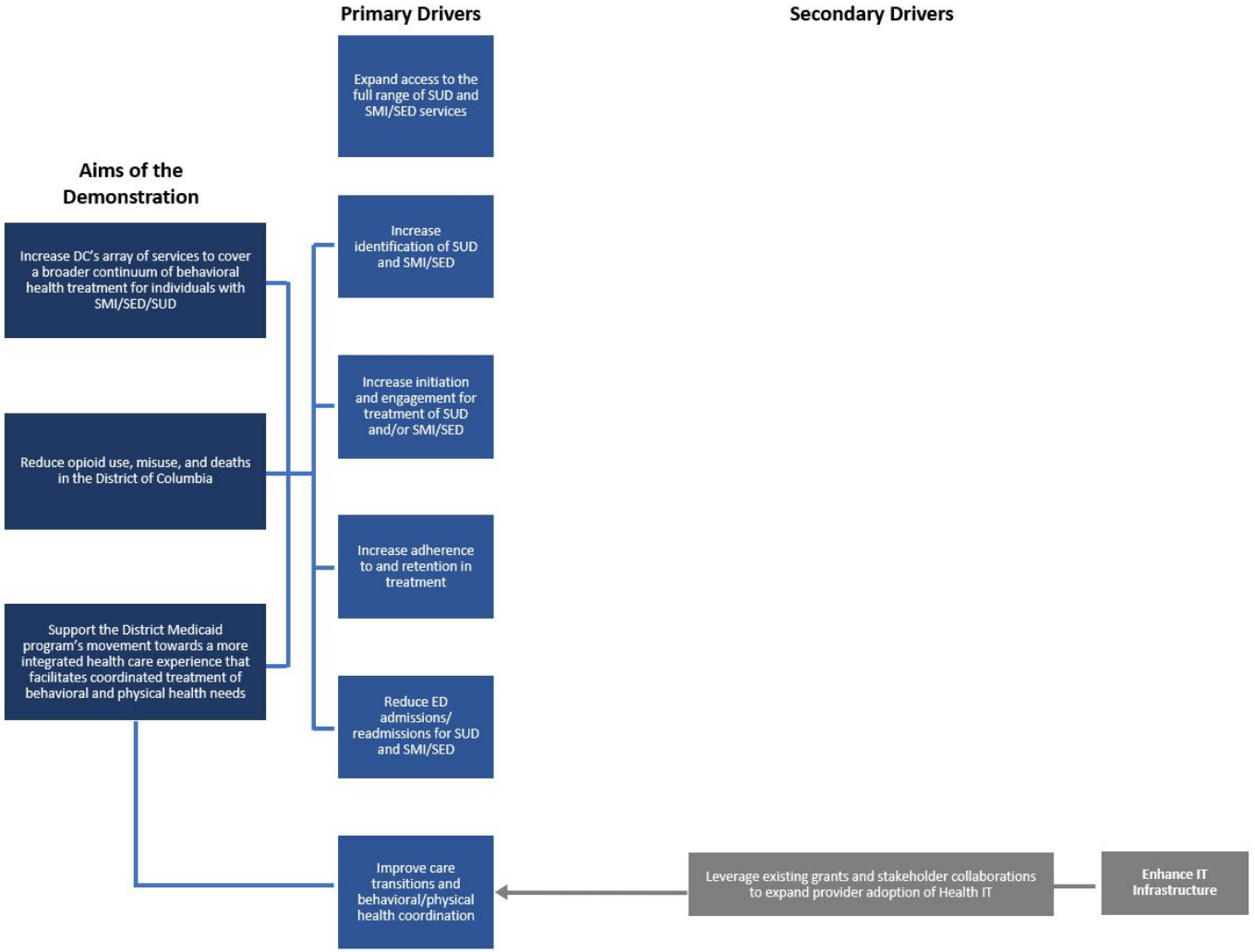
ARC=Assessment and Referral Center; ED=emergency department; SED=serious emotional disturbance; SMI=serious mental illness; SUD=substance use disorder.

Exhibit E: Behavioral Health Transformation Demonstration Driver Diagram – *Improve Quality Domain*



ED=emergency department; MAT=medication assisted treatment; PDMP=prescription drug monitoring program; SED=serious emotional disturbance; SMI=serious mental illness; SUD=substance use disorder.

Exhibit F: Behavioral Health Transformation Demonstration Driver Diagram – *Enhance IT Infrastructure Domain*



ED=emergency department; IT=information technology; SED=serious emotional disturbance; SMI=serious mental illness; SUD=substance use disorder.

B.2 HYPOTHESES AND RESEARCH QUESTIONS

B.2.1 Demonstration Goal-Based Hypotheses and Research Questions

Based on the aims and goals of the Demonstration, we propose the hypotheses below that we will test as part of the evaluation. Each hypothesis will be tested by one or more research questions that can be answered through quantitative and/or qualitative measures (Exhibit G).

Goal 1: Increased rates of identification, initiation, and engagement in treatment for SUD. (SUD-1 in STCs)

Hypothesis 1.1 The Demonstration will increase rates of identification and initiation of treatment for SUD.

Research Question 1.1 Was there an increase in the identification and initiation of treatment for beneficiaries with SUD?

Hypothesis 1.2 The Demonstration will increase access to specific SUD treatment services.

Research Question 1.2a Did the number of providers who were enrolled in Medicaid and qualified to deliver SUD services increase during the Demonstration period?

Research Question 1.2b How does the implementation of reimbursement for services provided in IMD settings influence access to specific SUD treatment services?

Research Question 1.2c How does the implementation of reimbursement for withdrawal management in IMD settings influence access to these SUD treatment services?

Research Question 1.2d How does the implementation of requirements to offer or facilitate access to all Food and Drug Administration (FDA)-approved medications for use in SUD influence access to these SUD treatment services?

Research Question 1.2e How does the implementation of reimbursement for independent licensed behavioral health (BH) clinicians providing SUD services influence access to specific SUD treatment services?

Hypothesis 1.3 The Demonstration will increase utilization of specific SUD treatment services.

Research Question 1.3a. Was there an increase in community knowledge of available SUD treatment and services?

Research Question 1.3b Was there an increase in the utilization of specific SUD treatment services?

Research Question 1.3c How does the implementation of the removal of the $1 copay for certain MAT prescriptions influence utilization of SUD services?

Goal 2: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care. (SMI/SED-4 in STCs)

Hypothesis 2.1 The Demonstration will increase access to specific community-based SMI/SED treatment services.

Research Question 2.1a Was there an increase in access to community-based SMI/SED treatment services?

Research Question 2.1b Was there an increase in community knowledge of available community-based SMI/SED treatment and services?

Research Question 2.1c How does the implementation of changes to the reimbursement methodology for Trauma Systems Therapy (TST) and Trauma Recovery and Empowerment Model (TREM) influence access to TST and TREM?

Research Question 2.1d How does the implementation of reimbursement for independent licensed BH clinicians for SMI/SED services influence access to independent licensed BH clinicians?

Research Question 2.1e How does creating separate services definitions for TREM and TST influence access to TREM and TST?

Research Question 2.1f How does the implementation of FFP for short-term stays for acute care in IMD settings influence access to short-term stays for acute care in IMD settings?

Hypothesis 2.2 The Demonstration will increase utilization of specific community-based SMI/SED treatment services.

Research Question 2.2a Was there an increase in utilization of community-based SMI/SED treatment services?

Research Question 2.2b How does the Demonstration influence utilization of TST and TREM services?

Research Question 2.2c How does the availability of the Clubhouse influence utilization of SMI/SED treatment services?

Research Question 2.2d How does the Demonstration influence utilization of independent licensed BH clinicians by beneficiaries with SMI or SED?

Hypothesis 2.3 The Demonstration will increase integration of primary and behavioral health care.

Research Question 2.3a Did beneficiaries being treated in an IMD setting receive treatment for physical health conditions experienced by beneficiaries with SMI/SED?

Research Question 2.3b Did the Demonstration increase integration of primary and behavioral health care for beneficiaries with SMI or SED?

Goal 3: Increased adherence to and retention in treatment. (SUD-2 in STCs)

Hypothesis 3.1 The Demonstration will increase adherence to and retention in SUD treatment.

Research Question 3.1a Did the Demonstration increase adherence to SUD treatment?

Research Question 3.1b Did the Demonstration increase retention in SUD treatment?

Research Question 3.1c How does the implementation of the removal of the $1 copay for certain MAT prescriptions influence adherence to and retention in SUD treatment?

Research Question 3.1d How does the availability of supported employment influence adherence to and retention in SUD treatment?

Research Question 3.1e How does the availability of recovery support services influence initiation of, adherence to, and retention in SUD treatment?

Research Question 3.1f How does the availability of transition planning services influence adherence to and retention in SUD treatment?

Research Question 3.1g How does the availability of independent licensed BH clinician services influence adherence to and retention in SUD treatment?

Goal 4: Reduced utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings. (SMI/SED-1 in STCs)

Hypothesis 4.1 The Demonstration will decrease the utilization of ED services by beneficiaries with SMI/SED.

Research Question 4.1a Was there a decrease in ED service utilization by beneficiaries with SMI/SED?

Research Question 4.1b How does the Demonstration influence the ED service utilization by beneficiaries with SMI/SED (e.g., through improved access to other continuum of care services)?

Hypothesis 4.2 The Demonstration will decrease the lengths of stay (LOS) in hospital EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

Research Question 4.2a Was there a decrease in the LOS in hospital EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings?

Research Question 4.2b How does the Demonstration influence the length of stay (LOS) in hospital EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings (e.g., through improved access to other continuum of care services)?

Goal 5: Reduced utilization of hospital emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services. (SUD-4 in STCs)

Hypothesis 5.1 The Demonstration will reduce utilization of hospital emergency departments and inpatient hospital settings.

Research Question 5.1a Was there a reduction in ED or inpatient utilization for beneficiaries with SUD?

Research question 5.1b How does the Demonstration influence preventable utilization of ED or inpatient care through improved access to other continuum of care services?

Research question 5.1c How does the Demonstration influence medically inappropriate utilization of ED or inpatient care through improved access to other continuum of care services?

Goal 6: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. (SMI/SED-5 in STCs)

Hypothesis 6.1 The Demonstration will improve follow-up for beneficiaries with SMI/SED after episodes of acute care in hospitals.

Research Question 6.1a Was there an increase in utilization of follow-up services for beneficiaries with SMI/SED after episodes of acute care in hospitals?

Research Question 6.1b How does the implementation of the requirement that psychiatric hospitals initiate contact with the beneficiary and community-based providers within 72 hours of discharge influence care coordination?

Research Question 6.1c How does the implementation of reimbursement for transition planning services influence care coordination?

Research Question 6.1d How did changes in care coordination infrastructure influence experiences of care coordination for beneficiaries with SMI/SED?

Research Question 6.1e How does the implementation of requirements for IMDs to conduct psychiatric and medical screenings influence assessment and treatment of physical health conditions for beneficiaries with SMI/SED?

Research Question 6.1f Did care coordination improve for beneficiaries with SMI/SED?

Goal 7: Reduced preventable readmissions to acute care and specialty hospitals and residential settings. (SMI/SED-2 in STCs)

Hypothesis 7.1 The Demonstration will reduce preventable readmissions to acute care and specialty hospitals and residential settings for beneficiaries with SMI/SED.

Research Question 7.1 Was there a decrease in preventable readmissions to acute care, specialty hospitals, and residential settings for beneficiaries with SMI/SED?

Goal 8: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. (SUD-5 in STCs)

Hypothesis 8.1 The Demonstration will decrease preventable or medically inappropriate readmissions to the same or higher level of care for beneficiaries with SUD.

Research Question 8.1 Was there a decrease in preventable or medically inappropriate readmissions to the same or higher level of care for beneficiaries with SUD?

Goal 9: Improved access to care for physical health conditions among beneficiaries with SUD. (SUD-6 in STCs).

Hypothesis 9.1 The Demonstration will increase access to care for physical health conditions among beneficiaries with SUD.

Research Question 9.1a Was there an increase in access to care for physical health conditions among beneficiaries with SUD?

Research Question 9.1b Did care coordination improve for beneficiaries with SUD?

Research Question 9.1c How did changes in care-coordination infrastructure influence experiences of care coordination for beneficiaries with SUD?

Research Question 9.1d How does the implementation of requirements for IMDs to conduct psychiatric and medical screenings influence assessment and treatment of physical health conditions for beneficiaries with SUD?

Goal 10: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the District. (SMI/SED-3 in STCs)

Hypothesis 10.1 The Demonstration will increase the availability of crisis-stabilization services.

Research Question 10.1a Was there an increase in the availability of crisis-stabilization services?

Research Question 10.1b How does the Demonstration influence the availability of crisis stabilization services (i.e., CPEP, Psychiatric Crisis Stabilization Program, Youth Mobile Crisis Intervention, and Adult Mobile Crisis and Behavioral Health Outreach)?

Goal 11: Reductions in overdose deaths, particularly those due to opioids. (SUD-3 in STCs)

Hypothesis 11.1 The Demonstration will reduce the rate of overdose deaths.

Research Question 11.1 Was there a decrease in the rate of overdose deaths?

B.2.2 Research Questions for Cost Analysis

In addition to addressing the above Demonstration goals-based research questions, the evaluation will also include a cost analysis, which will address the following questions.[21]

Research Question 12.1 Has the total healthcare spending for targeted beneficiaries increased, decreased, or stayed the same in the Demonstration period?

Research Question 12.2 Have the total federal costs for the health care of targeted beneficiaries increased, decreased, or stayed the same in the Demonstration period?

Research Question 12.3 Have the costs related to the diagnosis and treatment of targeted beneficiaries increased, decreased, or stayed the same during the Demonstration period?

Research Question 12.4 What are the treatment cost drivers for the target population in the Demonstration period?

[21] Research questions are formulated based on CMS guidance on evaluating 1115 waiver demonstrations, as shown in Table C: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf

C. METHODOLOGY

This section describes our planned methodology, which we will refine in consultation with DHCF and based on CMS feedback, subject to the availability of data and feasibility of analysis. The subsections below follow CMS's recommended structure for the methodology section of the evaluation design.

- Evaluation design
- Target and comparison populations
- Evaluation period
- Evaluation measures
- Data sources
- Analytic methods

C.1 EVALUATION DESIGN

Quantitative and Qualitative Analytic Methods Under a Mixed-Methods Approach.

The IMPAQ Team will employ a mixed-methods approach to this evaluation and will use multiple quantitative and qualitative analyses to answer the evaluation questions. A mixed-methods approach will account for the complexity and variety of the Demonstration activities shown in the Driver Diagrams (Exhibit B–F). This section gives an overview of the three main types of analyses we will conduct.

Qualitative analysis. We will conduct key informant interviews, site visits with providers, a beneficiary survey, and a document review to gather primary data that characterizes the interventions the District will implement to achieve the Demonstration's goals. This data will also yield insights into providers' and beneficiaries' awareness and perspectives of systems changes enacted through the Demonstration. We will employ thematic coding and triangulation to analyze the data qualitatively. Sections C.5.1 and C.6.1 describe the qualitative data sources and methods.

Quantitative analysis. We will evaluate the Demonstration's impact on quantifiable measures, such as access to services for SUD and SMI/SED. The data sources for the quantitative analyses include Medicaid claims and other administrative data as well as data from two rounds of a beneficiary survey fielded under the evaluation. The quantitative analysis will include descriptive statistics and an impact analysis using an interrupted time series (ITS) design. We will conduct descriptive subgroup analysis by stratifying the data by beneficiary characteristics, treatment setting, and service type. Descriptive statistics will include frequencies, means, and distributions of relevant metrics. ITS is the CMS-preferred methodology for impact analysis when there is no appropriate comparison group as is the case with this Demonstration. We will conduct the ITS analyses for the target population overall, as defined by each research question. In addition, we may conduct ITS analyses by treatment setting, service type, FFS and Managed Care, and dual status for selected measures, depending on sample sizes and relevance for the evaluation (see Section C.2 for relevant sample sizes). Where appropriate and feasible, we will incorporate quantitative measures from the beneficiary survey that capture beneficiaries' awareness of SUD or SMI/SED services in the District and their experiences with care. Sections C.5.2 and C.6.2 describe the quantitative data sources and methods.

Integrated mixed-methods analysis. We will integrate findings from the various quantitative and qualitative analyses using methods such as sequential exploratory design and concurrent triangulation.[22, 23] The mixed-methods evaluation approach will provide summative insights into how successful the Demonstration is in achieving its objectives. In addition, it will provide more formative insights into how and why the various components of the Demonstration work or could be improved. To integrate findings across both qualitative and quantitative methods, we will leverage qualitative data to contextualize or further inform quantitative results. For example, qualitative findings may help to explain patterns occurring in the descriptive statistics and ITS models, and those patterns may suggest areas to explore in the key informant interviews and site visits. In addition, we may use findings from the qualitative data analysis to update the quantitative data analysis methods, for example, by identifying which of the selected measures are most likely to show change based on Demonstration activities or new questions to add to the second wave of the beneficiary survey.

Implications of the COVID-19 pandemic for the evaluation. The COVID-19 pandemic has coincided with the launch of the Demonstration. This makes it particularly challenging for the evaluation to distinguish the effects of the Demonstration on Medicaid enrollment, service utilization, provider behavior and beneficiary outcomes from the effects of the pandemic. The pandemic may even affect how the Demonstration is implemented. Section C.6.2 discusses the quantitative impact estimation strategies the IMPAQ Team will use to address these challenges. These strategies include following an ITS design, inclusion of covariates that capture COVID-19 severity in regression models, and beneficiary-level sub-group analyses. Section C.5.1 describes how the primary data collection strategies will be adapted to overcome the challenges posed by the pandemic in reaching targeted site visit, interview, and survey participants. It also describes the additional research domains we will include in the questionnaires to gather qualitative insights into the effects of the pandemic on stakeholders.

C.2 TARGET AND COMPARISON POPULATIONS

Target Population

The target population of this evaluation will be any full-benefit Medicaid beneficiary in the District.[24] We will use District-provided Medicaid claims data to identify Medicaid beneficiaries with SMI/SED or SUD along with details on service use and outcomes. We will identify SMIs/SEDs and SUDs in the claims data using measure specifications for the selected measures. Based on DHCF Medicaid Management Information System (MMIS) data for September 2019 Medicaid beneficiaries with SMI/SED or SUD, there were 28,724 beneficiaries with SMI/SED only, 9,967 beneficiaries with SUD only and 12,542 beneficiaries with SMI/SED and SUD.[25]

Comparison Population

As CMS's SUD Demonstration Evaluation Guidance explains, the ideal comparison groups are comparable states without the Demonstration waiver flexibilities or similar programs affecting the same population occurring concurrently with the Demonstration, comparison populations

[22] Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field Methods, 18*(1), 3–20. doi:10.1177/1525822X05282260.

[23] Castro, F. G., Kellison, J. G., Boyd, S. J., & Kopak, A. A. (2010). Methodology for conducting integrative mixed methods research and data analyses. *J Mix Methods Res*., *4*(4), 342–360. doi:10.1177/1558689810382916.

[24] In the District, a full benefit beneficiary is any Medicaid enrollee who is not partially eligible for both Medicare and Medicaid with benefits limited to payment of Medicare premiums and cost sharing. All other Medicaid enrollees in the District receive full benefits.

[25] MMIS data extracted March 2020. Excludes individuals whose only SUD diagnosis is tobacco use disorder. SMI/SED diagnoses reflect state-based definition in the District's monitoring protocol.

that are not able to receive services due to geographic or demographic limitations, or late Demonstration-participants that can act as a comparison group for early Demonstration-participants. However, such comparison groups are not available for this evaluation because all eligible beneficiaries in the District are participating in the Demonstration, their participation begins at the same time, and obtaining access to administrative claims data or performing data collection for other states is out of scope of this project (as discussed further in section C.6.2). Therefore, we will use the ITS design as the main method for estimating the effects of the Demonstration. The ITS design compares the trend of the outcome after Demonstration implementation with the outcome trend that would have occurred if the pre-existing trend had continued after implementation.

C.3 EVALUATION PERIOD

The pre-Demonstration period will serve as the baseline for the ITS analysis and the period after the Demonstration begins will be considered the post-period. The baseline will be a fixed three-year period prior to January 1, 2020, for the ITS analysis. CMS guidance in the technical specifications for Monitoring Metrics indicates that the first measurement period (e.g., quarter) of the post-period will be the baseline period for monitoring metric purposes.[26, 27] However, for evaluation purposes we will ensure the baseline period includes only periods prior to the Demonstration, so that any early effects of the Demonstration on the outcomes of interest are reflected in the descriptive analysis. The full post-period will extend until the end of the Demonstration, December 31, 2024. The end point of the post-periods to be included in the analysis for the evaluation reports will be a few months prior to the due date of the first draft of each report to allow for the three-month claim-runout period and the time needed for data analysis and reporting. The Interim Evaluation Report will cover Demonstration activities between January 1, 2020, and June 30, 2022 (DY 1-2.5). The Summative Evaluation Report, the final evaluation deliverable to CMS, will cover the Demonstration activities from January 1, 2020, through December 31, 2024.

C.4 EVALUATION MEASURES

As noted above, we will use a mix of quantitative and qualitative measures to evaluate the effects of the Demonstration. Exhibit G describes the quantitative measures and the qualitative research domains, along with the data sources and analytic methods, that we will use to evaluate changes in access to SUD and SMI/SED services and patient outcomes associated with the Demonstration. The exhibit aligns the goals, hypotheses, research questions, and proposed measures/research domains. For efficiency, we will leverage 15 SUD and SMI/SED monitoring metrics that DHCF will regularly report to CMS. Six quantitative measures are drawn from the Healthcare Effectiveness Data and Information Set (HEDIS), Medicaid Core Set, or other standardized measure sets. We also propose 27 de novo quantitative measures that address specific dimensions of the Demonstration that are not captured in the monitoring metrics or established measures, including those based on the beneficiary survey that we will field under the evaluation.[28] The measure names, descriptions, numerators, and

[26] CMS. *Monitoring Metrics for Section 1115 Demonstrations with SMI/SED Policies*. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-monitoring-metrics.pdf

[27] CMS. *Monitoring Metrics for Section 1115 Demonstrations with SUD Policies*. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf

[28] The survey domains are provided in Section C.5.1. Once the survey questionnaire is finalized, we will update the measure list with additional survey-based measures.

denominators/populations of interest are drawn directly from CMS's specifications for monitoring metrics where available.

Where applicable and feasible, we will create measures also for beneficiary subpopulations, depending on whether the subpopulation sizes are sufficiently large to allow for the measures to be defined. Some of the beneficiary subpopulations of interest include:

- FFS/MCO
- Dually eligible for Medicare
- Age
- Pregnant
- Justice-involved
- Disability
- SUD
- OUD
- SMI/SED
- SMI/SED and co-occurring SUD
- SMI/SED and co-occurring physical condition
- Ward of residence

For IMD stay-related measures, if population sizes are sufficiently large, we will further stratify the data and construct the measures for beneficiaries at St. Elizabeths (the District's public psychiatric hospital), at Psychiatric Institute of Washington (PIW), or attended by other private providers, separately. We will select a subset of the above subgroups for inclusion in the ITS analysis and the remaining subgroups will be explored descriptively. We will select the subsets for various types of analyses in consultation with DHCF after preliminary data exploration.

We will also report additional program statistics that DHCF deems relevant to describe the Demonstration landscape (e.g., the number of active DC Health Information Exchange [HIE] users) but which are not included in the exhibit and for which ITS analysis is not feasible.[29]

The qualitative domains that will be assessed as part of the evaluation mainly align with the secondary drivers in the driver diagram. For efficiency, we will assess the document reviews and reserve primary data collection for clarification and for collecting information that cannot be gleaned through documents.

In addition to the measures in Exhibit G that we will use to assess the Demonstration goals-based research questions, we show the cost measures that we will assess under the cost analysis in Exhibit H.

[29] These measures will be selected from the monitoring reports submitted by DHCF to CMS. Therefore, we do not separately report them in Exhibit G.

Exhibit G: Proposed Evaluation Measures

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Goal 1: Increased rates of identification, initiation, and engagement in treatment for SUD. (SUD-1 in STCs)							
Primary Driver: *Increase identification of SUD and SMI/SED*	**Research question 1.1:** Was there an increase in the identification and initiation of treatment for beneficiaries with SUD?						
	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period	CMS-constructed SUD Monitoring Metric #2	Number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD related treatment during the measurement period but not in the three months before the measurement period	All Medicaid beneficiaries enrolled for any amount of time during the measurement period *(Population of interest)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Change in beneficiary self-report of barriers to treatment		IMPAQ defined, with input from DHCF	Number of beneficiaries who report a barrier to treatment	Total number of survey respondents *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Primary Driver: *Expand access to the full range of SUD and SMI/SED services*	**Research question 1.2a:** Did the number of providers who were enrolled in Medicaid and qualified to deliver SUD services increase during the Demonstration period?						
	SUD Provider Availability	Number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	CMS-constructed SUD Monitoring Metric #13	Total number of eligible SUD providers	SUD providers who were enrolled in Medicaid and qualified to deliver Medicaid services during the measurement period *(Population of interest)*	▪ Provider enrollment database ▪ Claims data	▪ ITS ▪ Descriptive statistics
	Capacity of newly enrolled Medicaid providers qualified to deliver SUD services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Increase in newly enrolled Medicaid providers qualified to deliver SUD services relative to overall increase in providers qualified to deliver SUD services in the District		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
Secondary Driver: *Provide reimbursement for residential and inpatient treatment in IMDs, including short-term, monitored WM; and transition planning services*	**Research Question 1.2b:** How does the implementation of reimbursement for services provided in IMD settings influence access to specific SUD treatment services?						
	Availability of reimbursement for services in IMD settings		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Content of reimbursement policy for services in IMD settings (e.g., which services are covered and at what rate)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of reimbursement for services in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement incentivized or facilitated expanded access to services in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Research Question 1.2c: How does the implementation of reimbursement for withdrawal management in IMD settings influence access to these SUD treatment services?						
	Availability of reimbursement for withdrawal-management services in IMD settings		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Content of reimbursement policy for withdrawal-management services in IMD settings (e.g., which services are covered and at what rate)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of reimbursement for withdrawal-management services in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement incentivized or facilitated expanded access to withdrawal-management services in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
Secondary Driver: *Require evidence-based assessment tools and practices, availability of MAT, and participation in the PDMP*	**Research Question 1.2d:** How does the implementation of requirements to offer or facilitate access to all FDA-approved medications for use in SUD influence access to these SUD treatment services?						
	Whether and through what mechanisms the District implements requirements to offer or facilitate access to all FDA-approved medications for use in SUD		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the extent to which requiring the availability of all FDA-approved medications facilitated expanded access to SUD services		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceived facilitators and barriers to offering or facilitating access to all FDA-approved medications for use in SUD		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
Secondary *Driver: Provide Medicaid reimbursement for independent licensed BH clinicians*	**Research Question 1.2e:** How does the implementation of reimbursement for independent BH clinicians for SUD services influence access to specific SUD treatment services?						
	Availability of reimbursement for independent licensed BH clinicians for SUD services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Content of reimbursement policy for independent licensed BH clinicians for SUD services (e.g., which services are covered and at what rate)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of reimbursement to independent licensed BH clinicians for SUD services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement of independent licensed BH clinicians for SUD services incentivized or facilitated expanded access to SUD services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Primary Driver: *Expand access to the full range of SUD and SMI/SED services* Secondary Driver: *Decentralize the intake and assessment functions of the ARC*	**Research question 1.3a:** Was there an increase in community knowledge of available treatment and services?						
	Change in beneficiary awareness of available SUD treatment and services		IMPAQ defined, with input from DHCF	Number of beneficiaries who indicate awareness of SUD treatment and services	Total number of survey participants *(Denominator)*	▪ Beneficiary survey	▪ Descriptive statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Primary Driver: *Increase initiation and engagement for treatment of SUD and/or SMI/SED*	**Research question 1.3b:** Was there an increase in the utilization of specific SUD treatment services?						
	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	CMS-constructed SUD Monitoring Metric #6	Number of unique beneficiaries (de-duplicated) enrolled in the measurement period receiving at least one SUD treatment service or pharmacy claim during the measurement period	All Medicaid beneficiaries enrolled for any amount of time during the measurement period *(Population of interest)*	▪ Claims	▪ ITS ▪ Descriptive statistics

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Change in self-reported utilization of SUD treatment and services		IMPAQ defined, with input from DHCF	Number of beneficiaries who report receiving the SUD services that they wanted or needed	Total number of survey participants *(Denominator)*	▪ Beneficiary survey	▪ Descriptive statistics ▪ Regression ▪ Thematic Analysis Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Primary Driver: *Expand access to the full range of SUD and SMI/SED services* Secondary Driver: *Remove $1 copay for certain MAT prescriptions; add reimbursement for Clubhouse services, RSS, vocational SE for SMI, and vocational and therapeutic SE for SUD*	**Research question 1.3c:** How does the implementation of the removal of the $1 copay for certain MAT prescriptions influence utilization of appropriate SUD services?						
	Beneficiary awareness of MAT copay removal		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating awareness of the copay removal for MAT	Total number of survey participants *(Denominator)*	▪ Beneficiary survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Mechanisms through which the District removed the $1 copay for certain MAT prescriptions		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the extent to which the removal of the $1 copay incentivized or facilitated increased utilization of SUD services		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating copay removal for MAT increased their utilization of SUD services	Total number of survey participants who were aware of the copay removal for MAT *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Goal 2: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care. (SMI/SED-4 in STCs)							
	Research question 2.1a: Was there an increase in access to community-based SMI/SED treatment services?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Primary Driver: *Expand access to the full range of SUD and SMI/SED services*	Mental health providers	Number of mental health providers who delivered services to beneficiaries with SMI/SED under the demonstration, in total and stratified by type (e.g., MHRS providers, physicians, other licensed practitioners)	IMPAQ defined, with input from DHCF	Total number of eligible mental health practitioners delivering services to SMI/SED beneficiaries (includes stratifications for provider type)	SMI/SED providers who were enrolled in Medicaid and qualified to deliver Medicaid services during the measurement period *(Population of interest)*	▪ Provider enrollment database ▪ Claims data	▪ ITS ▪ Descriptive statistics
	Capacity of newly enrolled Medicaid providers qualified to deliver SMI/SED services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Increase in newly enrolled Medicaid providers qualified to deliver SMI/SED services relative to overall increase in providers qualified to deliver SMI/SED services in the District		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Change in beneficiary self-report of barriers to treatment		IMPAQ defined, with input from DHCF	Number of beneficiaries who report a barrier to treatment	Total number of survey respondents *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Research question 2.1b: Was there an increase in community knowledge of available community-based SMI/SED treatment and services?						
	Change in beneficiary awareness of SMI treatment and services		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating they know where to go to receive treatment for SMI	Total number of survey participants *(Denominator)*	▪ Beneficiary survey	▪ Descriptive statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Secondary Driver:	**Research question 2.1c:** How does the implementation of changes to the reimbursement methodology for Trauma Systems Therapy (TST) and Trauma Recovery and Empowerment Model (TREM) influence access to TST and TREM?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Revise/clarify reimbursement methodology for crisis stabilization services, TREM, TST, and telemedicine	Content of the changes to the reimbursement methodology for TST and TREM		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of changes to the reimbursement methodology for TST and TREM		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Expanded TST and TREM services as reported by providers		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which changes to the reimbursement methodology for TST and TREM incentivized or facilitated expanded access to TST and TREM		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Secondary Driver: *Provide Medicaid reimbursement for independent licensed BH clinicians*	**Research Question 2.1d:** How does the implementation of reimbursement for independent licensed providers for SMI/SED services influence access to independent licensed BH clinicians?						
	Availability of reimbursement for independent licensed BH clinicians for SMI/SED services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of reimbursement to independent licensed BH clinicians for SMI/SED services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement of independent licensed BH clinicians for SMI/SED services incentivized or facilitated expanded access to SMI/SED treatment services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic analysis
Secondary Driver: *Revise/clarify reimbursement methodology for crisis stabilization services, TREM, TST, and telemedicine*	**Research Question 2.1e:** How does creating separate service definitions for TREM and TST influence access to TREM and TST treatment services?						
	Content of changes to the definitions or to the regulations for TREM and TST		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of changes to the definitions or regulations for TREM and TST		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which changes to the definitions or regulations for TREM and TST incentivized or facilitated expanded access to TREM and TST treatment services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic analysis

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Secondary Driver: *Provide reimbursement for residential and inpatient treatment in IMDs, including short-term, monitored WM, and transition planning services*	**Research Question 2.1f:** How does the implementation of FFP for short-term stays for acute care in IMD settings influence access to short-term stays for acute care in IMD settings?						
	Availability of FFP for short-term stays for acute care in IMD settings		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Content of reimbursement policy for short-term stays for acute care in IMD settings (e.g., eligible services, payment rate)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of reimbursement for short-term stays for acute care in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement incentivized or facilitated expanded access to short-term stays for acute care in IMD settings		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Primary Driver: *Increase initiation and engagement for treatment of SUD and/or SMI/SED*	**Research question 2.2a:** Was there an increase in utilization of community-based SMI/SED treatment services?						
	Mental Health Services Utilization–Any Services	Number of beneficiaries in the demonstration with SMI/SED who used any services related to mental health during the measurement period.	CMS-constructed SMI Monitoring Metric #18	Number of unique beneficiaries (de-duplicated total) with a service claim for any services related to mental health during the measurement period	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period *(Population of interest)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Change in self-reported utilization of SMI treatment and services		IMPAQ defined, with input from DHCF	Number of beneficiaries who report receiving the SMI services that they wanted or needed	Total number of survey participants *(Denominator)*	▪ Beneficiary survey	▪ Descriptive statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Primary Driver: *Increase initiation and*	**Research Question 2.2b:** How does the Demonstration influence utilization of TST and TREM?						
	Perceptions of whether the Demonstration increased utilization of TST and TREM		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
engagement for treatment of SUD and/or SMI/SED	Perceptions of how the Demonstration increased utilization of TST and TREM		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Secondary Driver: *Remove $1 copay for certain MAT prescriptions; add reimbursement for Clubhouse services, RSS, vocational SE for SMI, and vocational and therapeutic SE for SUD*	**Research Question 2.2c:** How does the availability of the Clubhouse influence utilization of SMI/SED treatment services?						
	Availability of the Clubhouse		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Resources and services available at the Clubhouse		N/A, Qualitative Measure			▪ Document Reviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the resources and services provided through the Clubhouse		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the extent to which the availability of the Clubhouse increased utilization of SMI/SED treatment services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis
Primary Driver: *Increase initiation and engagement for treatment of SUD and/or SMI/SED*	**Research Question 2.2d:** How does the Demonstration influence utilization of independent licensed BH clinicians by beneficiaries with SMI or SED?						
	Perceptions of whether the Demonstration increased utilization of independent licensed BH clinicians by beneficiaries with SMI or SED		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of how the Demonstration increased utilization of independent licensed BH clinicians by beneficiaries with SMI or SED		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Primary Driver: *Improve care transitions and behavioral/ physical health coordination*	**Research question 2.3a:** Did beneficiaries being treated in an IMD setting receive treatment for physical health conditions experienced by beneficiaries with SMI/SED?						
	Assessment of physical health during IMD stay	Number and percentage of episodes of care where IMD providers billed for assessments or treatment of physical conditions	IMPAQ defined, with input from DHCF	Number of beneficiaries receiving a physical health service during an IMD stay	Number of beneficiaries with an IMD stay during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive Statistics
	Research Question 2.3b: Did the Demonstration increase integration of primary and behavioral health care for beneficiaries with SMI or SED?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Perceptions of whether the Demonstration increased integration of primary and behavioral health care for beneficiaries with SMI or SED		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Descriptions of ways primary and behavioral health care are integrated for beneficiaries with SMI or SED		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Beneficiary self-reported receipt of behavioral health and physical health care from same provider		IMPAQ defined, with input from DHCF	Number of beneficiaries who report they have received behavioral health and physical health care from same provider	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			NA, Qualitative Measure			▪ Beneficiary Interviews	
Goal 3: Increased adherence to and retention in SUD treatment. (SUD-2 in STCs)							
Primary Driver: *Increase adherence to and retention in treatment*	**Research question 3.1a:** Did the demonstration increase adherence to SUD treatment?						
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	Percentage of beneficiaries with a new episode of alcohol or other drug (AOD) abuse or dependence who received Initiation or Engagement of AOD Treatment	National Committee for Quality Assurance (NCQA), National Quality Forum (NQF) #0004 SUD Monitoring Metric #15	Initiation or engagement of AOD treatment within 14 days of the index episode	Medicaid beneficiaries aged 18 and older during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Continuity of Pharmacotherapy for Opioid Use Disorder	Number and percentage of beneficiaries who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	USC, NQF#3175 SUD Monitoring Metric #22	Number of beneficiaries who have at least 180 days of continuous pharmacotherapy with a medication prescribed for SUD without a gap of more than seven days	Individuals who had a diagnosis of OUD and at least one claim for an OUD medication *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Beneficiary self-report of how well they have adhered to their providers' treatment advice		IMPAQ defined, with input from DHCF	Number of beneficiaries who indicate they have adhered to their providers' treatment advice	Total number of survey respondents (*Denominator*)	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			NA, Qualitative Measure			▪ Beneficiary Interviews	
	Perceptions of facilitators and barriers to adherence to SUD treatment		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Primary Driver: *Increase adherence to and retention in treatment*	**Research question 3.1b:** Did the demonstration increase retention in SUD treatment?						
	Beneficiaries retention in SUD treatment	Beneficiaries receiving ongoing SUD treatment during the measurement period	IMPAQ defined, with input from DHCF	Number of Medicaid beneficiaries receiving ongoing SUD treatment during the measurement period	Number of Medicaid beneficiaries with at least one DBH service during the measurement period (*Denominator*)	▪ DBH key performance indicator data	▪ Descriptive statistics ▪ ITS
	Beneficiary self-report of how well they have adhered to their providers' treatment advice		IMPAQ defined, with input from DHCF	Number of beneficiaries who indicate they have adhered to their providers' treatment advice	Total number of survey respondents (*Denominator*)	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Beneficiary Interviews	
	Perceptions of facilitators and barriers to retention in SUD treatment		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Secondary Driver: *Remove $1 copay for certain MAT prescriptions; add reimbursement for Clubhouse services, RSS, vocational SE for SMI, and vocational and therapeutic SE for SUD*	**Research Question 3.1c:** How does the implementation of the removal of the $1 copay for certain MAT prescriptions influence adherence to and retention in SUD treatment?						
	Mechanisms through which the District removed the $1 copay for certain MAT prescriptions		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Beneficiary awareness of the removal of the $1 copay for certain MAT prescriptions		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating awareness of the copay removal for MAT	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Perceptions of the extent to which removal of the $1 copay for certain MAT prescriptions increased adherence to and retention in SUD treatment		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating copay removal for MAT increased their adherence to/retention in SUD treatment services	Total number of survey participants who were aware of the copay removal for MAT *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
Secondary Driver: *Remove $1 copay for certain MAT prescriptions; add reimbursement for Clubhouse services, RSS, vocational SE for SMI, and vocational and*	**Research Question 3.1d:** How does the availability of supported employment services influence adherence to and retention in SUD treatment?						
	Availability of supported employment services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Type of supported employment service(s) available		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
therapeutic SE for SUD	Awareness of the availability of supported employment services		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating awareness of services	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Survey	
	Use of supported employment services		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating that they used services	Total number of survey participants indicating that they are aware of services *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression
	Perceptions of the supported employment services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of whether the supported employment services influenced adherence to and retention in SUD treatment		IMPAQ defined, with input from DHCF	Number of beneficiaries indicating services influenced their adherence to and retention in SUD treatment	Total number of survey participants who indicated that they have used services *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Research Question 3.1e: How does the availability of recovery support services influence initiation of, adherence to, and retention in SUD treatment?						
	Availability of recovery support services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Types of recovery support services available		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Awareness of the availability of recovery support services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Perceptions of the recovery support services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of whether the recovery support services influenced initiation of, adherence to, and retention in SUD treatment		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Primary Driver: *Increase adherence to and retention in treatment*	**Research Question 3.1f:** How does the availability of transition planning services influence adherence to and retention in SUD treatment?						
	Availability of transition planning services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Types of transition planning services available		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Awareness of the availability of transition planning services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the transition planning services		IMPAQ defined, with input from DHCF	Number of beneficiaries who report they knew what the next step in their care would be	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression Analysis ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Perceptions of whether the transition planning services influenced adherence to, and retention in SUD treatment		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Research Question 3.1g: How does the availability of independent licensed BH clinician services influence adherence to and retention in SUD treatment?						
	Availability of independent licensed BH clinician services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Types of independent licensed BH clinician services available		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Awareness of the availability of independent licensed BH clinician services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the independent licensed BH clinician services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of whether the independent licensed BH clinician services influenced adherence to, and retention in SUD treatment		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Goal 4: Reduced utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings. (SMI/SED-1 in STCs)							
Primary Driver: *Reduce ED admissions /readmissions for SUD and SMI/SED*	**Research question 4.1a:** Was there a decrease in ED services by beneficiaries with SMI/SED?						
	Mental Health Services Utilization - ED	Number and percentage of beneficiaries in the demonstration or with SMI/SED who use emergency department services for mental health during the measurement period; average length of stay in ED will also be reported	CMS-constructed SMI Monitoring Metric #16	The total number of unique beneficiaries (de-duplicated total) who have a claim for emergency services for mental health during the measurement period	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Research question 4.1b How does the Demonstration influence ED service utilization among Medicaid beneficiaries with SMI/SED (e.g., through improved access to other continuum of care services)?						
	Perceptions of how the Demonstration has reduced utilization of ED services		IMPAQ defined, with input from DHCF	Number of beneficiaries who report that they know they can get help when in crisis outside of the ED	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression Analysis ▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Research question 4.2a: Was there a decrease in the length of stay in hospital EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?						
	ED length of stay for beneficiaries awaiting mental health treatment	Length of stay in EDs for Medicaid beneficiaries awaiting mental health treatment in specialized settings	IMPAQ defined, with input from DHCF	Length of stay for Medicaid beneficiaries receiving treatment for SMI/SED in emergency departments	Medicaid beneficiaries receiving treatment for SMI/SED in emergency departments followed by an inpatient stay for SMI/SED *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Perceptions of whether there was a decrease in the LOS in hospital EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Research question 4.2b How does the Demonstration influence the length of stay in hospital EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings (e.g., through improved access to other continuum of care services)?						
	Perceptions of how the Demonstration has reduced length of stay in hospital EDs		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Goal 5: Reduced utilization of hospital emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services. (SUD-4 in STCs)							
Primary Driver: *Reduce ED admissions /readmissions for SUD and SMI/SED*	**Research question 5.1a:** Was there a reduction in ED or inpatient utilization for beneficiaries with SUD?						
	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of SUD-related inpatient stays per 1,000 beneficiaries in the measurement period	CMS-constructed SUD Monitoring Metric #24	The number of inpatient discharges related to a SUD stay during the measurement period	Beneficiaries with diagnosed SUD enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	CMS-constructed SUD Monitoring Metric #23	The number of ED visits for SUD during the measurement period	Beneficiaries with diagnosed SUD enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Prevention Quality Indicator: chronic conditions composite	Inpatient hospital admissions for ambulatory care sensitive chronic conditions	IMPAQ defined, with input from DHCF (e.g., leveraging AHRQ PQI #92)	Discharges for Medicaid beneficiaries 18 years and older for chronic conditions	To be determined *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Research question 5.1b How does the Demonstration influence preventable utilization of ED or inpatient care through improved access to other continuum of care services?						
	Perceptions of whether the Demonstration has reduced preventable utilization of ED or inpatient care		IMPAQ defined, with input from DHCF	Number of beneficiaries who report that they know they can get help when in crisis outside of the ED	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression Analysis ▪ Thematic Analysis ▪ Triangulation
			N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Perceptions of how the Demonstration has reduced preventable utilization of ED or inpatient care		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Research question 5.1c: How does the Demonstration influence medically inappropriate utilization of ED or inpatient care through improved access to other continuum of care services?						
	Perceptions of whether the Demonstration has reduced medically inappropriate utilization of ED or inpatient care		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of how the Demonstration has reduced medically inappropriate of ED or inpatient care		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Goal 6: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. (SMI/SED-5 in STCs)							
Primary Driver: *Improve care*	**Research question 6.1a:** Was there an increase in utilization of follow-up services for beneficiaries with SMI/SED after episodes of acute care in hospitals?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
transitions and behavioral/ physical health coordination	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. -within 30 days -within 7 days	NCQA, NQF #0576 SMI Monitoring Metric #8	A follow-up visit with a mental health practitioner within 7 or 30 days after discharge.	Number of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
Secondary Driver: *Require and operationalize integrated, coordinated clinical care, particularly at care transitions*	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. -within 30 days of the ED visit -within 7 days of the ED visit	NCQA, NQF #2605 SMI Monitoring Metric #10	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 7 or 30 days after the ED visit	Number of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
Secondary Driver: *Require and operationalize integrated, coordinated clinical care,*	**Research Question 6.1b:** How does the implementation of the requirement that psychiatric hospitals initiate contact with the beneficiary and community-based providers within 72 hours of discharge influence care coordination?						
	Whether and through what mechanisms the District implements requirements for psychiatric hospitals and residential treatment settings to initiate contact within 72 hours of discharge with the beneficiary and community-based providers		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
particularly at care transitions	Perceived facilitators and barriers to initiating contact within 72 hours of discharge with the beneficiary and community-based providers		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Secondary Driver: *Provide reimbursement for residential and inpatient treatment in IMDs, including short-term, monitored WM; and transition planning services*	**Research Question 6.1c:** How does the implementation of reimbursement for transition planning services influence care coordination?						
	Availability of reimbursement for transition planning activities		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Content of reimbursement policy for transition planning activities (e.g., eligible beneficiaries, reimbursement rates)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of the availability of reimbursement for transition planning activities		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of whether the available reimbursement for discharge-planning activities incentivized or facilitated improved care coordination		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Utilization of transition planning service	Use of new transition planning service by eligible beneficiaries with SMI/SED	IMPAQ defined, with input from DHCF	Number and percentage of eligible beneficiaries using the new transition planning service for beneficiaries with SMI/SED	Medicaid beneficiaries eligible for the service (*Denominator*)	▪ Claims data	▪ ITS ▪ Descriptive statistics
Secondary Drivers: *Offer technical assistance and training on clinical care coordination; Leverage existing grants and stakeholder*	**Research Question 6.1d:** How did changes in care-coordination infrastructure influence experiences of care coordination for beneficiaries with SMI/SED?						
	Strategies implemented by the District to facilitate Health IT adoption and interoperability (e.g., via improvements to the HIE)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Challenges and facilitators to adopting and using Health IT		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
collaborations to expand provider adoption of Health IT	Workflows for integrating HIE data into care-coordination efforts		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceptions of information available via HIE		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Content, format, and reach of the technical assistance and training given to providers related to care coordination		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the technical assistance and training given to providers related to care coordination		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
Secondary Driver: *Require and operationalize integrated, coordinated clinical care, particularly at care transitions*	**Research Question 6.1e:** How does the implementation of requirements for IMDs to conduct psychiatric and medical screenings influence assessment and treatment of physical health conditions for beneficiaries with SMI/SED?						
	Whether and through what mechanisms the District implements requirements for IMDs to conduct psychiatric and medical screenings		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the extent to which requiring IMDs to conduct psychiatric and medical screenings influenced care coordination for beneficiaries with SMI/SED		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceived facilitators and barriers to conducting psychiatric and medical screenings in IMDs for beneficiaries with SMI/SED		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis
	Research Question 6.1f: Did care coordination improve for beneficiaries with SMI/SED?						
	Care coordination for beneficiaries with SMI/SED	Beneficiary perceptions of how their health care providers work together	IMPAQ defined, with input from DHCF	Number of beneficiaries who rate their providers' collaboration highly	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression
	Beneficiaries' experiences with coordinated care		N/A, Qualitative Measure			▪ Beneficiary Interviews	▪ Thematic Analysis

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Providers' experiences coordinating care		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
Goal 7: Reduced preventable readmissions to acute care and specialty hospitals and residential settings. (SMI/SED-2 in STCs)							
Primary Driver: *Reduce ED admissions /readmissions for SUD and SMI/SED*	**Research question 7.1:** Was there a decrease in preventable readmissions to acute care, specialty hospitals, and residential settings for beneficiaries with SMI/SED?						
	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission rate for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease	Inpatient Psychiatric Facility Quality Reporting (IPFQR), NQF #2860 SMI Monitoring Metric #4	The count of 30-day readmissions. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including critical access hospitals) that occurs within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. The measure uses the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0.	The count of index hospital admissions to IPFs *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Perceptions of whether there was a decrease in preventable readmissions to acute care and specialty hospitals and residential settings		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Goal 8: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. (SUD-5 in STCs)							
Primary Driver: *Reduce ED*	**Research question 8.1:** Was there a decrease in preventable or medically inappropriate readmissions to the same or higher level of care for beneficiaries with SUD?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
admissions /readmissions for SUD and SMI/SED	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	CMS-constructed SUD Monitoring Metric #25	The count of 30-day readmissions: at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.	The count of Index Hospital Stays for beneficiaries with SUD *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Perceptions of whether there was a decrease in preventable or medically inappropriate readmissions to the same or higher level of care for beneficiaries with SUD		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Goal 9: Improved access to care for physical health conditions among beneficiaries with SUD. (SUD-6 in STCs)							
Primary Driver: *Improve care transitions and behavioral/ physical health coordination*	**Research question 9.1a:** Was there an increase in access to care for physical health conditions among beneficiaries with SUD?						
	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	Percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period	NCQA, Adjusted HEDIS Measure SUD Monitoring Metric #32	Number of Medicaid beneficiaries who had an ambulatory or preventive care visit during the measurement period	Number of Medicaid beneficiaries with a diagnosis of SUD during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Receipt of behavioral health and physical health care from same provider		IMPAQ defined, with input from DHCF	Number of beneficiaries who report they have received behavioral health and physical health care from same provider	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression ▪ Thematic Analysis ▪ Triangulation
			NA, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	
	Research Question 9.1b: Did care coordination improve for beneficiaries with SUD?						

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
Secondary Driver: *Require and operationalize integrated, coordinated clinical care, particularly at care transitions*	Care coordination for beneficiaries with SUD	Beneficiary perceptions of how their health care providers work together	IMPAQ defined, with input from DHCF	Number of beneficiaries who rate their providers' collaboration highly	Total number of survey participants *(Denominator)*	▪ Beneficiary Survey	▪ Descriptive Statistics ▪ Regression
	Beneficiaries' experiences with coordinated care		N/A, Qualitative Measure			▪ Beneficiary Interviews	▪ Thematic Analysis
	Providers' experiences coordinating care		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic analysis
	Utilization of transition planning service	Use of new transition billing service by eligible beneficiaries	IMPAQ defined, with input from DHCF	Number and percentage of eligible beneficiaries using the new transition planning service for beneficiaries with SUD	Medicaid mental health providers (*Denominator*)	▪ Claims data	▪ ITS ▪ Descriptive statistics
Secondary Drivers: *Offer technical assistance and training on clinical care coordination; Leverage existing grants and stakeholder collaborations to expand provider adoption of Health IT*	**Research Question 9.1c:** How did changes in care-coordination infrastructure influence experiences of care coordination for beneficiaries with SUD?						
	Strategies implemented by the District to facilitate Health IT adoption and interoperability (e.g., via improvements to the HIE, increased use of the PDMP)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Challenges and facilitators to adopting and using Health IT		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Workflows for integrating HIE data into care-coordination efforts		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceptions of information available via HIE		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Content, format, and reach of the technical assistance and training given to providers related to care coordination		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the technical assistance and training given to providers related to care coordination		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Strategies implemented by the District to facilitate Health IT adoption and interoperability (e.g., via improvements to the HIE, increased use of the PDMP)		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
Primary Driver: *Improve care transitions and behavioral/physical health coordination*	**Research question 9.1d:** How does the implementation of requirements for IMDs to conduct psychiatric and medical screenings influence assessment and treatment of physical health conditions for beneficiaries with SUD?						
	Whether and through what mechanisms the District implements requirements for IMDs to conduct psychiatric and medical screenings		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Perceptions of the extent to which requiring IMDs to conduct psychiatric and medical screenings influenced care coordination		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
	Perceived facilitators and barriers to conducting psychiatric and medical screenings in IMDs		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis
Goal 10: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the District. (SMI/SED-3 in STCs)							
Primary Driver: *Expand access to the full range of SUD and SMI/SED services*	**Research question 10.1a:** Was there an increase in the availability of crisis stabilization services?						
	Any crisis stabilization service	Number and percentage of beneficiaries accessing crisis stabilization services	IMPAQ defined, with input from DHCF	Number and percentage of beneficiaries accessing crisis stabilization services	Medicaid beneficiaries in the demonstration or with SUD and/or SMI/SED enrolled for any amount of time during the measurement period *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics

Driver	Measure Name or Research Domain	Measure Description	Measure Steward, Endorsement	Numerator	Denominator/ Population of Interest	Data Source	Analytic Approach
	Crisis stabilization services, by setting	Number and percentage of beneficiaries accessing crisis stabilization services, by setting	IMPAQ defined, with input from DHCF	Number of beneficiaries receiving crisis stabilization service in the specified setting	Number of beneficiaries accessing crisis stabilization services *(Denominator)*	▪ Claims data	▪ ITS ▪ Descriptive statistics
	Awareness of available crisis stabilization services		N/A, Qualitative Measure			▪ Site Visits ▪ Beneficiary Interviews	▪ Thematic Analysis ▪ Triangulation
Secondary Driver: Revise/clarify *reimbursement for crisis stabilization services, TREM, TST, and telemedicine*	**Research Question 10.1b:** How does the Demonstration influence the availability of crisis stabilization services (i.e., CPEP, Psychiatric Crisis Stabilization Program, Youth Mobile Crisis Intervention, and Adult Mobile Crisis and Behavioral Health Outreach)?						
	Content of changes to the reimbursement methodology for crisis stabilization services		N/A, Qualitative Measure			▪ Document Reviews ▪ Key Informant Interviews	▪ Thematic Analysis ▪ Triangulation
	Awareness of changes to the reimbursement methodology for crisis stabilization services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of the extent to which reimbursement changes incentivize or facilitate increased availability of crisis stabilization services		N/A, Qualitative Measure			▪ Site Visits	▪ Thematic Analysis
	Perceptions of how the Demonstration influenced availability of crisis stabilization services		N/A, Qualitative Measure			▪ Key Informant Interviews ▪ Site Visits	▪ Thematic Analysis ▪ Triangulation
Goal 11: Reductions in overdose deaths, particularly those due to opioids. (SUD-3 in STCs)							
Primary Driver: *All primary drivers*	**Research question 11.1:** Was there a decrease in the rate of overdose deaths?						
	Opioid overdose deaths	Number and percentage of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration.	SUD Monitoring Metric #26	Number of SUD overdose deaths during the measurement period among Medicaid beneficiaries	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement Period *(Denominator)*	▪ Vital records data	▪ ITS ▪ Descriptive statistics

Exhibit H describes the various cost measures that will be used to address the research questions related to the changes in the health care costs of the targeted beneficiaries in the Demonstration period along with the level of analysis and data sources. We will reference the waiver's monitoring protocol when defining the SMI/SED and SUD populations and their related costs. We will estimate the measures below separately for beneficiaries with SMI/SED and SUD. The MMIS data source includes FFS claims and MCO encounters.

Exhibit H: Types of Costs and Proposed Data Sources

Level of Analysis	Type of Beneficiaries	Type of Costs	Description/Data Source
Level 1: Total costs	SMI/SED	Total costs	Sum of benefit and administrative costs. [a] Data sources are MMIS and other DHCF administrative data (e.g., on waiver evaluation contract costs).
		Total federal costs	Total Medicaid costs * Federal medical assistance percentage (FMAP)
	SUD	Total costs	Sum of benefit and administrative costs. Data sources are MMIS and other DHCF administrative data (e.g., on waiver evaluation costs).
		Total federal costs	Total Medicaid costs * Federal medical assistance percentage (FMAP)
Level 2: Cost related to diagnosis and treatment	SMI/SED	SMI/SED-IMD costs	IMD costs for beneficiaries with SMI/SED. Data source is MMIS.
		Other SMI/SED costs	Benefit costs for SMI/SED care other than IMD stays. Data source is MMIS.
		Non-SMI/SED costs	Benefit costs for non-SMI/SED care. Data source is MMIS.
	SUD	SUD-IMD costs	IMD costs for beneficiaries with SUD. Data source is MMIS.
		Other SUD costs	Benefit costs for SUD care other than IMD stays. Data source is MMIS.
		Non-SUD costs	Benefit costs for non-SUD care. Data source is MMIS.
Level 3: Source of treatment cost drivers for beneficiaries in the target population	SMI/SED	Outpatient costs, non-ED	Types of costs will be defined using HEDIS, CMS or DHCF standards and may utilize claim type, procedure code, revenue code, place of service, provider type, and other data elements. Data source is MMIS.
		Outpatient costs, ED	
		Inpatient costs	
		Pharmacy costs	
		Long-term care costs	
	SUD	Outpatient costs, non-ED	Types of costs will be defined using HEDIS, CMS or DHCF standards and may utilize

Level of Analysis	Type of Beneficiaries	Type of Costs	Description/Data Source
		Outpatient costs, ED	claim type, procedure code, revenue code, place of service, provider type, and other data elements. Data source is MMIS.
		Inpatient costs	
		Pharmacy costs	
		Long-term care costs	

[a] Benefit costs are defined as payments made by DHCF, or on behalf of DHCF by MCOs, to health care providers for services delivered to Medicaid beneficiaries. While the CMS guidance refers to inpatient [IP], outpatient [OT], pharmacy [RX], long-term care [LT] file types in Transformed Medicaid Statistical Information System (T-MSIS) as an example, equivalent data from DHCF's MMIS will be used in the cost analysis.

C.5 DATA SOURCES

To evaluate the Demonstration, the IMPAQ Team will use a combination of primary and secondary data sources. We will collect primary qualitative data through key informant interviews and site visits to Medicaid providers. We will also administer a beneficiary survey that will have questions designed to elicit further primary data, both quantitative and qualitative. We will abstract additional primary data through a document review. We will collect secondary data––Medicaid claims and other administrative data—in coordination with DHCF and DBH for the quantitative analysis. In addition, we will incorporate quantitative measures from the beneficiary survey to inform the quantitative analysis. To the extent feasible, we will leverage surveys already conducted by the District such as the DBH consumer satisfaction survey and the 2014–2015 CMS Center for Medicaid and CHIP (Children's Health Insurance Program) Services (CMCS) Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) and supplement the findings from the IMPAQ-administered beneficiary survey. In the sections that follow we describe how we plan to collect and use District-specific primary and secondary data for the evaluation.

C.5.1 Primary Data

The objectives of the primary data collection are to:

- Describe the systems changes that the District is able to make as part of the Demonstration, including the challenges and successes along the way.
- Assess the extent to which these systems changes facilitate achievement of Demonstration goals.
- Characterize provider and beneficiary awareness of and experiences with these systems changes.

There will be four sources of primary data for the evaluation: documents, key informant interviews, site visits, and beneficiary surveys. This section describes our methodology for collecting data from the first three data sources. The methodology for conducting the beneficiary surveys will be submitted in the Beneficiary Survey Methodology Memorandum.

Program Documents

The IMPAQ Team will conduct ongoing document reviews to stay abreast of the systems changes that are occurring under the Demonstration and the overlapping initiatives that may complicate or provide synergy to the Demonstration activities. Examples of key documents to review include:

- Demonstration Implementation Plans
- Demonstration Health Information Technology Plans
- Internal briefing materials about the Demonstration
- District policy (e.g., rules, legislation, contract language, care agreements)
- Provider guidance documents (e.g., Bulletins)
- Assessment and placement tools used to route beneficiaries to appropriate care
- Demonstration Monitoring Reports
- Stakeholder engagement and workgroup meeting materials
- Materials that describe relevant co-occurring initiatives (e.g., grant narratives, reports)

To identify relevant documents to review, the IMPAQ Team will monitor the SharePoint site DHCF has created for the evaluation, subscribe to public email listservs, such as the one the District maintains for the 1115 waiver, and ask key informants to share internal documents that are relevant to the evaluation. We also anticipate that the IMPAQ Team's weekly evaluation contract meetings with DHCF and DBH will provide information about relevant documents to review.

Key Informant Interviews

Each year during the Base Year–Option Year 3 period, we will conduct individual and/or small-group interviews with representatives from DHCF, DBH, DC Health, and District Medicaid health plans, as well as community stakeholders (e.g., DC Primary Care Association, DC Behavioral Health Association, Chesapeake Regional Information System for our Patients (CRISP) DC, DC Medical Care Advisory Committee (MCAC). The primary goals of the key informant interviews are to clarify information available via the document reviews as needed, to identify the challenges and facilitators to implementing Demonstration drivers, and to identify whether there are changes or delays to planned Demonstration activities associated with the COVID-19 public health emergency. Our goal is to interview individuals who are knowledgeable about the design, strategic planning, oversight, or systems-level implementation of waiver activities and relevant co-occurring activities in the District. Exhibit I provides a high-level overview of core topics to discuss during key informant interviews. We will work closely with DHCF to identify potential key informants who occupy relevant roles and to develop protocols for interview discussions tailored to each role.

Exhibit I: Proposed Discussion Topics for Key Informant Interviews

Discussion Topics
Historical context for current configuration of behavioral health payment and service delivery

Discussion Topics
Reimbursement/coverage strategies under the Demonstration
Policy strategies under the Demonstration
Changes or delays to Demonstration plans associated with COVID-19
Interagency and stakeholder relationships
Provider communications, technical assistance, and training
Co-occurring initiatives
Sustainability of Demonstration activities

When scheduling and logistics allow, our preference is to conduct key informant interviews in person. However, given the uncertainty of COVID-19, we are currently planning to conduct at least the first round of key informant interviews virtually. We anticipate that interviews that occur during the first round will last 60–90 minutes. Subsequent interviews will likely be shorter in duration. With the permission of interviewees, all interviews will be audio-recorded and transcribed. Real-time notetaking will also occur if interviewees prefer not to be audio-recorded or there is a technological failure.

Site Visits to Relevant Clinical Sites

We will conduct site visits during the Base Year, Option Year 2, and Option Year 3 of the evaluation contract period. The goals of the site visits are to characterize changes to the care-delivery continuum under the Demonstration, understand whether the drivers the District is using under the Demonstration are having the effect intended, and describe provider and beneficiary awareness and experiences of care and care coordination. In the Base Year, we will also use the site visits to characterize service and operational changes associated with COVID-19.

We recommend that the following organizations be prioritized for receiving a site visit:

- Assessment and Referral Centers (ARCs)
- Access Help Line (AHL)
- The Clubhouse
- The Psychiatric Institute of Washington
- St. Elizabeths Hospital
- The Comprehensive Psychiatric Emergency Program (CPEP)
- The Community Response Team (CRT)

We also suggest that when selecting additional clinical sites, we attempt to have some diversity within the following characteristics:

- ASAM Level of Care provided for SUD sites (e.g., outpatient, intensive outpatient, day treatment) and setting type for SMI/SED sites (e.g., core services agencies, Federally Qualified Health Centers (FQHCs), free-standing mental health clinics)

- Types of providers on staff (e.g., psychologists, psychiatrists, therapists, social workers, Advanced Practice Registered Nurses [APRNs], certified addiction counselors, peer providers)
- Geographic location
- Number of beneficiaries served
- Whether or not the site has expanded access to SUD and/or SMI/SED services, particularly those targeted by the Demonstration (Trauma Recovery and Empowerment Model (TREM), Trauma Systems Therapy (TST), transition planning)

Once sites have been selected, the IMPAQ Team will schedule an initial evaluation-briefing conference call with the participating site. Prior to the briefing, we will provide the site with materials that outline the core primary data–collection goals and the data-collection process. During the briefing call, the team will review the materials related to the evaluation and provide participants with an opportunity to ask questions. The team will also request any documents that can be used to characterize the services provided, identify the appropriate individuals to participate in key informant interviews and assess the feasibility of conducting interviews or focus groups with beneficiaries. At the conclusion of the briefing call, the team will identify the preferred approach to coordinating the logistics of the site visits. For example, the site may prefer to take the lead on coordinating the scheduling of interviews or provide contact information for site-visit key informants so that the evaluation team can schedule interviews.

The categories of site-visit key informants that we anticipate interviewing include:

- Executive leadership (e.g., CEO [Chief Executive Officer], CFO [Chief Financial Officer], COO [Chief Operating Officer])
- Staff responsible for regulatory compliance and governmental affairs
- Coding and billing staff
- Senior-level quality-improvement and innovation staff
- Clinical leaders (e.g., CMO [Chief Medical Officer], CNO [Chief Nursing Officer])
- Core implementing staff (e.g., clinicians, case managers, care coordinators/navigators, certified addiction counselors, peer counselors, intake, and other frontline staff)

Exhibit J provides a high-level overview of likely discussion topics for site-visit key informant interviews. Separate interview protocols for each type of site-visit key informant will be developed collaboratively with DHCF. We will also collaborate closely with DHCF to select sites to visit and key informants to interview based on the Demonstration priority areas and the need to minimize burden. For example, the evaluation team will crosswalk the list of organizations that we recommend for Demonstration site visits with the list of organizations that have participated in relevant interviews conducted by other District or stakeholder contractors and crosswalk the evaluation discussion topics with the reports associated with those efforts to avoid duplication.

Exhibit J: Sample Topics for Site Visit Interview and Focus Group Protocols

Sample Topics
Key Informants
Organizational description and background

Sample Topics
Impact of COVID-19 on services and operations
Perceptions of the reimbursement changes made through the Demonstration
Perceptions of policy changes made through the Demonstration
Perceptions of Demonstration-related communication, technical assistance, and training
Systems changes to implement changes made through the Demonstration
Experiences coordinating care throughout the continuum, particularly at care transitions
Perceptions and use of assessment and placement tools
Unmet beneficiary needs
Unmet provider needs
Sustainability of Demonstration activities
Beneficiaries
Awareness of available services
Removal of $1 copay for certain MAT prescriptions
Experiences of care, with an emphasis on cultural competence
Experiences of care coordination, particularly at care transitions
Experiences of supported employment services
Experiences of the Clubhouse
Unmet needs

The duration of each site visit will depend on the number and types of key informant interviews agreed upon. However, we anticipate that the visits will occur over the course of ½ – 1½ days. To facilitate efficient data collection, we will conduct small-group interviews when possible (e.g., for individuals in similar roles). Site-visit interviews will occur in person if scheduling, logistics, and COVID-19 progress allow. Each interview will last approximately 60 minutes and be audio-recorded and transcribed if interviewees permit. Real-time note taking will also occur if interviewees do not feel comfortable with audio-recording or if there is a technological failure.

If feasible, we will also conduct 30-minute individual interviews or 60-minute focus groups with beneficiaries during site visits. These interviews/focus groups will occur at the site or other convenient location (e.g., a community-organization facility). The IMPAQ Team will work closely with DHCF and site staff to assess the feasibility of collecting data with beneficiaries during site visits and identify the best option for recruiting beneficiaries if feasible. There are four likely options that have tradeoffs regarding selection bias associated with recruitment and likely response rates.

Option 1. Sites will provide the names and contact information of their Medicaid beneficiaries. We will then select a random sample of these patients to contact, screen, and solicit their participation in the evaluation. This option would reduce selection bias associated with recruitment, but may result in low response rates as the evaluation team does not have a relationship with beneficiaries and contact information may not be up to date (as is often the case in this type of hard-to-reach population).

Option 2. We will develop a contact information/release form for Medicaid beneficiaries. Site staff will ask patients as they interact with them whether they agree to have their contact information released to our staff for the purposes of requesting their participation in the evaluation. These staff will submit to us the names and contact information for patients who consent. We will then select a random sample of these patients to contact, screen, and solicit their participation in the evaluation. This option may introduce selection bias associated with recruitment as site staff may not ask all beneficiaries they interact with.

Option 3. We will develop a recruitment flyer and request that site staff hand the flyer to patients as they interact with them. Patients who are interested can contact us based on the information in the flyer, at which point we will screen and recruit participants. This option is likely to create the greatest problems with selection bias associated with recruitment and response rates because (1) staff may not give the flyers to all beneficiaries and (2) the approach relies on the beneficiary to initiate contact with the evaluation team.

Option 4. We will allow the sites to recruit patients to participate in the evaluation. We will provide relevant staff with recruitment scripts, as well as written and verbal instructions on how to recruit using methods that are consistent with human-subject protections and that minimize selection bias. This option is likely to generate the best response rate. However, it also is likely to introduce selection bias associated with recruitment because staff may focus on beneficiaries with whom they have a strong relationship or those they believe would be most willing to participate in the evaluation.

Options 1 or 4, in that order, are our preferred recruitment strategies as they offer the best tradeoffs in terms of selection bias associated with recruitment and likely response rates. However, experience suggests that sites may be reluctant to provide us with the names and contact information for their patients, even if appropriate protections are promised through data-use agreements (DUAs), and relying on sites to recruit beneficiaries may be too burdensome. Thus, we will work with sites to develop a strategy that is mutually satisfactory.

It is important to acknowledge that the Demonstration is targeting a vulnerable and marginalized population, whose members may be reluctant to participate in interviews or focus groups due to general distrust of research, particularly by outsiders, or the stigma associated with their conditions. Thus, we will also collaborate closely with site staff to devise strategies to mitigate these recruitment challenges and ensure that all site visitors are well versed in cultural competence, non-stigmatizing language, and harm reduction.

If the COVID-19 public-health emergency persists, we will conduct the site visits virtually. During the virtual site visits, interviews and focus groups for each site would still be scheduled to occur over the course of ½ – 1½ days; however, we would facilitate the discussions using Zoom or Microsoft Teams. We would request that site-visit participants use the audio and video capabilities of the platform we select and provide instructions on how to test their system's capabilities relative to the platform in advance to prevent technological disruptions. Virtual focus groups with laypersons are often difficult to facilitate and yield less rich data than in-person focus groups and virtual interviews; thus, we would recommend that only one-on-one interviews with beneficiaries be considered if we have to conduct virtual site visits.

Beneficiary Survey

The evaluation includes a beneficiary survey. The plans for the beneficiary survey are still being finalized as part of the IMPAQ submission and DHCF and CMS review of the Beneficiary Survey Methodology Memorandum. The Memorandum will include detailed information about the sampling and recruitment methodology, questionnaire, and plans for fielding the survey, including materials to support respondent-recruitment communications. Here, we provide a high-level summary of the current plans for the survey.

We expect to have two rounds of the survey with data collected through telephone interviews and the web. The first round of the survey will occur February – April 2021 (Demonstration Year 2). The second round of the survey will occur November 2023 – January 2024 (Demonstration Year 3 and 4). The target population of the beneficiary survey will be any Medicaid beneficiary of the District diagnosed with an SUD or SMI. We will select a sample that contains proportions

of beneficiaries with SUD, SMI, and SUD&SMI that reflect the proportions of sample frame Medicaid beneficiaries with SUD, SMI, and SUD&SMI. Based on administrative data provided by DHCF (see Section C.2), this is expected to correspond to a sample of 334 beneficiaries with SUD only, 935 beneficiaries with SMI only, and 401 beneficiaries with both SUD and SMI for a total sample size of 1,670 beneficiaries per survey round. Our goal response rate is 30 percent, or 500 completed surveys.

Our goal is to use the survey to collect data on:

- Awareness of care and services available;
- Care coordination;
- Perceptions of services;
- Barriers to access/utilization;
- Perceived health status;
- Suggestions for improvement;
- Adherence to treatment;
- Behavioral and physical health care integration;
- Utilization of services available; and
- Beneficiary characteristics and social determinants of health.

Where appropriate, we will include survey items from other validated surveys (such as the CAHPS Experience of Care and Health Outcomes Survey, which captures beneficiary experiences with behavioral health services) in order to minimize measurement error and maximize reliability and validity. We will use CMS-recommended practices to guide and inform the process of designing the survey.[30] If it is not feasible to collect data on all the desired topics via the survey (e.g., due to length constraints or because there is not language that beneficiaries would recognize for certain services), we will assess these topics via the beneficiary interviews.

To the extent feasible, we will also leverage surveys already conducted by the District, such as the DBH consumer satisfaction survey and the 2014–2015 CMS CMCS Nationwide Adult Medicaid CAHPS and supplement the findings from the IMPAQ-administered beneficiary survey.

C.5.2 Secondary Data

Data Sources

The evaluation will independently calculate evaluation-related measures using Medicaid FFS and Managed Care Program (Medicaid MCO) claims data, as well as administrative data such as lists of Medicaid providers certified to provide Demonstration-relevant services. The Medicaid claims data, along with Medicaid beneficiary enrollment data and other DHCF data, will come from the District's Medicaid Management Information System (MMIS) accessed through the

[30] Mathematica. (2019 Jun). *Beneficiary survey design and administration for eligibility and coverage demonstration evaluations*. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-beneficiary-survey-guide.pdf

Medicaid Data Warehouse (MDW). Additional administrative data needed for the evaluation will be extracted from data sources such as CRISP (the District's HIE) and the databases of DBH, including specific clinical systems, such as DBH's electronic medical record system iCAMS and DATA/WITS, the District's Automated Treatment Accounting System. Vital records data on overdose deaths during the baseline and Demonstration periods will be sourced from the Office of the Chief Medical Examiner (OCME) for the District of Columbia, and will include name, date of birth, gender, date of death, and cause of death. The vital records data is expected to be available by March 2021, after a memorandum of agreement is executed between DHCF and OCME.

The DC MCO encounter data on claims paid by managed care plans have a similar level of quality and completeness as the FFS claims data. The MCO encounter claims include information on the actual payments to providers. No further imputation of costs is necessary and we can use the MCO encounters in the same fashion as the FFS claims when we conduct the cost analysis.

A limitation of the secondary data sources is that DHCF may not have complete crossover claims data on dual-eligibles (particularly for those in Medicare Advantage plans), and thus analyses on the dual subpopulation might not capture the full effect of the Demonstration. (See Section D for a discussion of methodological limitations.)

Quantitative Data Management

The IMPAQ Team will access the MDW directly and create analytic datasets. DHCF and DBH will provide additional administrative data as aggregate data extracts to the IMPAQ Team. These data will be exported out of MDW and transferred to IMPAQ's Federal Information Security Management Act (FISMA)-compliant secure server. The data will be transferred to IMPAQ's secure servers using SSH [Secure Shell] File Transfer Protocol (SFTP). All confidential data are stored and protected in the Data Zone of the FISMA server. The server has capacity for data analysis using SAS, STATA, and NVivo, among others.

The IMPAQ Team will verify the integrity of the data received from DHCF and DBH by implementing data-validation checks immediately on receipt. Only authorized research staff will access the project-related folders on the FISMA server to execute queries, extract data, and run various scientific, analytical, and programming applications. All data use is recorded in detailed logs to track access and activities.

IMPAQ has procedures and processes in place to ensure that all quantitative data-processing activities produce high-quality outputs. For analytic tasks, quality-assurance procedures encompass three types of activities: (1) all data-analysis programmers will use strong coding standards to ensure that the resulting code is well documented, consistently formatted, and easy to read; (2) all programmers will also use programmer self-checks, with a variety of techniques that test program code to assess whether it accomplishes its intent; and (3) programmers will use peer reviews in which a programmer not involved in the original work formally reviews the written code.

C.6 ANALYTIC METHODS

C.6.1 Qualitative Data Analysis

All documents and primary data collected will be housed in an NVivo database on IMPAQ's secure server. We will begin the analysis process by developing a start list of codes based on the driver diagram, research questions, and data-collection protocols. We will refine this start list of codes based on insights gleaned through data-collection debriefs. Once we have a stable

code book, the evaluation team will systematically code the data using the code book. In the early phases of the coding, we will conduct checks for inter-rater reliability to ensure standardized, thorough, and precise coding. After data have been coded, we will draw conclusions from the data by identifying and interpreting coding patterns, such as high-frequency codes and coding clusters. The overarching analytic framework that we will use for the qualitative analysis is data triangulation. Triangulation methods begin with the assumption that each data point (i.e., document, interview, focus group) is one piece of evidence as it relates to the analyses above and that this information may be complementary, contradictory, or confirmatory when compared to other data sources. Thus, the analytic task is to synthesize the data provided across data sources to develop the most comprehensive and accurate description and analyses of the Demonstration possible. The evaluation team will ensure that assessments of the influence of COVID-19 on the Demonstration are conducted throughout the analytic process.

C.6.2 Quantitative Data Analysis

We will first report simple summary statistics by pre- vs. post-Demonstration periods to assess how the measures change over time. The summary statistics on quantitative measures will include mean, minimum, maximum, and standard deviation, among others. We will identify seasonal patterns, outliers, and anomalies as we explore the data using a data visualization approach, which will also inform the specifications of the regression models. Furthermore, for measures successfully defined for sub-populations, in addition to creating simple summary statistics by pre- vs. post-Demonstration periods, we will also conduct t-tests to see if there exist statistically significant differences between the measures across sub-groups, during the pre- and post-Demonstration periods.

For survey-based measures, we will tabulate the answers for key questions and illustrate using bar charts or pie charts as applicable. Where meaningful, we will conduct t-tests to see if there exist statistically significant differences in the measures across the two waves of the survey.

Impact Analysis – District-Quarter Level Analysis using an ITS Design

The main impact analysis will use an ITS design, which is a robust research design when a quasi-experimental approach requiring a comparison group is not feasible.[31, 32, 33, 34] A comparison group is not feasible because all eligible Medicaid beneficiaries in the District are considered to be participating in the Demonstration, their participation begins at the same time, and obtaining access to claims and administrative data for other states is out of scope for this project.[35] This design is particularly suited for interventions introduced at the population level that have a clearly defined time period and targeted health outcomes.

[31] Soumerai, S. B., Starr, D., & Majumdar, S. R. (2015). How do you know which health care effectiveness research you can trust? A guide to study design for the perplexed. *Preventing Chronic Disease*, *12,* E101.

[32] Wagner, A. K., Soumerai, S. B., Zhang, F., & Ross-Degnan, D. (2002). Segmented regression analysis of interrupted time series studies in medication use research. *Journal of Clinical Pharmacy and Therapeutics*, *27*(4), 299–309.

[33] Bernal, J. L., Cummins, S., & Gasparrini, A. (2017). Interrupted time series regression for the evaluation of public health interventions: A tutorial. *International Journal of Epidemiology*, *46*(1), 348–355.

[34] Ewusie, J. E., Soobiah, C., Blondal, E., Beyene, J., Thabane, L., & Hamid, J. S. (2020). Methods, Applications and Challenges in the Analysis of Interrupted Time Series Data: A Scoping Review. *Journal of multidisciplinary healthcare*, *13*, 411–423. https://doi.org/10.2147/JMDH.S241085

[35] We have explored the feasibility of using out of state data, such as the Transformed Medicaid Statistical Information System Analytic Files Research Identifiable Files (TAF RIF), and using another state (or a

The ITS design compares the trend of each outcome of interest after Demonstration implementation with the outcome trend that would have occurred if the pre-Demonstration trend had continued after implementation. The difference between an ITS and a pre-post design is that the ITS design compares the actual outcome trend in the post-period to the baseline outcome trend projected into the post-period. Alternatively, the pre-post design compares the mean of the outcome in the post-period to the mean of the outcome in the baseline period. As a result, the ITS design will provide a more accurate estimate than the pre-post design if there was a trend in the outcome of interest in the baseline period and if that trend would have continued after implementation of the Demonstration.

The disadvantage of both the pre-post and ITS designs is that programs or events occurring at the same time as the Demonstration could confound the impact estimates they produce. We do not anticipate that it will be feasible to fully separate out the impact of certain services from the Demonstration because the services overlap, and they are implemented concurrently or nearly concurrently. In addition, there are several concurrent programs targeting a similar population and similar outcomes. To the extent feasible, we will control for concurrent programs. If there are District-level factors that are changing quickly or unpredictably throughout the sample period, they should be included in the model as covariates. The prime example would be characteristics from other programs happening concurrently with the Demonstration or variation in provider implementation of key Demonstration activities. We will use qualitative data to inform covariate data for the regression models. However, we anticipate that the ITS design will likely estimate the combined impact of the services of the Demonstration as well as that of concurrent programs.

In light of the potential effects of the COVID-19 pandemic on the evaluation, the ITS design may be a relatively robust approach, because this design uses many observations over a long period and does not require (1) a known trajectory for the pandemic or its effects or (2) a similar comparison group.

For the reasons described above, the unit of analysis for the primary specification of the claims-based impact analysis implemented using the ITS design will be the District-quarter. Estimating the model at the District level will allow us to obtain the impact of the Demonstration and concurrent programs on outcomes for the entire District. The estimates from the model are also more directly interpretable from a policy perspective.

We propose splitting calendar years into quarters because quarters are a suitably granular length of time for controlling for outcome trends and used in many CMS evaluations. However, we will also test the model using months to identify which specification of the model performs best. One consideration is that there is strong seasonality in the receipt of behavioral health

metropolitan area) as the comparison group and potentially conducting analysis using frameworks such as difference-in-differences (DID). However, we think TAF RIF is not an adequate data source for two reasons. First, the data lag of the TAF RIF means that analyses using another state will not be feasible for the interim evaluation report, and only be feasible for the summative evaluation report, in which we may evaluate the impact of the Demonstration during the first two years of the Demonstration. However, such a short period of analysis from the early years of the Demonstration is unlikely to produce reliable findings about the full impact of the Demonstration, especially given the likelihood that the COVID-19 public health emergency will likely be a huge confounding factor (that is, different states will have different responses during the pandemic, making it difficult to isolate Demonstration effects from the pandemic effects). Second, according to CMS guidance in the “Implications of Covid-19 for Section 1115 Demonstration Evaluations: Considerations For States and Evaluators,” using interrupted time series analysis may be a relatively robust approach, because this design uses many observations over a long period and does not require (1) a known trajectory for the pandemic or its effects or (2) a similar comparison group. Because the pandemic is still evolving, it is difficult to determine which state (or a metropolitan area) could potentially be a good comparison group at this stage. Therefore, we recommend not using a comparison group and using the ITS design for this evaluation.

services, so whether monthly or quarterly seasonality in behavioral health services is stronger will be a factor in the final model specification.

We will implement the ITS design using a regression model specified as follows:

Equation 1: $Y_t = \beta_0 + \beta_1 time_t + \beta_2 demo_t + \beta_3 time_after_demo_t + X_t + \varepsilon_t$

Where:

- Y_t is the outcome in time period *t* (assume quarters). An example of the outcome could be the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during time period *t.*
- $time_t$ indicates the number of quarters from the first quarter of the baseline period (January 1, 2017, to December 31, 2019)
- $demo_t$ is an indicator variable taking the value of 0 in the baseline period and 1 in the post-period (the period starting January 1, 2020).
- $time_after_demo_t$ equals 0 in the baseline period and in the post-period takes on the value of the number of quarters from the first post-period quarter. That is, the first post-period quarter takes on a value of 1, the second post-period quarter takes on a value of 2, etc.
- X_t represents District-level characteristics that change over time. The ITS design assumes that District-level characteristics are either fixed or changed slowly over time so that they are captured by the linear trend. If there are District-level factors that are changing quickly or unpredictably throughout the sample period, they should be included in the model as covariates. The prime example would be characteristics from other programs happening concurrently with the Demonstration or variation in provider implementation of key Demonstration activities. We will use qualitative data to inform covariate data for the regression models. Another example would be proxies for the exposure to the COVID-19 pandemic, such as the number of COVID-19 cases per 100,000 DC population in each quarter.[36]
- β_0 estimates the base level of the outcome in the first quarter of the baseline period or the intercept at the baseline.
- β_1 estimates the baseline trend. It is the change in the outcome in the baseline period or the slope of the trend in the baseline period.
- β_2 estimates the change in level of the outcome from the baseline period to the post-period or the change in the intercept after the post-period started. This is one of the policy parameters of interest.
- β_3 estimates the post-period trend. It is the change in the outcome in the post-period or the slope of the trend in the post-period. This is one of the policy parameters of interest.
- Depending on the features of the observed data, we will explore replacing $time_after_demo_t$ with two (or more variables) to indicate the first- and the second-half

[36] The best practices for isolating demonstration effects in the context of the pandemic are not settled yet. The best measures to proxy the severity of the pandemic and exposure to the pandemic are also controversial and not settled yet. We will finalize our approach as more information and guidance become available throughout the evaluation process.

(or more) of the post-period. This will generate a more versatile specification that can reflect the non-linear effects of the Demonstration during the post-period. This strategy of splitting the post-period and estimating effects separately by period may also be useful as a sensitivity test to assess the potential effects of the COVID-19 pandemic on the Demonstration and the impact estimation. For example, we will explore splitting the post-period as (1) 2020 Quarter (Q)1-Q2, and (2) 2020 Q3 and later to assess if the effects of the pandemic are stronger in the first quarters of 2020.

- ε_t is the error term.

The standard regression model for an ITS design is a linear regression model. However, there are several assumptions of the regression model which, if not met, may cause bias or imprecision in the estimates. As a first step to address possible violations of the assumptions, we will use heteroscedasticity and auto-correlation consistent standard errors.[37] We will then investigate whether other violations of the model assumptions exist. We discuss below two examples of potential violations, and the associated tests and solutions.

First, errors should not be correlated over time. We will test this assumption by constructing auto-correlation plots of the residuals. In addition, we will conduct a Durbin-Watson test to detect auto-correlation. [38] If the Durbin-Watson test is below 1 or above 3, there is an indication of serial correlation. In this case, we would test whether an auto-regressive model, such as the Cochrane-Orcutt model or the auto-regressive integrated moving average (ARIMA) model, performs better than linear regression.[39, 40] Mortality and behavioral health outcomes are typically highly auto-correlated at a quarterly frequency and provider level, so we are prepared to apply the appropriate auto-regressive model based on the results of the testing.

Second, the variance of errors should be constant over time (homoscedasticity). In addition to using heteroscedasticity-robust standard errors, we will test for the presence of heteroscedasticity using a plot of residuals versus predicted values. The points should be symmetrically distributed around a horizontal line with roughly constant variance. If they are not, the data may be nonlinear, and we will test the option of transforming the outcome measure using logging or deflating. The effects of the Demonstration are likely to be non-linear, and there is likely to be high heterogeneity in terms of providers and beneficiaries, so we anticipate that transformation may be necessary at least for some outcomes.

Exhibit K illustrates different types of impact models estimated from an ITS design: (a) Level change; (b) Slope change; (c) Level and slope change; (d) Slope change following a lag; (e) Temporary level change; (f) Temporary slope change leading to a level change.[41] Our specification (Equation 1) is flexible to account for all these types of relationships. For each measure, we will experiment with different model specifications and select the model with the

[37] Kiefer, N. M., & Vogelsang, T. J. (2002). Heteroskedasticity-autocorrelation robust standard errors using the Bartlett kernel without truncation. *Econometrica*, *70*(5), 2093–2095.

[38] Savin, N. E., & White, K. J. (1977). The Durbin-Watson test for serial correlation with extreme sample sizes or many regressors. *Econometrica, 45*(8), 1989–1996.

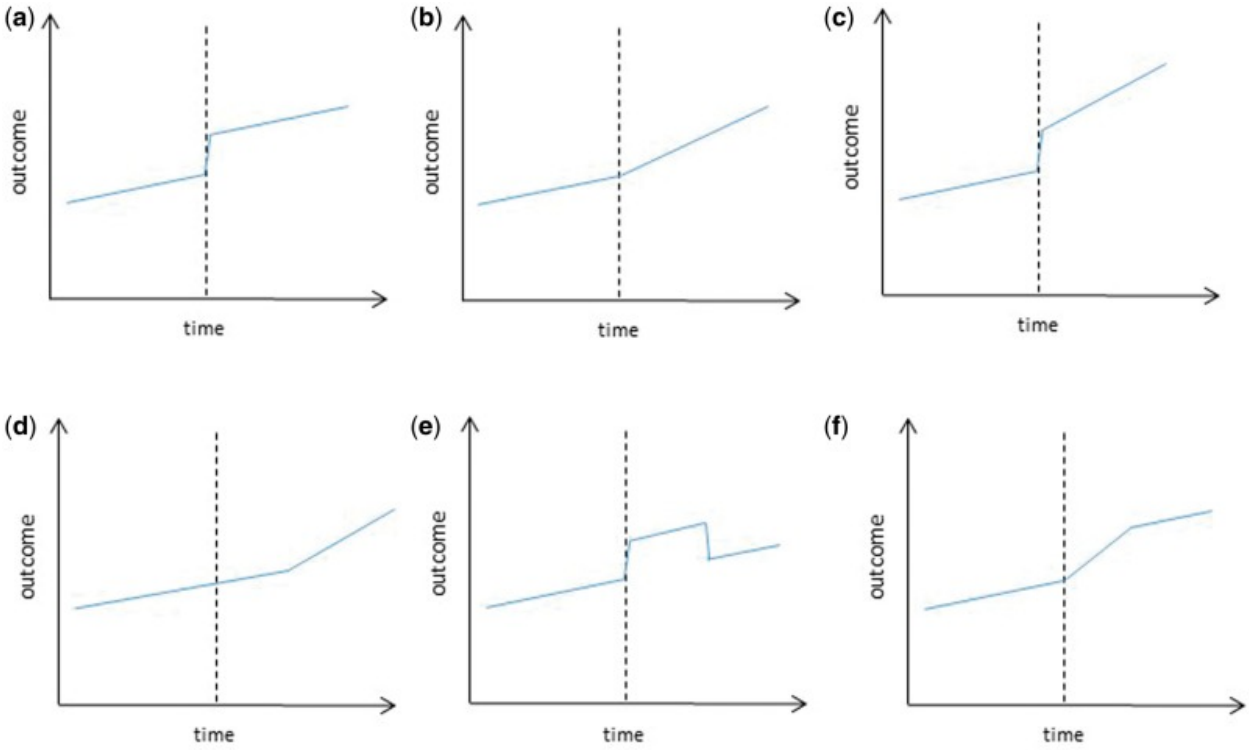
[39] Betancourt, R., & Kelejian, H. (1981). Lagged endogenous variables and the Cochrane-Orcutt procedure. *Econometrica, 49*(4), 1073–1078.

[40] Nelson B. K. (1998). Statistical methodology: V. Time series analysis using autoregressive integrated moving average (ARIMA) models. *Academic emergency medicine: official journal of the Society for Academic Emergency Medicine*, *5*(7), 739–744. https://doi.org/10.1111/j.1553-2712.1998.tb02493.x

[41] Bernal, J. L., Cummins, S., & Gasparrini, A. (2017). Interrupted time series regression for the evaluation of public health interventions: a tutorial. International journal of epidemiology, 46(1), 348–355.

best fit. We will provide scatter plots of each measure over time along with the fitted model in the evaluation reports.

Exhibit K: Illustration of Potential ITS Relationships



Note: Examples of impact models used in ITS (a) Level change; (b) Slope change; (c) Level and slope change; (d) Slope change following a lag; (e) Temporary level change; (f) Temporary slope change leading to a level change.[42]

We will also explore measures defined for sub-populations and use beneficiary-group by quarter as the unit of analysis to separately estimate the impact of the Demonstration for each beneficiary-group, if population sizes are sufficiently large to allow for the measures to be defined. Some of the sub-groups of interest include dual/non-dual status and Medicaid FFS/managed care status. We will estimate Equation 1 separately for each sub-group and report the estimated coefficients. The covariates for the sub-group analyses will be the same as those for the main analyses. We will also conduct statistical tests such as z-tests to see whether the estimated coefficients are statistically significantly different across sub-groups.[43, 44]

Impact Analysis – Individual-Year Level Analysis using a Fixed effects Model

The district-quarter level analysis using an ITS design is our primary model. However, there could be a concern that the number of observations (the number of quarters under the

[42] Ibid.

[43] Clogg, C. C., Petkova, E., & Haritou, A. (1995). Statistical methods for comparing regression coefficients between models. *American Journal of Sociology*, *100*(5), 1261-1293.

[44] Paternoster, R., Brame, R., Mazerolle, P., & Piquero, A. (1998). Using the correct statistical test for the equality of regression coefficients. *Criminology*, *36*(4), 859-866.

Demonstration) might not be sufficiently large enough for the detection of statistically significant effects associated with the Demonstration. This is more of a concern at the stage when we conduct analysis for the interim evaluation report. Furthermore, the type of covariates allowed for in the district-level ITS model is limited and may mask the heterogeneity of effects at the individual level within the District's Medicaid population.

Therefore, to supplement the District-quarter level analysis, we will also conduct an individual-year level analysis for a select subset of outcomes, preferably using an individual-level fixed effects model.[45] The individual-level fixed effects model analysis requires panel data in which the same individual is observed for multiple periods, and thus individual-fixed effects can be included to capture any unobserved factors that affect the outcomes but do not vary over time. This is an effective way to remove individual-level time-invariant confounding factors such as individuals' unobservable underlying health conditions, preference and motivation for seeking treatment, etc., which cannot be controlled for in a District-quarter level ITS model.

The individual level analysis may also help isolate Demonstration effects from the COVID-19 pandemic effects through subgroup analysis. For example, one concern of the effects of the COVID-19 pandemic on the evaluation is that the number of Medicaid beneficiaries might increase as people experience adverse economic shocks, which in turn affects the denominator of measures such as "Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis." We will explore the feasibility of comparing the measures defined among "incumbent Medicaid beneficiaries" and among "new Medicaid beneficiaries" and see if there are significant differences. In addition, we will also define both the "conditional" (percentage) and "unconditional" (counts of numerator) measures to see if there are differential changes in the denominator and the numerator.

The individual level analysis will be implemented with a fixed-effects model specified as follows:

Equation 2: $Y_{it} = \beta_0 + \beta_1\, demo_t + X_{it} + \theta_i + \theta_t + \varepsilon_{it}$

Where:

- Y_{it} is the outcome for individual *i* in year *t*. An example of the outcome is an indicator variable that equals 1 if beneficiary *i* (with SMI/SED) had an ED visit during year *t*.
- $demo_t$ is an indicator variable taking the value of 0 in the baseline period and 1 in the post-period (the period starting January 1, 2020).
- β_1 is the parameter of interest, and it captures changes associated with the Demonstration at the individual level.
- X_{it} denotes individual-level characteristics that vary over time. An example is the number of chronic conditions individual *i* has in year *t*.
- θ_i denotes the individual fixed effects.
- θ_t denotes the year fixed effects.
- ε_{it} is the error term.

[45] This analysis is not applicable for all outcomes listed in Exhibit G. For example, this analysis will not be applicable for provider outcomes such as the "SUD provider availability" and "Mental health providers," measures that can only be observed once for each individual such as "opioid overdose deaths," and measures that are only observed during the Demonstration period such as the survey measures.

This specification might not be feasible for all outcomes of interest. The reason is that it might be challenging to have a balanced panel—all the beneficiaries in the sample have observations in all the time periods—with a large enough sample size (relative to the sample used to compute the District level outcomes for ITS). Because not all individuals can be observed for multiple periods in the claims data, the sample for this analysis is a sub-set of the universe of individuals in the main ITS analysis at the District level. We will construct summary statistics and explore the difference between this sub-sample and the ITS sample to assess the degree of selection, if any. If we find that the bias of non-random missing values could outweigh the benefits of an individual fixed-effects model, we will analyze the same sample using a model without the individual fixed effects. The latter model estimated from repeated cross-sectional data at the individual level will include individual-level covariates and will still provide additional statistical power and evidence that would complement the ITS analysis at the District level.

Regression Analysis of Beneficiary Survey Data

Although the beneficiary survey covers the Demonstration period only, two rounds of data are available with the first round from the first year of the Demonstration itself (baseline survey). The survey data will contain information not available through claims and a relatively large set of variables on respondents' characteristics. Therefore, in addition to descriptive analysis, we will conduct regression analysis of the survey data. The regression-based analysis will assess if there are changes in self-reported outcomes associated with the later round of the survey (endline survey) relative to the baseline.

We will estimate a regression model specified as follows:

Equation 3: $Y_i = \beta_0 + \beta_1 \, Endline_i \; + \; X_i + \varepsilon_i$

Where:

- Y_i is the outcome for respondent *i*. An example of the outcome is an indicator variable that equals 1 if respondent *i* is aware of the available SUD treatment and services, and 0 otherwise.
- $Endline_i$ is an indicator variable taking the value of 1 if the respondent is a participant of the endline survey, and 0 otherwise.
- β_1 is the parameter of interest, and it captures changes associated with the endline survey relative to the baseline survey, which reflects part of the changes associated with the Demonstration.
- X_i denotes respondent characteristics for respondent *i*. Examples include race/ethnicity and age groups.
- ε_i is the error term.

If feasible, we will conduct sub-sample analysis and see if these changes differ across respondents in different sub-groups.

Cost Analysis

The goal of the cost analysis is to better understand the Medicaid program costs for beneficiaries with SMI/SED and SUD, the factors driving these costs and how this may evolve over the course of the demonstration. We will conduct three levels of cost analysis following

CMS guidance on conducting cost analyses for 1115 waiver demonstrations.[46] All the analyses will be conducted separately for beneficiaries with SMI/SED and beneficiaries with SUD.

All cost outcome measures will be expressed in terms of dollars per beneficiary per month (PBPM). Analyses at all levels will utilize actual MCO payments to providers. The cost outcomes by level of analysis and populations are defined as follows (the detailed cost outcome measures are defined in Exhibit H).

- Level 1:
    - The first level of analysis will reflect total costs. This calculation will be the sum of benefit and administrative costs. There will be separate analyses for SMI/SED beneficiaries and SUD beneficiaries.
- Level 2:
    - The second level of analysis will reflect costs related to SMI/SED and SUD. This level of analysis identifies cost drivers by splitting out costs associated with an SMI/SED diagnosis and/or services, or with an SUD diagnosis and/or services. There will be separate analyses for SMI/SED beneficiaries and SUD beneficiaries.
- Level 3:
    - The third level of analysis will identify source of treatment cost drivers. This level of analysis identifies cost drivers for the target population—beneficiaries with SMI/SED or beneficiaries with SUD—by splitting out benefit costs that include outpatient, inpatient, prescription drugs and long-term care costs. We will separate ED-related outpatient costs from other outpatient costs. There will be separate analyses for SMI/SED beneficiaries and SUD beneficiaries.

We will follow CMS guidance to construct the dataset used in the cost analysis. There will be separate datasets for beneficiaries with SMI/SED and SUD. We will take the following approach, as directed in CMS guidance:

- We will identify eligible beneficiaries with a relevant diagnosis and/or treatment during the specified time periods and create a beneficiary-month dataset. The dataset will identify each month that a beneficiary has a relevant diagnosis and/or treatment and enrollment in the months following the relevant diagnosis and/or treatment.
- The analysis will identify the first month in which a relevant diagnosis or treatment occurred for SMI/SED or SUD and identify the 11 months following (as long as the beneficiary remained enrolled in Medicaid).
- If a beneficiary has additional claims with the relevant diagnosis and/or treatment code values, the observation period included in the analysis will be extended to include up to 11 additional months following the subsequent claims if the beneficiary remained enrolled in Medicaid. For each month in which a beneficiary is enrolled, the data file will contain an observation with the beneficiary's Medicaid costs in that month (for each of the cost outcome variables) and demographic characteristics.

[46] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf. While the CMS guidance refers to inpatient [IP], outpatient [OT], pharmacy [RX], long-term care [LT] file types in Transformed Medicaid Statistical Information System (T-MSIS) as an example, equivalent data from DHCF's MMIS will be used in the cost analysis.

From the beneficiary-month dataset, we will calculate and report average costs. We will plot the means of costs to show trends visually and to verify that month-to-month variation is within expectations and does not indicate an underlying data error.

Like the main evaluation strategy, we will use an ITS model to assess trends in costs over time. This model can estimate different linear effects in the pre-demonstration and post-demonstration periods. We will include three pre-Demonstration years. We will report marginal effects and standard errors in the evaluation reports. We will run separate ITS models for each cost outcome and each beneficiary type (SMI/SED or SUD), and the model is specified as follows:

Equation 4: $Cost_{it} = \beta_0 + \beta_1 time_t + \beta_2 demo_t + \beta_3 time_t \times demo_t + X_{it} + \theta_t + \varepsilon_{it}$

Where:

- $Cost_{it}$ is the cost outcome, for example, the total cost, of beneficiary *i* during month *t.*
- $time_t$ indicates the number of quarters from the beginning of the baseline period (January 1, 2017, to December 31, 2019).
- $demo_t$ is an indicator variable taking the value of 0 in the baseline period and 1 in the post-period (the period starting January 1, 2020).
- X_{it} denotes covariates, such as age, gender, race, and dual Medicare-Medicaid enrollment.
- β_0 estimates the base level of the outcome in the first month of the baseline period or the intercept at the baseline.
- β_1 estimates the baseline trend. It is the change in the outcome in the baseline period or the slope of the trend in the baseline period.
- β_2 estimates the change in level of the outcome from the baseline period to the post-period or the change in the intercept after the post-period started.
- β_3 estimates the post-period trend. It is the change in the outcome in the post-period or the slope of the trend in the post-period.
- θ_t denotes the month-fixed effects.
- ε_{it} is the error term.

The estimates from the ITS model demonstrate the trends in PBPM costs in the treatment group. If the average marginal effect of the interaction term ($\beta_3 time_t \times demo_t$) is a positive dollar amount, then the costs in the post-Demonstration period are higher than the costs in the pre-Demonstration period. If the interaction term is a negative dollar amount, then the costs in the post-Demonstration period are lower than in the pre-Demonstration period. We will also assess whether the effect is statistically significantly different from zero. ITS models without a comparison group cannot determine whether any observed changes are caused by the Demonstration.

While we will conduct cost analyses separately for SMI/SED beneficiaries and SUD beneficiaries, beneficiaries with both SMI/SED and SUD are included in both sets of analyses. The post-Demonstration changes in costs for beneficiaries with both SMI/SED and SUD could

be different from those with either SMI/SED or SUD only. We will conduct sub-group analyses to assess whether such differences are observed by type of beneficiary.

D. METHODOLOGICAL LIMITATIONS

In this section, we summarize the main limitations to our methodological approach. Exhibit L describes the potential challenges we will face with the quantitative and qualitative analysis and provides potential solutions for mitigating these limitations.

Exhibit L: Anticipated Methodological Limitations

Challenge/Limitation	Solution
Quantitative Methods	
Because all eligible Medicaid beneficiaries are considered to be participating in the Demonstration, their participation begins at the same time, and obtaining access to administrative claims data or performing data collection for other states is out of scope of this project, there is no appropriate comparison group that is not affected by the Demonstration to compare to the Demonstration group.	Following CMS evaluation guidance, we will use an ITS design to evaluate the effects of the Demonstration, which is the preferred methodology when there is no appropriate comparison group.
Data features such as serial correlation and heteroscedasticity may pose inferential challenges to the ITS design.	We will test for both serial correlation and heteroscedasticity and, if needed, we will update the econometric model to obtain precise estimates.
Because several concurrent programs targeting similar populations and outcomes exist, it can be difficult to rule out alternative explanations and disentangle the precise estimates of the impact of the Demonstration using the ITS design. This is a limitation of the ITS design. The concurrent programs include: State Opioid Response (SOR) grant, Integrated Community Response Team and District-wide Health Information Exchange.	We will try to control for concurrent programs based on the available data from these programs. Yet, it is still likely that our proposed ITS evaluation-design approach will estimate the impact of both the Demonstration and elements of other concurrent programs. Nevertheless, our qualitative data on the nature of these concurrent programs may provide insights into the relative contributions of Demonstration-specific versus pre-existing or new concurrent services to outcomes.
The Demonstration includes several types of programs. The programs vary in features such as goal, length of coverage, target population, and type of services covered, etc.	We will evaluate the heterogeneous effects of the Demonstration by conducting ITS in different subsamples, if the sample sizes are sufficiently large. The subsamples will be defined using categorical variables of characteristics of program, provider, and beneficiaries.
Most non-dual disabled adult beneficiaries have transitioned to managed care as of FY 2021 (October 2020) and many behavioral health services currently carved out of managed care may be carved in as of FY 2022 (October 2021).	We will conduct descriptive subgroup analysis by FFS and managed care status. If feasible, we will conduct ITS analysis for the two groups on selected outcome measures.

Challenge/Limitation	Solution
The COVID-19 pandemic may pose challenges to the ITS design, because the timing of the pandemic coincides with the beginning of the Demonstration and the pandemic may exert long-term effects on the outcomes of interest and confound the ITS estimates.	We may not be able to disentangle the effects of COVID-19 from an ITS model at the district level, so we will discuss the concern for potential confounding factors when we interpret the ITS findings. We will explore whether adding covariates such as the number of COVID-19 cases per 100,000 DC population in each quarter may mitigate the effects of the pandemic. We will consider splitting the post-period in the ITS analysis into two (or more) to account for non-linear effects of the Demonstration. To assess how the COVID-19 pandemic may affect the impact of the Demonstration, we will explore splitting the post-period as (1) 2020 Q1-Q2, and (2) 2020 Q3 and later, and assessing if the effects of the pandemic are stronger in the first quarters of 2020. The individual level analysis may help isolate Demonstration effects from the COVID-19 pandemic effects through subgroup analysis. For example, we may compare outcome changes for incumbent vs. new Medicaid beneficiaries as the number of Medicaid beneficiaries might increase because of the adverse economic shocks of COVID-19.
With an ITS design, estimating the level and slope parameters requires a minimum number of observations (usually at least eight; see table note below for citation) before and after the intervention in order to have sufficient statistical power to estimate the regression coefficients.	We will require at least eight quarters (two years) of data prior to the beginning of the Demonstration to obtain reasonable impact estimates. While level changes due to the intervention can be estimated sooner, we will need about eight quarters of data after the Demonstration starts to obtain an accurate estimate of the changes in post-Demonstration trends. For the Interim Evaluation Report, we may use bootstrapped confidence intervals to estimate the impact of the Demonstration with fewer observations and with some assumptions, along with providing insightful descriptive statistics.
Payment amounts for prescription drugs on FFS claims and MCO encounters in DHCF's MMIS data do not reflect rebates.	This is a limitation that would apply to any claims-based analysis and will be noted in the discussion that accompanies results of the cost analysis.
Qualitative Methods	
Key informant interviews and focus groups will obtain information from a relatively small number of individuals, and we might inadvertently miss important individuals and/or perspectives.	Our approach to qualitative data collection uses the evidence-based standard that saturation is commonly reached after 5–7 interviews as a baseline for the number of stakeholder

Challenge/Limitation	Solution
	interviews, site-visit key informants, and beneficiary interviews/focus groups.
Beneficiary recruitment methods may lead to selection bias (e.g., disproportionately include beneficiaries with positive experiences and outcomes).	We have developed several options for beneficiary recruitment that would minimize selection bias, including the preferred option of random selection.
Key informants may be reluctant to share negative information about the Demonstration out of worry that it will affect their ability to maintain the waiver and institutionalized Demonstration activities.	To mitigate potential response bias, we will inform evaluation participants that DHCF can use the interim qualitative research findings to address emerging challenges with the Demonstration or to modify their Implementation Plan. This may help evaluation participants view discussions of Demonstration challenges as constructive feedback rather than punitive.
Beneficiary Data Collection	
Medicaid beneficiaries are a hard-to-reach population group and this is more so for the subset who have SMI/SED or SUD issues.	IMPAQ will employ multiple survey modes (telephone and in-person) and recruitment through the support of service sites to achieve reasonably high response rates. As SMI/SUD beneficiaries may be harder to engage, and/or not have access to personal cell phones or mailing addresses, the survey team will use service-delivery sites as a way to locate and connect with beneficiaries.
The interviews/focus groups/survey will address certain sensitive topics related to the treatment experiences as well as mental health and substance use of respondents.	IMPAQ interviewers are well trained and experienced working with populations with SMI, SED, and SUD. Interviewers understand the importance of cultural competency, cultural humility, and trauma-informed care. The interviewers understand the importance of building rapport and trust at the start of the interview, emphasizing confidentiality, and explaining the purpose of the survey. Respondents will be given the opportunity to pause as well as skip questions they are not comfortable answering.
Due to co-occurring SMI, cognitive issues, and trauma, some respondents may need additional support and time to answer questions, as well as explanation of questions in easy-to-understand language and flexibility in timing and breaks.	IMPAQ interviewers are experienced in working with people with SMI, SED, and SUD. Interviewers will be prepared to take their time, build rapport, provide breaks, offer flexibility, and reframe questions as needed.
The COVID-19 public-health restrictions pose challenges in conducting in-person data collection at beneficiary residences or provider sites. The restrictions may limit the provision of in-person SUD/SMI services in the District. Those programs still offering in-person residential and outpatient services may not	IMPAQ will assess the current guidelines at the start of the fielding of the data collection and follow all local restrictions related to COVID-19. In cases in which in-person interviews are not an option, the team will work with programs to access beneficiaries via telephone.

Challenge/Limitation	Solution
approve of outside visitors entering their facilities.	
The beneficiary survey will only be offered in English.	Administrative data suggests that less than two percent of Medicaid beneficiaries with SUD, SMI or SUD&SMI are non-English speakers. Given this low percentage, we do not anticipate that an English-only survey will pose a significant problem relative to our ability to achieve the desired response rate or to the representativeness of the survey respondents. However, we will acknowledge this limitation when analyzing and reporting survey results.

Note: Penfold, R. B., & Zhang, F. (2013). Use of interrupted time series analysis in evaluating health care quality improvements. Academic Pediatrics, 13(6), S38–S44.

E. ATTACHMENTS

ATTACHMENT 1: INDEPENDENT EVALUATOR

On November 22, 2019, the District of Columbia Office of Contracting and Procurement (OCP), on behalf of the Department of Health Care Finance, issued a solicitation for proposals from vendors qualified to complete an independent evaluation of the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration in accordance with criteria set forth by the Centers for Medicare & Medicaid Services. Proposals were due to the District on December 20, 2019. After review by a Technical Evaluation Panel and OCP, IMPAQ International was selected as the independent evaluator and a contract was executed on May 14, 2020.

Vendor qualifications were laid out in the District's solicitation. The criteria for evaluation of proposals included an understanding of CMS guidance and District requirements for an independent evaluation, an appropriate approach to execution of the independent evaluation and related deliverables, and a demonstration of organizational capacity, experience, and expertise. Solicitation criteria specified that a prospective contractor must demonstrate to the satisfaction of the District its capability in all respects to perform fully the contract requirements, supported by the submission of relevant documentation. In accordance with STCs for the District's Demonstration, IMPAQ has signed a "No Conflict of Interest" and indicated that it will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft evaluation design (see Exhibit M).

Exhibit M: Signed Statement of Independent Evaluator

IMPAQ

Conflict of Interest Certification Form

Sponsor: District of Columbia, Department of Health Care Finance
Reference: Contract #CW82733
IMPAQ Project Title: DC 1115 Waiver Evaluation
IMPAQ Project Director: Rekha Varghese
IMPAQ Internal Reference: Project # 2867

This letter is to certify that IMPAQ International, LLC maintains a written policy and an administrative process for identification, evaluation, and reporting of financial conflicts of interest meeting the requirements of Title 42 CFR Part 50, Title 42 CFR Part 94, Subpart F, NSF AAG Chapter IV.A, FAR 9.5 and other applicable federal regulations. Additionally, IMPAQ's Conflict of Interest Compliance Program, as detailed in the attachment hereto, includes a process for individual or organizational conflict of interest review that is responsive to any Sponsor's application or guidelines requesting this type of review.

Therefore, to the best of IMPAQ's knowledge and belief, it certifies:

ORGANIZATIONAL CONFLICTS OF INTEREST:
There are no facts relevant to any possible sources of organizational conflict of interest (such as ownership or proprietary rights) in conducting the evaluation as defined in the proposal guidelines or contract Statement of Work. IMPAQ will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft evaluation design.

INDIVIDUAL CONFLICTS OF INTEREST:
This section certifies that any individual team members of IMPAQ, who will perform work as investigators under this project have completed the disclosure process and there are no personal conflicts of interest to report.

FUTURE CONFLICTS OF INTEREST:
This is to certify that IMPAQ will promptly report to DHCF any organizational or individual conflicts of interest that may arise during the performance of this contract. This also certifies that IMPAQ has a Conflict of Interest Compliance Program that includes periodic review of financial interest of employees, subcontractors and consultants, and their immediate families, in order to assess actual or apparent conflicts of interest.

By: Jack Robinson

Title: Compliance Officer

Signature:

Date: September 3, 2020

IMPAQ International | Maher & Maher | ASCEND
10420 Little Patuxent Parkway, Suite 300, Columbia, MD 21044
info@impaqint.com | (443) 259-5500

Conflict of Interest Compliance Program

IMPAQ is strongly committed to ethical and legal conduct in the operation of our business, in the production of high quality research, and in participation in government-sponsored research activities. As part of IMPAQ's commitment to ethical and legal conduct, we have developed and implemented a set of policies, practices, and standards, which are the basis for our operations. These are detailed in a comprehensive Compliance Program, which includes our conflict of interest identification, avoidance, and mitigation plan.

Identification of Conflicts of Interest

IMPAQ's Internal Audit System (IAS), a part of our Compliance Program, is designed to ensure that the company and its personnel are in compliance with the organizational and personal conflict of interest provisions in the Federal Acquisition Regulation (FAR) as well as any additional provisions required by a Request for Proposals (RFP) or issued contract such as conflict of interest requirements. Whenever IMPAQ begins the proposal writing process in response to a Solicitation or RFP, IMPAQ's Compliance Officer and Business Development Teams immediately review the RFP to see if it contains specific Organizational Conflict of Interest (OCI) or Personal Conflict of Interest (PCI) provisions. If PCI requirements exist, the Compliance Officer will ensure that the appropriate personnel review, respond, prepare, and sign any requested PCI forms. If production of the completed and signed PCI forms is required under the terms of the Solicitation or RFP, the Compliance Officer sends copies to IMPAQ's Business Development team for incorporation into the proposal. If production of the PCI forms is not required, the Compliance Officer and Contracts Team retains and archives the signed PCI forms for the duration of the contract, if awarded. For OCI requirements, the Compliance Officer's review will similarly look for specific forms in the RFP that may be required in addition to a more thorough review of the company's past contracts and relationships. The OCI review focuses on four primary forms of OCI: unequal access to information, biased ground rules, impaired objectivity, and procurement integrity. In all cases, the thorough review is designed to ensure compliance with FAR and RFP rules and to identify issues requiring disclosure and/or mitigation. IMPAQ's Compliance Officer, Contracts Team, Business Development Team, and technical staff review IMPAQ's contracts and other available data to determine if the nature of the work, personnel involved, clients, partners, subcontractors, or consultants present a conflict of interest. IMPAQ further requires, via contractual documents at the time of proposal and at the time of award, all partners, consultants, and potential subcontractors to certify that they too have conducted a similar review with respect to an opportunity and can accurately represent that they do not have any PCIs or OCIs.

If a conflict is discovered or disclosed to IMPAQ by a potential partner or consultant, the Compliance Officer meets with the technical staff, Business Development team, and the Vice President of the Division or Practice Area under which the proposal is being submitted to determine (1) whether the conflict of interest can be mitigated, and (2) whether the proposal should be submitted. This review may be escalated to the IMPAQ Compliance Committee. IMPAQ conducts internal audits each time an RFP is identified for pursuit, and in accordance with any applicable procedures set forth in those RFPs that specifically require a conflict of interest review or certification.

Recognizing that IMPAQ has an ongoing duty to discover and disclose any OCIs or PCIs that may arise, IMPAQ also conducts an annual audit, conducted by an outside, independent auditor, which is unrelated to specific RFPs to ensure company compliance and conflict of interest avoidance and mitigation.

Conflict of Interest Compliance Program

Subcontractors are also under an ongoing contractual duty to monitor for conflicts and disclose all potential, apparent, or actual conflicts of interest to IMPAQ immediately for appropriate action, which includes disclosure to the Client as set forth in IMPAQ's Prime Contract. IMPAQ further ensures that all subcontractors are subject to the requirements of the Prime Contract with respect to identification, monitoring, disclosure, and mitigation of conflicts of interest.

Key elements of audits conducted under our Compliance Program, and practices in identifying OCIs or personal conflicts include, without limitation:

- Staff: Review backgrounds of staff including compliance and ethics complaints, education, training, and former employment;
- Procedures, Systems, and Processes: Review procedures for training, education and conflict of interest identification and mitigation; Review systems and processes to ensure they are sufficient for IMPAQ to organize, plan, control, and evaluate financial and marketing activities, the furnishing of services, and the administration and management aspects of the organization including systems/capabilities to provide data and/or reports to clients in the manner and formats requested;
- Policy: Review diligence, effectiveness, and application of IMPAQ's Conflict of Interest Policy;
- Documentation: Review IMPAQ's ability to document and maintain critical conflict of interest documentation for employees and incidents; and
- Compliance with Laws and Regulations: Review IMPAQ's ability to deliver service within compliance laws and regulations.

Avoidance, Neutralization, Mitigation, and Resolution Policies and Procedures

In accordance with the FAR, each individual contracting situation is examined based on its particular facts and the nature of the proposed contract. IMPAQ's policy is to avoid conflicts of interest. Generally, IMPAQ's policy calls for IMPAQ to decline work that presents an actual or potential conflict of interest that cannot be appropriately mitigated. Since no conflicts of interest have been identified for this opportunity, at any time during the project, should a conflict of interest be identified, IMPAQ will adopt a mitigation strategy to minimize risk until a final decision as to the action(s) required are rendered in writing by the Contracting Officer.

In the event a potential, apparent, or actual conflict of interest exists and depending upon the related facts and circumstances, IMPAQ may:

- Divest itself of, or reduce the financial relationship that IMPAQ may have in another organization to a level that is acceptable to the Contracting Officer;
- Separate lines of business management or critical staff or consultants from working on the resultant contract;
- Ensure that the individuals who have potential conflicts of interest due to direct financial relationships to the organizations divest themselves of those relationships, or remove the individual(s) from the contract;
- Have the individuals who have potential conflicts of interest due to indirect financial relationships to the organizations divest themselves of those relationships or obtain approval from the

Conflict of Interest Compliance Program

Contracting Officer of an acceptable level which would allow the individuals to continue working on the contract, or remove the individual(s) from the contract;

- Remove or recuse a subcontractor or consultant, or other partner, and pursue alternative contracting strategies.

IMPAQ may transfer the conflicted party from the work assignment pending resolution of the situation. If an investigation shows that no conflict exists, the employee may return to work on the task with the concurrence of the Contracting Officer.

If the investigation reveals an actual personal conflict of interest, IMPAQ will permanently reassign the employee to non-conflicting work and replace him or her with an equally qualified employee who has no such conflict. Alternate courses of action will be considered only if the Contracting Officer provides written authorization to proceed.

Should the Government, knowing of a potential conflict of interest, desire that IMPAQ perform the work despite a perceived or potential conflict of interest, IMPAQ may agree to perform such work as long as the Contracting Officer directs such an action in writing, and as long as there is informed consent of all parties involved.

Subcontractor & Partner Compliance

In addition to the requirements of subcontractors noted above, IMPAQ takes additional steps to identify, avoid, neutralize, or mitigate apparent, potential, or actual conflicts of interest that our subcontractors or consultants may have. For example, if the subcontractor or consultant has no established procedures, IMPAQ will require them to follow the procedures it uses to identify, evaluate, and disclose conflicts of interest, consistent with any terms of IMPAQ's Prime Contract or RFP. To further facilitate monitoring of subcontractor conflicts of interests, IMPAQ maintains a list of subcontractors and their financial relationships, which include company affiliations as well as parent or subsidiary company relationships, and client relationships, to the extent discoverable. Periodic review of this information helps IMPAQ screen for possible conflicts of interest and ensure subcontractor compliance with the terms of their agreements.

In the event a conflict of interest is discovered, IMPAQ will work with the subcontractor or consultant to develop an appropriate approach to disclosing and mitigating conflicts, taking the subcontractor's own policies into account, within the confines of the Prime Contract requirements. Remedies such as recusal, divestiture, or alternative contracting strategies will be considered. IMPAQ will maintain all documentation necessary to support its determination that any subcontractor or consultant conflicts have been resolved.

ATTACHMENT 2: EVALUATION BUDGET

The budget for the District's evaluation contract totals $1.551 million over five years. Exhibit N provides a breakout of the costs (inclusive of staff, administrative, and other) by major task and contract year.

Exhibit N: Evaluation Contract Budget

Item Description	Base Year	Option Year 1	Option Year 2	Option Year 3	Option Year 4	Total
Project Planning	$36,590	$0	$0	$0	$0	**$36,590**
Project Management	$43,829	$39,294	$40,272	$41,571	$46,123	**$211,089**
Evaluation Design	$111,446	$0	$0	$0	$0	**$111,446**
Data Collection and Analysis	$123,477	$95,446	$121,791	$200,960	$137,400	**$679,075**
Beneficiary Survey	$77,724	$9,777	$0	$60,281	$8,456	**$156,237**
Mid-Point Assessment	$29,597	$48,159	$17,981	$0	$0	**$95,737**
Interim Evaluation Report	$0	$38,430	$57,359	$28,704	$0	**$124,492**
Summative Evaluation Report	$0	$0	$0	$48,804	$87,229	**$136,033**
Total	**$422,662**	**$231,106**	**$237,403**	**$380,319**	**$279,208**	**$1,550,698**

ATTACHMENT 3: EVALUATION TIMELINE AND MAJOR MILESTONES

Exhibit O presents the work plan for the evaluation, with deliverables and anticipated time frames noted. As indicated in the District's STCs, the Final Summative Evaluation report for the Demonstration is due to CMS within 18 months of June 30, 2024 (i.e., by December 31, 2025).

Exhibit O: Evaluation Work Plan

TASK / ACTIVITY	Base Year 2020 - 2021												Option Year 1 2021 - 2022												Option Year 2 2022 - 2023											
	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Task 1: Project Planning																																				
Kickoff Meeting	▲																																			
Project Planning Memorandum		△	▲																																	
Task 2: Project Management																																				
Weekly DHCF meetings		▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
Monthly Evaluation Update		▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
Task 3: Evaluation Design																																				
Evaluation Design Memorandum		▲																																		
Initial Evaluation Design			△	▲																																
Final Evaluation Design							△	▲																												
Task 4: Data Collection and Analysis																																				
Design and implement interviews and primary data collection					━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━
Data Inventory Memorandum		▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
Provide analytic files and documentation						━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━	━
Task 5: Interim Evaluation Report																																				
Initial Interim Evaluation Report																											━	━	━	━	━	━	━	△		
Final Interim Evaluation Report																																				
Task 6: Summative Evaluation Report																																				
Initial Summative Evaluation Report																																				
Final Summative Evaluation Report																																				
Task 7: Mid-Point Assessment																																				
Mid-Point Assessment Memorandum						△		▲																												
Mid-Point Assessment Report														━	━	━	━	━	━	△		▲															
Task 8: Beneficiary Survey Development and Fielding																																				
Beneficiary Survey Methodology Memorandum							△	▲																												
Survey Development			━	━	━	━	━	━																												
Field beneficiary survey									━	━	━	━	━	━																						
Provide results of beneficiary survey																				△		▲												△		

Key: Draft △ Final ▲

Ongoing ━

TASK / ACTIVITY	Option Year 3												Option Year 4											
	2023 - 2024												2024 - 2025											
	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Task 1: Project Planning																								
Kickoff Meeting																								
Project Planning Memorandum																								
Task 2: Project Management																								
Weekly DHCF meetings	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
Monthly Evaluation Update	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
Task 3: Evaluation Design																								
Evaluation Design Memorandum																								
Initial Evaluation Design																								
Final Evaluation Design																								
Task 4: Data Collection and Analysis																								
Design and implement interviews and primary data collection	▬	▬	▬	▬	▬	▬	▬	▬	▬															
Data Inventory Memorandum	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲				
Provide analytic files and documentation	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬				
Task 5: Interim Evaluation Report																								
Initial Interim Evaluation Report	▲																							
Final Interim Evaluation Report					△	▲																		
Task 6: Summative Evaluation Report																								
Initial Summative Evaluation Report								▬	▬	▬	▬	▬	▬	△						▲				
Final Summative Evaluation Report																								△
Task 7: Mid-Point Assessment																								
Mid-Point Assessment Memorandum																								
Mid-Point Assessment Report																								
Task 8: Beneficiary Survey Development and Fielding																								
Beneficiary Survey Methodology Memorandum																								
Survey Development																								
Field beneficiary survey							▬	▬	▬	▬	▬	▬												
Provide results of beneficiary survey	▲				△	▲								△						▲				△

Key: Draft △ Final ▲

Ongoing ▬