



September 23, 2026

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

Dear Director Byrd:

The Centers for Medicare & Medicaid Services (CMS) is approving the District of Columbia's (D.C. or "the District") request to renew its Medicaid section 1115(a) demonstration entitled, "Whole-Person Care Transformation" (Project Number 11-W-00331/3), in accordance with section 1115(a) of the Social Security Act (the Act). This renewal also authorizes the District to change the title of the demonstration, from "Behavioral Health Transformation" to "Whole-Person Care Transformation," to reflect the District's efforts to broaden the scope of its demonstration by adding pre-release services. This approval is effective October 1, 2026 through September 30, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Whole-Person Care Transformation demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality, clinically appropriate services and improving care transitions for beneficiaries with a substance use disorder (SUD) and/or serious mental illness (SMI), while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD) and for certain individuals leaving incarceration and entering back into a community setting. This approval is in alignment with State Medicaid Director Letter (SMDL) #17-003 RE: Strategies to Address the Opioid Epidemic¹ and SMDL #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.²

This approval renews most of the authorities from the 2019 demonstration approval, including the authority to cover short-term stays in IMDs and to waive cost-sharing for medication-assisted treatment (MAT) prescriptions until the District transitions this authority to the Medicaid state plan. The remaining authorities from the 2019 demonstration transitioned to state plan authority in 2022; these authorities allowed the District to provide behavioral health services, such as mobile crisis and outreach and recovery support services, that were not included in the District's Medicaid state plan at the time of the 2019 demonstration approval. Approval of this

¹ <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>

² <https://www.medicare.gov/federal-policy-guidance/downloads/smd18011.pdf>

demonstration renewal also provides the District a new expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for a period of time immediately prior to the individual's expected date of release.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authorities, expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The District may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the District provide a plan detailing the District's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Demonstration Renewal

The following sub-sections provide a detailed explanation of the continuing and new authorities in the demonstration and the requests not being approved at this time.

Renewal of Existing Authorities

(1) Treatment of Individuals with SUD or SMI in IMDs

With this renewal, the District will continue to operationalize and refine its SUD and SMI demonstration initiatives. CMS is renewing the District's current authority to receive federal

financial participation (FFP) for SUD and SMI treatment services for short-term residents in residential and inpatient treatment settings that qualify as an IMD.

(2) Temporary Waiver of Cost-Sharing Requirements for MAT Prescriptions

The demonstration renewal continues waiver authorities for amount, duration and scope, and comparability, which exempt beneficiaries from the \$1.00 pharmacy copayment requirement established under the District’s Medicaid state plan. This copayment is waived when an individual receives a prescription for MAT to minimize barriers to accessing MAT prescriptions.

States may exempt beneficiaries from MAT prescription copayments through Medicaid state plan authority, making the 1115(a)(1) waiver authorities unnecessary. The District plans to pursue an amendment to its Medicaid state plan to modify its cost-sharing policies rather than use 1115 waiver authorities. CMS will work closely with the District to facilitate the state plan amendment (SPA) approval process to the greatest extent feasible for approval of this SPA, provided it is submitted. If the state plan addresses this policy in the future, the demonstration authority related to the MAT prescription copayment would no longer be in effect. The demonstration approval continues these waiver authorities until the effective date of approved changes to the state plan.

New Demonstration Authority

(1) Pre-Release Services under the Reentry Demonstration Initiative

Approval of this demonstration will enable the District to provide coverage for a targeted set of services furnished to certain incarcerated individuals for up to 60 days immediately prior to the individual’s expected release date in jails, and for up to 90 days prior to the individual’s expected date of release from a youth correctional facility. The District’s proposed approach closely aligns with CMS’s “Reentry Demonstration Opportunity” as described in SMDL #23-003³, released on April 17, 2023, and the recently released Frequently Asked Questions document.

CMS has conducted additional scrutiny of Reentry Demonstration policy to ensure the program is based on evidence and appropriate stewardship of taxpayer dollars. Through evaluation of published research, consultation with states and reentry policy stakeholders, and collaboration with federal partners, CMS has identified specific refinements and enhancements, described below, that will improve transparency, sustainability, and program integrity for newly approved reentry demonstrations.

CMS expects to release further updated reentry demonstration guidance in the next year describing these policy changes, updated monitoring, additional oversight, and strengthened financial requirements to ensure transparency and robust program integrity.

³www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

Eligible Individuals

The District will cover a set of pre-release benefits for certain individuals who are inmates residing in jails and youth correctional facilities (hereinafter “correctional facility”). To qualify for services covered under the demonstration approval, individuals residing in a correctional facility must have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, and have an expected release date within 60 days from jails, and within 90 days from youth correctional facilities.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration, that the District make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities where the pre-release coverage of demonstration services will be available.

For a Medicaid covered individual entering a correctional facility, the District will not terminate Medicaid coverage, but will suspend the individual’s coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, the District will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of incarcerated individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of physical, behavioral, and other health-related needs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing the District to provide coverage for the following services, defined in Attachment C to the demonstration’s STCs:

- Case management to assess and address physical and behavioral health needs, and social determinants of health;
- MAT services for all types of SUD as clinically appropriate, including coverage for medications in combination with accompanying counseling/behavioral therapies;
- A 30-day supply of all prescription medications, as clinically appropriate, that have been prescribed for the individual at the time of release, provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;
- Practitioner office visits (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);

- Diagnostic services, including laboratory and radiology services;
- Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration;
- Peer support services; and
- Behavioral health clinical consultation services for individuals in youth correctional facilities.

Under no circumstances should the provision of these services or related policies, procedures, or processes developed to support implementation of this demonstration result in a delay of an individual's release from incarceration or lead to increased involvement in the juvenile or adult justice systems.

Duration of Pre-Release Coverage

The District requested 90 days of pre-release coverage for all eligible beneficiaries. CMS has determined that up to 60 days of pre-release coverage is appropriate for all individuals in jails. Available data demonstrate that providing access to services such as MAT in the 60 days leading up to release reduces the risk of overdose, supporting the provision of pre-release coverage for up to 60 days.^{4,5,6,7,8,9} Furthermore, 60 days of pre-release coverage helps ensure that incarcerated individuals are stabilized and receive adequate case management and other pre-release services under the demonstration and is likely sufficient to test whether pre-release services improve transitions of care for individuals in adult facilities. Based on ongoing monitoring and rapid cycle reports with approved and pending states, CMS understands that it would be unduly burdensome to offer different lengths of pre-release coverage to individuals incarcerated in the same facility due to significant administrative complexity, and CMS's forthcoming Rapid Cycle Report findings indicate that key state and carceral stakeholders identified reducing complexity in operational and administrative burdens as a key facilitator to success. As such, CMS is approving coverage of these services for up to 60 days for individuals in jails. CMS continues to approve up to 90 days of pre-release services for individuals in youth correctional facilities.

⁴ Burns, et al. (2022). Duration of Medication Treatment for Opioid-Use Disorder and Risk of Overdose among Medicaid Enrollees in Eleven States: A Retrospective Cohort Study. *Addiction*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10683938/>

⁵ Volkow, N. D., & Wargo, E. M. (2018). *Overdose prevention through medical treatment of opioid use disorders*. *Annals of Internal Medicine*, 169(3), 190–192. <https://doi.org/10.7326/M18-1397>

⁶ Au, V. Y. O., Rosic, T., Sanger, N., Hillmer, A., Chawar, C., Worster, A., Marsh, D. C., Thabane, L., & Samaan, Z. (2021). Factors associated with opioid overdose during medication-assisted treatment: How can we identify individuals at risk? *Harm Reduction Journal*, 18, Article 71. <https://doi.org/10.1186/s12954-021-00521-4>

⁷ Hayes et al. (2026). Evaluating the optimal duration of medication treatment for opioid use disorder. Study for the Society of Addiction. <https://onlinelibrary.wiley.com/doi/10.1111/add.70211>

⁸ Friedmann, P.D., et al. (2025). Medications for Opioid Use Disorder in County Jails—Outcomes After Release. *The New England Journal of Medicine*. <https://www.nejm.org/doi/full/10.1056/NEJMsa2415987>

⁹ Martin, R.A., et al. (2022). Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: a retrospective cohort study. *Lancet Regional health*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9950664/>

Implementation and Reinvestment Plans

As described in the STCs, as a condition of demonstration approval, the District is required to submit a Reentry Initiative Implementation Plan (here called Implementation Plan) to document how the District will operationalize coverage and provision of pre-release services. The Implementation Plan must be submitted to CMS on a timeline consistent with the STCs, and must describe the milestones and associated actions being addressed under this demonstration and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the District's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for program policy implementation. The Implementation Plan will also outline any potential operational challenges that the District anticipates and the District's intended approach to resolving these and other challenges the District may encounter in implementing the reentry demonstration initiative. The section 5121 operational plan requirement in sections 1902(a)(84)(D) of the Act is satisfied by the District's Implementation Plan. The District is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in sections 1902(a)(84)(D) or 2102(d)(2) of the Act that is not covered under this demonstration.

The District is also required to submit a Reentry Demonstration Initiative Reinvestment Plan (here called Reinvestment Plan) as a condition of demonstration approval. The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in the District of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid programs.

To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, the District agrees to reinvest all new federal dollars, equivalent to the amount of FFP expended for such previously existing services, into allowable justice-related activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement and the STCs, the District will develop and submit a Reinvestment Plan to CMS that documents an estimated calculation of the amount of federal dollars the District will receive over the course of the demonstration period, a detailed description of the District's plans

to reinvest the required funds into allowable activities, and an assessment of the impact of reinvested funds on privately-owned or -operated carceral facilities and associated safeguards to prevent increasing profit or operating margins for such facilities. In order to ensure state accountability for this requirement, the District must submit annual progress updates on their reinvestment as part of the District's annual monitoring report. The District will also be required to submit a Final Reinvestment Assessment detailing the total amount of FFP received over the demonstration period, the total amount reinvested, and the outcome of those activities.

Interaction between the District's Reentry Demonstration and the CAA, 2023 Mandate

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends section 1902(a)(84) of the Social Security Act (the Act) to describe a mandatory population of eligible juveniles in Medicaid who are incarcerated in a public institution post adjudication of charges¹⁰ who are to receive a set of pre-release and post-release services. Section 5122 of the CAA, 2023 amends section 1905(a) of the Act to give states the option to receive FFP for the full range of coverable services for eligible individuals who are incarcerated in a public institution while pending disposition of charges.¹¹ The requirements of section 5121 of the CAA, 2023 have a statutory effective date of January 1, 2025. Every state is required to submit a Medicaid State Plan Amendment assuring compliance with these requirements.¹²

To the extent there is overlap between the services required to be covered under section 1902(a)(84)(D) of the Act and coverage under this demonstration, CMS understands that it would be administratively burdensome for a state to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage under this demonstration, CMS is approving a waiver of the otherwise mandatory state plan coverage requirements to permit the District instead to claim for at least the same pre-release services for the same beneficiaries under this demonstration.¹³ This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring and evaluation of the District's reentry coverage under the demonstration. The District will provide pre-release coverage under the reentry demonstration initiative to eligible juveniles described in section 1902(nn) of the Act in alignment with section 1902(a)(84)(D) of the Act, as applicable, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Any required services that are not provided through the demonstration during the pre-release period as well as any post-release services will continue to

¹⁰ Section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old).

¹¹ For CHIP, section 2110(b)(7) creates an optional exception to the CHIP eligibility exclusion for inmates of a public institution under section 2110(b)(2)(A) so incarcerated youth who are pending disposition of charges are not excluded from the definition of targeted low-income child.

¹² SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth.
<https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf>

¹³ Section 5122 of the CAA, 2023 gives a state the option to cover the full breadth of otherwise-covered Medicaid and CHIP services for eligible juveniles who are incarcerated pending disposition of charges. We have not yet approved this claiming flexibility for Section 5122 services and we are not providing this claiming flexibility in this approval.

be covered under the state plan. Additionally, coverage of the population and benefits identified in section 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions. To effectuate this approach, CMS is adding a new waiver of section 1902(a)(84)(D) of the Act.

Requests Not Being Approved at this Time

CMS and the District are continuing discussions regarding the District's pending requests under the demonstration renewal application submitted June 6, 2024. The requests below continue to be under review:

- Case Management for Eligible Individuals in Federal Prisons;
- Social Determinants of Health (SDOH) Services; and
- SDOH Infrastructure.

The District also requested transitional non-service expenditures to support implementation of the reentry demonstration initiative. CMS is working with the District on pathways to otherwise allowable administrative claiming such as Implementation Advance Planning Documents to support implementation costs associated with the reentry demonstration. As a result, we do not anticipate approving the District's request for transitional non-service expenditures as proposed and will no longer consider this an active request.

Budget Neutrality

This demonstration project is being renewed using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.¹⁴ However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21 the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.¹⁵ CMS issued SMDL #26-003¹⁶ on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #24-003, as a condition of demonstration approval, demonstrations must be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.¹⁷ The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are

¹⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf>

¹⁵ <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

¹⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf>

¹⁷ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html>

limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” [WOW] costs). The District will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines

Under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline by using a weighted average of the District’s historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President’s Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as “hypothetical” for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality “supplemental test” for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the District’s “with waiver” (WW) hypothetical spending exceeds the supplemental test’s expenditure limit, the District agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

There is one new MEG in the demonstration that will be treated as hypothetical for budget neutrality purposes. For this MEG, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with this MEG in the WOW baseline has been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President’s Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be “hypothetical” because

the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral site, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in IMDs primarily to receive treatment for SUD, or SMI, under the SUD and SMI section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry services MEG.

Mid-Course Correction

CMS has included a mid-course correction STC in this demonstration approval to provide flexibility and stability for the District over the life of a demonstration. This update identifies a list of circumstances under which the District's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the District's control (for example, if expensive new drugs that the District is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the District to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the District should submit to support a potentially approvable request for an adjustment.

Monitoring and Evaluation

Consistent with the demonstration STCs, the District submitted its draft Interim Evaluation Report for the prior demonstration approval period with the renewal application. The evaluation findings from the Interim Evaluation Report demonstrate notable progress toward some demonstration goals. For example, compared to the pre-demonstration period, emergency department (ED) use for SMI declined during the demonstration approval period. Access to crisis stabilization services and to community-based services increased for SMI. The rate of initiation of SUD treatment increased. However, several quality-of-care measures trended opposite the desired direction, including an increase in the 30-day readmission rate for SUD and a decline in the rate of physical care for SUD. The evaluation identified several contributing factors including limited provider capacity for partial hospitalization and intensive outpatient services and ongoing gaps in care coordination and transitions.

The District has begun to address these challenges through various initiatives including implementation of IMD reimbursement and crisis stabilization services, enhancement of health information exchange and telehealth capabilities, and improvements to behavioral health integration and peer support services. CMS is approving the renewal to allow the District additional time to further implement demonstration policies and assess whether improved access leads to sustained improvements in outcomes and reductions in avoidable utilization.

With this demonstration renewal, the District is required to continue conducting systematic monitoring and robust evaluation of the demonstration in accordance with the STCs. An Annual Monitoring Report capturing key metrics and narrative updates will be due to CMS 180 days after the end of each demonstration year. The District must conduct a Reentry Early

Implementation Rapid Cycle Report, as described in the Reentry STCs, to assess implementation planning of the demonstration and provide actionable insights to support program refinement during the initial implementation phase.

The District is required to incorporate the demonstration into its evaluation activities to support a comprehensive assessment of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the District's overall Medicaid programs. Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others. The evaluation of the demonstration should also include the temporary extension approval period January 1, 2025, through September 30, 2026.

The state plan requirements for eligible juveniles under section 1902(a)(84)(D) of the Act for Medicaid are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from June 24, 2024 through July 24, 2024. CMS received 10 comments, 9 of which were related to the demonstration renewal. Most commenters were supportive of renewing the District's demonstration and adding the reentry demonstration initiative.

Several commenters provided recommendations regarding the reentry demonstration initiative, such as encouraging the District to address the unique needs of women who are incarcerated and establishing a stakeholder advisory committee to support the implementation of the reentry demonstration initiative. CMS appreciates these recommendations; however, the decisions outlined above fall within the District's discretion.

One commenter recommended that CMS deny the renewal of the District's authority to receive FFP for IMD stays, citing concerns with the District's ability to address safety in IMDs and achieve continuity of care goals to help beneficiaries successfully transition to community-based care. Regarding the safety issues, the District worked with the IMD to come into compliance with hospital certification requirements. CMS staff reviewed these concerns with the District and the District committed to taking meaningful steps to strengthen its oversight of IMDs and to improve services for individuals with SUD and SMI. The District reported it is working to improve continuity of care by expanding transition planning and improving follow-up after inpatient visits. CMS will continue to monitor the District's progress through its required monitoring and evaluation reports and will engage with the District should any findings raise additional concerns.

CMS has concluded that renewing the Whole-Person Care Transformation demonstration is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this demonstration renewal is conditioned upon compliance with the enclosed set of waivers, expenditure authorities, and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Jamie John, who is available to answer any questions concerning your section 1115 demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Jamie.John@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

A large black rectangular redaction box covering the signature of Dr. Mehmet Oz. A blue ink flourish is visible above the right side of the redaction.

Dr. Mehmet Oz

Enclosure

Cc: Taneka Rivera, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00331/3

TITLE: Whole-Person Care Transformation Section 1115(a) Demonstration

AWARDEE: Government of the District of Columbia, Department of Health Care Finance

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning October 1, 2026 through September 30, 2031.

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

To enable the District to exempt beneficiaries from \$1 pharmacy co-payments for medication assisted treatment (MAT). If the District submits a state plan amendment (SPA) to eliminate this co-payment, this waiver authority will expire as of the effective date of the approved SPA.

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

To enable the District to exempt beneficiaries from \$1 pharmacy co-payments for MAT. If the District submits a SPA to eliminate this copayment, this waiver authority will expire as of the effective date of the approved SPA.

3. Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release **Section 1902(a)(84)(D)**

To enable the District not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the District instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The District will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00331/3

TITLE: Whole-Person Care Transformation Section 1115(a) Demonstration

AWARDEE: Government of the District of Columbia, Department of Health Care Finance

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 October 1, 2026 through September 30, 2031, unless otherwise specified, be regarded as expenditures under the District’s title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as “not applicable” may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the District to operate the above-identified section 1115(a) demonstration.

Title XIX Expenditure Authority:

- 1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
- 2. Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment services for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
- 3. Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these special terms and conditions (STCs), provided to qualifying Medicaid beneficiaries for up to 90 days immediately prior to the expected date of release in youth correctional facilities participating in the reentry demonstration initiative. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 60 days immediately prior to the expected date of release in jails participating in the reentry demonstration initiative.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness

Section 1902(a)(1)

To enable the District to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability

Section 1902(a)(10)(B)

To enable the District to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice

Section 1902(a)(23)(A)

To enable the District to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00331/3

TITLE: Whole-Person Care Transformation Section 1115(a) Demonstration

AWARDEE: Government of the District of Columbia, Department of Health Care Finance

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the “Whole-Person Care Transformation” section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the Government of 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 (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 populations affected by the demonstration are effective from October 1, 2026, through September 30, 2031, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Enrollment
5	Substance Use Disorder (SUD) Program and Benefits
6	Serious Mental Illness (SMI) Program and Benefits
7	Reentry Demonstration Initiative
8	Cost Sharing
9	Delivery System
10	Monitoring and Reporting Requirements
11	Evaluation of the Demonstration
12	General Financial Requirements
13	Monitoring Budget Neutrality for the Demonstration
14	Schedule of Deliverables for the Demonstration Period

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

Attachment A	SUD/SMI/SED Implementation Plan
Attachment B	Reserved for Evaluation Design
Attachment C	Reentry Demonstration Initiative Services
Attachment D	Reserved for Reentry Demonstration Initiative Implementation Plan
Attachment E	Reserved for Reentry Demonstration Initiative Reinvestment Plan
Attachment F	Reserved for Reentry Demonstration Initiative Final Reinvestments

2. PROGRAM DESCRIPTION AND OBJECTIVES

The District’s section 1115 demonstration, originally titled the “Behavioral Health Transformation” demonstration, was first approved on November 6, 2019, and implemented on January 1, 2020. The demonstration authorized the District to receive federal financial participation (FFP) to provide services that address gaps in the behavioral health delivery system for Medicaid beneficiaries with serious mental illness (SMI) and/or substance use disorder (SUD) (hereafter collectively “SMI and/or SUD”).

Under the renewal of the demonstration, the District will maintain and enhance access to mental health services, opioid use disorder (OUD) and other SUD services, and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI or SUD. This demonstration will provide the District with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI or SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support District efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT), and improve access to a continuum of SMI or SUD evidence-based services at varied levels of intensity, including withdrawal management services.

During the demonstration period, the District seeks to achieve the following goals related to SUD and SMI treatment:

SUD Goals:

1	Increase rates of identification, initiation, and engagement in treatment for SUD
2	Increase adherence to and retention in treatment
3	Reduce overdose deaths, particularly those due to opioids
4	Reduce utilization of 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
6	Improve access to care for physical health conditions among beneficiaries with SUD

SMI Goals:

1	Reduce utilization and lengths of stay in EDs among beneficiaries with SMI while awaiting mental health treatment in specialized settings
2	Reduce preventable readmissions to acute care hospitals and residential settings
3	Improve 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, psychiatric hospitals, and residential treatment settings throughout the District
4	Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI including through increased integration of primary and behavioral health care
5	Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

As part of the 2026 demonstration renewal, CMS is approving authority for the District to provide coverage of a targeted set of pre-release services to certain individuals immediately prior to their expected date of release from a participating correctional facility. The District will provide these services for either 60 or 90 days, depending on the type of correctional facility.

The District will also continue authority to remove the cost-sharing requirement for prescriptions associated with MAT until this authority is approved under the Medicaid state plan. Other services authorized in the first demonstration period, such as recovery support services and supported employment, transitioned from the 1115 demonstration to state plan authority in 2022.

CMS is approving the District's request to change the name of its demonstration to, "Whole-Person Care Transformation," to reflect the District's efforts to broaden the focus of its demonstration by including pre-release services.

3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **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).
- 3.2. **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.
- 3.3. **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

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 3.7. 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.

3.4. 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 3.7 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.

3.5. 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.

3.6. 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 3.7 below, except as provided in STC 3.3.

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 3.12. 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 monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **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 3.9.

3.9. **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 3.12, 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 redeterminations 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 redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the District must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The District must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. 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.
- 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 be 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.

- 3.10. **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 and 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's 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.

- 3.11. **Adequacy of Infrastructure.** The District must 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.
- 3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The District must comply with the state notice procedures as required in 42 CFR section 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 3.7 or extension, are proposed by the District.
- 3.13. **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.
- 3.14. **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.
- 3.15. **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).

4. ELIGIBILITY AND ENROLLMENT

- 4.1. **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.

5. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

- 5.1. **SUD Program Benefits.** The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The District is eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The District will aim for a statewide average length of stay of 30 days or less in residential treatment settings to be monitored pursuant to STC 10.5, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing care for these conditions in cost-effective community-based settings.

- 5.2. **SUD Implementation Plan.** The District's SUD Implementation Plan, initially approved for the period from January 1, 2020 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031, and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. 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 10.2. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD project:

- a. Access to Critical Levels of Care for OUD and other SUDs. Coverage of SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the District); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management;
- b. Use of Evidence-based SUD-specific Patient Placement Criteria.
 - i. 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;
 - ii. *Utilization Management.* 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;

- c. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.
 - i. Implementation of residential treatment provider qualifications. 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;
 - ii. 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;
 - iii. Availability of MAT. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site;
- d. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OD. 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;
- e. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OD.
 - i. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
 - ii. Expand coverage of and access to naloxone for overdose reversal;
 - iii. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;
- f. 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;
- g. SUD Health IT Plan. Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 5.3 and Attachment A.

- 5.3. **SUD Health Information Technology Plan (“Health IT Plan”).** The 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 #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 5.2[g]), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, standards adopted by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) in accordance with 45 CFR part 170, subpart B.

The District’s Health IT Plan, initially approved for the period from January 1, 2020 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031 and is affixed to the STCs as Attachment A.

- a. The District must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 10.5).
- b. As applicable, the District should advance HHS adopted standards in 45 CFR 170 Subpart B in developing and implementing the District’s SUD Health IT policies and in all related applicable District procurements (e.g., including managed care contracts) that are associated with this demonstration.¹
- c. 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 to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B, the District should use the federally-recognized standards.
- d. Where there are opportunities at the District- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170 Subpart B, the District should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).²
- e. Specific components of the Health IT Plan are listed below:

¹ Where the plan involves health IT that is acquired, upgraded, or implemented by health care providers that have been eligible for CMS incentives to adopt health IT certified under the ONC Health IT Certification Program, states should advance the use of certified health IT, as applicable. Certified health IT incorporates the standards in 45 CFR 170 Subpart B.

² <https://www.healthit.gov/isp/>

- i. The Health IT Plan must describe the District’s alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).³
- ii. The Health IT Plan must address how the District’s Qualified PDMP will enhance ease of use for prescribers and other District and federal stakeholders.⁴ States should favor procurement strategies that incorporate Qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in open interfaces and exposed application program interfaces.
- iii. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

5.4. **Unallowable Expenditures Under the SUD Expenditure Authority.** The District may not receive FFP for room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

6. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

6.1. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such 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 for beneficiaries receiving treatment in an IMD treatment setting through this demonstration’s SMI Program, to be monitored pursuant to STC 10.5.

6.2. **SMI/Serious Emotional Disturbance (SED) Implementation Plan.** The District’s SMI/SED Implementation Plan, initially approved for the period from January 1, 2020, through September 30, 2026, remains in effect for the approval period from October 1, 2026, through September 30, 2031, and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. 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 10.2. The approved SMI Implementation Plan describes 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 of this SMI/SED project:

- a. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

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.*

- i. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the District or locality responsible for licensing hospitals prior to the District 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 either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have 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.
- ii. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the District to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the District claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
- iii. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable District licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
- iv. 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;
- v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a District process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of 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 providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- vi. Implementation of a District requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and 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).

b. Improving Care Coordination and Transitions to Community-Based Care.

- i. 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 these settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
- ii. 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 have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
- iii. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was referred to;
- iv. Implementation of strategies to prevent or decrease the length of stay in emergency departments (ED) among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- v. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

c. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

- i. 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 (the District must provide a yearly update on how it has increased the availability of mental health services via the Annual Monitoring report);
- ii. Commitment to implementation of the SMI/SED financing plan described in STC 6.4. The District must maintain a level of District and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration.

The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 10.5;

- iii. 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;
- iv. 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., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to help determine appropriate level of care and length of stay.

d. Earlier Identification and Engagement in Treatment and Increased Integration.

- i. 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;
- ii. 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;
- iii. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

e. The Implementation Plan must also include sections containing the SMI/SED Health IT Plan and the SMI/SED Financing Plan. Further information which describes the requirements are detailed in STC 6.3, STC 6.4 and Attachment A.

6.3. **SMI/SED Health IT Plan.** The Health IT Plan(s) details the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) is also used to identify areas of health IT ecosystem improvement. The Plan includes implementation milestones and projected dates for achieving them (see Attachment A) and is aligned with the District's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the District's Behavioral Health (BH) IT Health Plan.

The District's Health IT Plan, initially approved for the period from January 20, 2020 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031 and is affixed to the STCs as Attachment A.

- a. The District will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 10.5).
- b. As applicable, the District should advance HHS-adopted standards identified in 45 CFR 170 Subpart in developing and implementing the District's SMI/SED Health IT policies and in all related applicable District procurements (e.g., including managed care contracts) that are associated with this demonstration.

- c. Where there are opportunities at the District- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B, the District should use the federally recognized standards.
- d. Where there are opportunities at the District- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170 Subpart B, the District should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).
- e. Specific components of the Health IT Plan are listed below:
 - i. The Health IT Plan as applicable, describes the District's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI/SED care delivery. The District also indicates current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
 - ii. The Health IT Plan describes the District's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

6.4. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan referred to in STC 6.2(e), the District is required to submit a financing plan for approval by CMS. The District's SMI/SED Financing Plan, initially approved for the period from January 1, 2020 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031 and is affixed to the STCs as Attachment A. Components of the financing plan include:

- a. 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
- b. 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;

6.5. **Maintenance of Effort (MOE).** The District must maintain a level of District and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 10.5.

- 6.6. **Average Length of Stay Requirements and FFP.** Federal Financial Participation (FFP) is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The District may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the District shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs 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 District may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the District can demonstrate that it is meeting the 30 day or less ALOS requirement. The District will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.
- 6.7. **Unallowable Expenditures Under the SMI Expenditure Authority.** 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:
- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
 - c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
 - d. 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.

7. REENTRY DEMONSTRATION INITIATIVE

7.1. Overview of Pre-Release Services and Program Objectives.

This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in youth correctional facilities. This component will also provide coverage for pre-release services up to 60 days immediately prior to the expected date of release in jails participating in the reentry demonstration initiative. All facilities defined in STC 7.5 Participating correctional facilities will hereinafter be called “correctional facilities.” To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date specified in STC 7.3 below.

- 7.2. The objective of this component of the demonstration is to facilitate individuals’ access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based

providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatments, as appropriate for the individual.

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

- a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;
- b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;
- d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;
- e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs and social determinants of health;
- f. Reduce all-cause deaths in the near-term post-release;
- g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;
- h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release;
- i. Reduce recidivism;
- j. Reduce SUD relapse; and
- k. Increase access to and adherence for SMI treatment.

7.3. Qualifying Criteria for Pre-Release Services. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

- a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 7.5; and
- b. Have been determined eligible for Medicaid; and
- c. Meet one of the following two criteria to receive the described length of pre-release services:
 - i. Be an individual in a jail with an expected release date within 60 days to receive up to 60 days of pre-release services, or
 - ii. Be an individual in a youth correctional facility with an expected release date within 90 days to receive up to 90 days of pre-release services.
- d. Have a status of pre- or post-adjudication.

7.4. **Scope of Pre-Release Services.** The pre-release services authorized under the reentry demonstration initiative are the following services, which are described in Attachment C, Reentry Demonstration Initiative Services.

- a. The covered pre-release services are:
 - i. Case management to assess and address physical and behavioral health needs, and social determinants of health;
 - ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;
 - iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy.
 - iv. Practitioner office visits (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);
 - v. Diagnostic services, including laboratory and radiology services;
 - vi. Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration;
 - vii. Peer support services; and
 - viii. Behavioral health clinical consultation services for individuals in youth correctional facilities.
- b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act (“inmate exclusion rule”). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not

otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the District Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

7.5. Participating Correctional Facilities. The pre-release services will be provided at jails and youth correctional facilities participating in the demonstration, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Department of Health Care Finance approval of a facility's readiness, according to the implementation timeline described in STC 7.11. The District must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also IMDs are not allowed to participate in the reentry demonstration initiative.

7.6. Participating Providers.

- a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under District scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as Medicaid providers.
- b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.
- c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.
- d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise and/or training working with justice-involved individuals.
- e. The District must develop processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.
- f. The District must develop processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or ensure individuals have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

- g. The District must develop policies so that case managers are engaged and have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community.

7.7. **Suspension of Coverage.** Upon entry of a Medicaid-enrolled individual into a correctional facility, the Department of Health Care Finance must not terminate and generally shall suspend their Medicaid coverage, in accordance with sections 1902(a)(84)(A) and 2102(d)(1)(A) of the Act.

- a. If an individual is not enrolled in Medicaid when entering a correctional facility, the District must ensure that such an individual receives outreach and assistance with completing and submitting an application for Medicaid, unless the individual declines such assistance or wants to decline enrollment.

7.8. **Opportunity to Enroll in Medicaid or CHIP.** Any Medicaid or CHIP-eligible person who is incarcerated at a participating facility but not yet enrolled must be afforded the opportunity to apply for Medicaid or CHIP in the most feasible and efficient manner and must be offered assistance with the Medicaid application process in accordance with 42 CFR 435.906, 435.908, and 457.340(a). The District must accept an application submitted via any of the methods described at 42 CFR 435.907 and 457.330.

- a. All individuals who are incarcerated at a participating facility must be allowed to access and complete a Medicaid or CHIP application and must be assisted in this process, including by providing information about where to complete the Medicaid or CHIP application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.
- b. All individuals enrolled in Medicaid or CHIP during their incarceration must be provided with a Medicaid, CHIP, or managed care plan card or some other Medicaid, CHIP, or managed care enrollment documentation upon release, along with information on how to use their coverage.

7.9. **Managed Care Contract Requirements.** If the District elects to implement the demonstration through managed care, managed care plan contracts must reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to a region of the District served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

7.10. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children.** To the extent the District includes coverage in the reentry demonstration initiative that is otherwise required to be provided under section 1902(a)(84)(D) of the Act, and may include this coverage in the base expenditures used to determine the budget neutrality expenditure limit, the District may claim for these expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

7.11. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative

(FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Department of Health Care Finance will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

- a. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
- b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 7.3;
- c. The provision or facilitation of pre-release services for a period of time immediately prior to the expected date of release, as described in STC 7.1 and 7.3, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;
- d. If the District optionally elects to phase in pre-release services, the District will require participating facilities to select a Service Level for implementation. Service Level One consists of the minimum benefit package pre-release services identified in STC 7.4(a) and (b), and must be the first Service Level category that is implemented. The District may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the District that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable.
- e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans (as applicable).
- f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the up to 90-day pre-release period, as described in STC 7.3(c), and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply of the medications as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;
- g. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable

promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

- h. A data exchange process to support the care coordination and transition activities described in (e), (f), and (g) of this subsection subject to compliance with applicable federal, District, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;
- i. Reporting of data requested by the District to support program monitoring, evaluation, and oversight; and
- j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

7.12. **Reentry Demonstration Initiative Implementation Plan.** The District is required to submit a Reentry Demonstration Initiative Implementation Plan for CMS approval that will identify for each milestone, as well as each associated action, what the District anticipates to be the key implementation challenges and the District's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The District must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The District must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan, subject to CMS approval, will be incorporated into the STCs as Attachment D titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the District with a template to support developing the Implementation Plan.

7.13. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, the District must reinvest all new federal dollars, equivalent to the amount of FFP expended for such previously existing service(s), into allowable justice-related activities defined below. FFP projected to be expended for new services covered under the reentry demonstration initiative or state plan services required under this demonstration to meet the requirements of section 1902(a)(84)(D) of the Act are not required to be reinvested pursuant to this STC. New services are defined as 1) services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative or 2) any additional increases in expenditures for existing services that have been expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative. For services that were previously provided prior to the demonstration and now, under the demonstration, have been expanded, augmented, or enhanced, the District must calculate the proportion of FFP attributed to existing services, and reinvest an amount equivalent to the amount of FFP.

- a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments may only include:
- i. The District share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;
 - ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;
 - iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;
 - iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, District, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;
 - v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;
 - vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and
 - vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.
- b. Within 180 days of approval of the reentry demonstration initiative, the District will submit a reentry demonstration initiative Reinvestment Plan (Attachment E) for CMS approval that memorializes the District's reinvestment approach. The Reinvestment Plan must include:
- i. An assessment of each authorized pre-release service, the extent to which it is a new or existing service, and a calculation of the projected amount of FFP required to be reinvested for each existing service per year;
 - ii. A description of the allowable activities described above in which the District plans to reinvest the required dollars, a timeline of when those reinvestments will occur, and the goals and outcomes for those activities. The District cannot use reinvested funds to build new or conduct capital improvements for existing correctional facilities.
 - iii. An assessment of whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the District proposes to ensure that such funds are used for the intended purpose and do not have the effect of

increasing profit or operating margins for privately-owned or -operated carceral facilities.

- c. The District will be required to include updates on reinvestment as part of the annual monitoring report. The District must describe the actual amount of required reinvestment based on actual FFP received, the amount the District has already reinvested and into what activities, and an update on how the Plan is progressing. The District must also include outcomes from the activities the District reinvested in.
- d. No later than one year after the expiration of the demonstration period, the District will submit to CMS a Final Reinvestment Assessment (Attachment F) that will fully describe the final amount of required reinvestment based on actual FFP received, the amount the District reinvested and into what activities, and the outcomes of those activities.

8. COST SHARING

- 8.1. **Cost Sharing.** The demonstration removes the \$1 co-payment cost sharing requirement currently in effect under the state plan for beneficiaries using prescription medications associated with MAT. If the District submits a state plan amendment (SPA) to eliminate this co-payment under the state plan and CMS approves this SPA, the demonstration authority to waive these cost sharing requirements will expire as of the effective date of the District's SPA. Otherwise, cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

9. DELIVERY SYSTEM

- 9.1. **Delivery System.** Under the demonstration, the delivery system will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent section 1115(a) demonstration.

10. MONITORING AND REPORTING REQUIREMENTS

- 10.1. **Deferral 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 found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the 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) 30 calendar 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) 30 calendar 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. The extension request must explain the reason why the required deliverable was not submitted, the steps the District has taken to address such issue, and the District's anticipated date of submission. Should CMS agree in writing to the District's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the District's written extension request.
- c. If CMS agrees to an interim corrective process 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) that meets 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 for submitting deliverable(s), and the District submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, the 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.

- 10.2. **Deferral of Federal Financial Participation from IMD Claiming 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 as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the District has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.
- 10.3. **Submission of Post-Approval Deliverables.** The District must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the District mutually agree to another timeline.
- 10.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 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 section 1115 demonstration, 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.

10.5. **Monitoring Reports.** The District must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The District must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the District might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the District might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report 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 Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and 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; legislative updates; and descriptions of any public forums held. The Annual 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 the District's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The District and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The District must report these metrics for

all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the District is expected to report monitoring metrics for the following demonstration initiative(s), as described below and per applicable CMS guidance:

- i. For the SUD and/or SMI component(s), the District's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17-003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).
- ii. For the Reentry demonstration initiative, the District must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 7.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the District is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the District's Reentry Initiative Implementation Plan, the District must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the District has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the District's Medicaid population.

- 10.6. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
- 10.7. **SUD and SMI Mid-Point Assessment.** The District must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by October 1, 2029. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the District should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the District must require that the Independent Assessor consult with key stakeholders such as,

representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

- a. The District must require that the assessor provide a Mid-Point Assessment to the District that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the District must brief CMS on the Mid-Point Assessment. The District must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any.
- b. Elements of the Mid-Point Assessment must include:
 - i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;
 - ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;
 - iii. 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;
 - iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the District's Implementation Plan, or to pertinent factors that the District can influence that will support improvement.

10.8. **Corrective Action Plan Related to Monitoring.** 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. A District corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the District's demonstration goals and desired directionality, and the District has not implemented corrective action, and the circumstances described in STC 3.10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

10.9. **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 Close-Out Report must comply with the most current guidance from CMS.
- b. In consultation with CMS, and per guidance from CMS, the District will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation

requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STCs 11.8 and 11.9, respectively.

- c. The District will present to and participate in a discussion with CMS on the Close-Out Report.
- d. The District must take into consideration CMS's comments for incorporation into the final Close-Out Report.
- e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
- f. A delay in submitting the draft or final version of the Close-Out Report may subject the District to penalties described in STC 10.1.

10.10. Monitoring Calls. CMS will convene, no less frequently than quarterly, monitoring calls with the District.

- a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the District's demonstration monitoring reports, including (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, eligibility and access, and progress on evaluation activities.
- b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.
- c. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- d. The District and CMS will jointly develop the agenda for the calls.

10.11. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six 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 30 calendar 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 Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the District must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

11. EVALUATION OF THE DEMONSTRATION

- 11.1. Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the District shall 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 shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the District's participation – including representation from the District's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and 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 10.1.

- 11.2. **Independent Evaluator.** The District must use an independent entity (herein referred to as the Independent Evaluator) 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 Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved 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.
- 11.3. **Evaluation Design.** The District must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi- experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The District is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 11.8 and 11.9.

For any amendment to the demonstration, the District will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the District and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the District's Interim and Summative Evaluation Reports, described below.

- 11.4. **Evaluation Design Approval and Updates.** The District must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the District will publish the approved Evaluation Design within 30 calendar days of CMS approval. The District must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the

District wishes to make changes and the changes are substantial in scope, the District must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the District may include updates to the Evaluation Design in an Annual Monitoring Report.

- 11.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the District intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

The District must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

- a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.
- b. Hypotheses for the SMI component must map to the goals of the program, including reducing utilization and lengths of stay in emergency departments, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.
- c. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the District, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings;

preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

In instances where the District is testing services beyond the minimum benefit package or providing coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date, the District is required to incorporate additional hypotheses to describe those tests. The District must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes. For example, the District could include the following: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the District is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the District might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the District must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

As part of its evaluation efforts, the District must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the District must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the District's Medicaid program.

CMS underscores the importance of the District undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the District is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the District's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the District may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

- 11.6. **Evaluation Budget.** A budget for the evaluations must be provided with the 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 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.
- 11.7. **Reentry Early Implementation Rapid Cycle Report.** The District must conduct and submit a Rapid Cycle Report (RCR) to CMS as a required evaluation deliverable for this demonstration. The purpose of the RCR is to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement-during the initial implementation phase.

The District must submit the RCR no later than 180 calendar days following the onset of claiming for demonstration services (“go-live”). The District must notify CMS of the anticipated go-live date no later than 30 calendar days in advance. CMS may, at its discretion, approve an alternative submission timeline if warranted by the District’s implementation schedule or operational milestones.

The RCR must use a mixed-methods approach, incorporating both qualitative and quantitative information, and must assess implementation progress and key milestones, including the status of data-sharing agreements, provider onboarding, systems readiness, and care coordination processes, as well as a comparison of planned versus actual implementation timelines and approaches for service delivery and operations, including explanations for any deviations from the approved implementation plan. The RCR must also highlight any known gaps in data needed for future evaluations and potential mitigation strategies.

The RCR must also assess early operational experiences, including successes and challenges associated with coordination across correctional facilities and community-based providers, and must identify mitigation strategies where appropriate. The RCR must further include early financial information, including expenditures and any identified claiming considerations, as feasible, and an assessment of data infrastructure, reporting capabilities, and data quality, including limitations that may affect future evaluation activities. The RCR must make the methodology clear (e.g., financial analyses, interviews, focus groups) as well as the sources of the data (e.g., carceral facilities, community providers, District staff/contractors). The RCR may also include recommendations for refining the District’s CMS-approved Evaluation Design, including identification of feasible outcome measures, data sources, and analytic approaches based on actual implementation experience.

The District must participate in discussions with CMS to review RCR findings and must identify and implement programmatic improvements, as appropriate. The District must document any changes made in response to RCR findings in subsequent monitoring reports. The District must publish the final RCR on its public website within 30 calendar days of CMS approval. The Rapid Cycle Report must incorporate structured input from key demonstration interest holders (e.g.,

correctional facilities, community-based providers, and other partners). The report must address core implementation questions aligned with CMS evaluation guidance.

The report must also include a structured assessment of implementation plan activities, including the status of key milestones, explanations for deviations from planned timelines, and recommended modifications to implementation strategies.

- 11.8. **Interim Evaluation Report.** The District must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.
- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
 - b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the District.
 - c. If the District is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the District's website with the application for public comment. If the District does not request an extension for the demonstration, the Interim Evaluation Report is due one 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 a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.
 - e. Once approved by CMS, the District must post the final Interim Evaluation Report to the District's Medicaid website within 30 calendar days.
- 11.9. **Summative Evaluation Report.** The District must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.
- a. The District must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

- b. Once approved by CMS, the District must post the final Summative Evaluation Report to the District's Medicaid website within 30 calendar days.

- 11.10. **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 an extension process when associated with the District's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 11.11. **State 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, or the Summative Evaluation Report.
- 11.12. **Public Access.** The District shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the District's Medicaid website within 30 calendar days of approval by CMS.
- 11.13. **Additional Publications and Presentations.** For a period of 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 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

12. GENERAL FINANCIAL REQUIREMENTS

- 12.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred 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.
- 12.2. **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 under this Medicaid section 1115 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 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.

- 12.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the District certifies that its funds that make up the non-federal share are obtained from permissible District and/or local funds that, unless permitted by law, are not other federal funds. The District further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.
- a. If requested, the District must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
 - b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the District must address CMS's concerns within the time frames allotted by CMS.
 - c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.
- 12.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the District certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:
- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the District must certify that District or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
 - b. To the extent the District utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the District must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the District identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the District the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be

used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

- c. The District may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the District. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and District and/or local governments, or third parties to return and/or redirect to the District any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. 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.
- e. The State Medicaid Director or his/her designee certifies that all District and/or local funds used as the District's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

12.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the District attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.
- b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the District will recoup the excess and return the federal share of the excess to CMS.

12.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the District attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

- c. If the health care-related tax is either not broad-based or not uniform, the District has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

12.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the District must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 10.1. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the District, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the District will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

12.8. **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 following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 13:

- 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.

12.9. **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.

12.10. **Medicaid Expenditure Groups.** Medicaid Expenditure 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 1: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
BHT SUD IMD Services MCO	Hypo 1	X		X	All expenditures for medical assistance incurred by an enrollee during the month of their IMD stay to treat SUD, for those enrolled in managed care.
BHT SUD IMD Services FFS	Hypo 1	X		X	All expenditures for medical assistance incurred by an enrollee during the enrollee's IMD stay to treat SUD, for individuals who receive their Medicaid services via FFS.
BHT SMI IMD Services MCO	Hypo 2	X		X	All expenditures for medical assistance incurred by an enrollee during the month of their IMD stay to treat SMI, for those enrolled in managed care.
BHT SMI IMD Services FFS	Hypo 2	X		X	All expenditures for medical assistance incurred by an enrollee during the enrollee's IMD stay to treat SMI, for individuals who receive their Medicaid services via FFS.
Reentry Services	Hypo 3	X		X	Expenditures for pre-release services provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.

ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.
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BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

- 12.11. **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.
- 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), or line 7. 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.
 - 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. 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 demonstration year 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.
 - 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.
 - 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 MEG Charts and in the STCs in section 13, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- e. **Member Months.** Using the Budget Neutrality Monitoring Tool, 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 per person, 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 2. MEG Detail for Expenditure and Member Months Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
BHT SUD IMD Services MCO	All expenditures for medical assistance incurred by an enrollee during the month of their IMD stay to treat SUD, for those enrolled in managed care.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/1/20	9/30/31
BHT SUD IMD Services FFS	All expenditures for medical assistance incurred by an enrollee during the enrollee's IMD stay to treat SUD, for individuals who receive their Medicaid services via FFS.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/1/20	9/30/31
BHT SMI IMD Services MCO	All expenditures for medical assistance incurred by an enrollee during the month of their IMD stay to treat SMI, for those enrolled in managed care.	See STC 6.7	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/1/20	9/30/31
BHT SMI IMD Services FFS	All expenditures for medical assistance incurred by an enrollee during the enrollee's IMD stay to treat SMI, for individuals who receive their Medicaid services via FFS.	See STC 6.7	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/1/20	9/30/31
Reentry Services	Report all expenditures for pre-release services provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	10/1/26	9/30/31
ADM	All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of Payment	ADM	N	1/1/20	9/30/31

- 12.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3. Demonstration Years

Demonstration Year 8	October 1, 2026 to September 30, 2027	12 months
Demonstration Year 9	October 1, 2027 to September 30, 2028	12 months
Demonstration Year 10	October 1, 2028 to September 30, 2029	12 months
Demonstration Year 11	October 1, 2029 to September 30, 2030	12 months
Demonstration Year 12	October 1, 2030 to September 30, 2031	12 months

- 12.13. **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.
- 12.14. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- To be consistent with enforcement of laws and policy statements, including regulations and guidance, 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.
 - 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.
 - 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.

12.15. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the District may request that CMS make an adjustment to its budget neutrality agreement based on changes to the District's Medicaid expenditures that are unrelated to the demonstration and/or outside the District's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the District must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the District's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The District must also submit the budget neutrality update described in STC 12.15.c. If approved, an adjustment could be applied retrospectively to when the District began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the District needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the District establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the District's Medicaid expenditures that are unrelated to the demonstration and/or outside of the District's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
 - i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or District technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
 - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
 - iv. District legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
 - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
 - vi. High-cost innovative medical treatments that states are required to cover; or,
 - vii. Corrections to coverage/service estimates where there is no prior District experience (e.g., SUD) or small populations where expenditures may vary widely.

- c. **Budget Neutrality Update.** The District must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
 - i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the District's Medicaid expenditures that are unrelated to the demonstration and/or outside the District's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

13. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 13.1. **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 consists of 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.
- 13.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. 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.
- 13.3. **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.

- 13.4. **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 any of the Hypothetical Budget Neutrality Tests must be returned to CMS.
- 13.5. **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), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the District could have received FFP for them absent the demonstration. 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 expenditures on those services. When evaluating budget neutrality, however, 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 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 Hypothetical Budget Neutrality Test’s expenditure limit, the District agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.
- 13.6. **Hypothetical Budget Neutrality Test 1: 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 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
BHT SUD IMD Services MCO	PC	Both	5.3%	\$2,100.65	\$2,211.98	\$2,329.21	\$2,452.66	\$2,582.65
BHT SUD IMD Services FFS	PC	Both	5.3%	\$2,181.52	\$2,297.14	\$2,418.89	\$2,547.09	\$2,682.09

- 13.7. **Hypothetical Budget Neutrality Test 2: SMI Services (see Expenditure Authority #2).** The table below identifies the MEGs that are 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 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5. Hypothetical Budget Neutrality Test 2

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
BHT SMI IMD Services MCO	PC	Both	5.30%	\$16,682.80	\$17,566.99	\$18,498.04	\$19,478.44	\$20,510.80
BHT SMI IMD Services FFS	PC	Both	5.3%	\$10,278.56	\$10,823.32	\$11,396.96	\$12,001.00	\$12,637.05

- 13.8. **Hypothetical Budget Neutrality Test 3: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are 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 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6. Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 8	DY 9	DY 10	DY 11	DY 12
Reentry Services	PC	Both	6.1%	\$2,692.92	\$2,857.19	\$3,031.48	\$3,216.40	\$3,412.60

- 13.9. **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 Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

- 13.10. **Budget Neutrality Monitoring Tool and Reporting Requirements.** Per 42 CFR 431.428, the District must document the financial performance of the demonstration. The District must provide quarterly budget neutrality status updates that meet all 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), 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 the demonstration’s actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 10.1. CMS will provide technical assistance, upon request.⁵
- 13.11. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from October 1, 2026 to September 30, 2031. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test(s) has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 13.12. **Corrective Action Plan.** 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 table below as a guide for determining when corrective action is required.

Table 7. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration	Cumulative Target Definition	Percentage
DY 8	Cumulative budget neutrality limit plus:	2.0 percent

⁵ Per 42 CFR 431.420(a)(2), 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 states agree to use the tool as a condition of demonstration approval.

Demonstration	Cumulative Target Definition	Percentage
DY 8 through DY 9	Cumulative budget neutrality limit plus:	1.5 percent
DY 8 through DY 10	Cumulative budget neutrality limit plus:	1.0 percent
DY 8 through DY 11	Cumulative budget neutrality limit plus:	0.5 percent
DY 8 through DY 12	Cumulative budget neutrality limit plus:	0.0 percent

14. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Deliverable	Timeline	STC Reference
Reentry Demonstration Initiative Implementation Plan	120 days after reentry demonstration approval	STC 7.12
Reentry Demonstration Initiative Reinvestment Plan	180 days after reentry demonstration approval	STC 7.13
Reentry Demonstration Initiative Rapid Cycle Report	180 days after reentry go-live	STC 11.7
Reentry Demonstration Initiative Final Reinvestment Assessment	One year after end of demonstration period.	STC 7.13.d
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 10.5
Mid-Point Assessment	The District must contract with an independent entity to conduct an independent Mid-Point Assessment and submit to CMS by December 31, 2028.	STC 10.6
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STC 11.3
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.8
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.9
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter	STC 12.2
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4th quarter which is due 90 days after the end of each DY	STC 13.11
Annual Budget Neutrality Monitoring Report	90 calendar days after the end of each demonstration year	STC 13.11

ATTACHMENT A SUD/SMI/SED Implementation Plan

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

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	<i>Current State:</i> 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).
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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)

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	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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> Already implemented. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> The District will require psychiatric hospitals to conduct the required psychiatric and other medical screenings. <i>Summary of Actions Needed:</i> 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.

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1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	<i>Current State:</i> See responses to Sections 1.a, 1.b, 1.c, 1.d, 1.e, and 1.f.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> No action needed.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
<i>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.</i>	
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.	<i>Current State:</i> 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

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	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.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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.	<i>Current State:</i> 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.
	<i>Future State:</i> 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.

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	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital and non-residential crisis stabilization services.

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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. <i>Future State:</i> See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital, non-residential crisis stabilization services. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> No action needed.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
<i>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.</i>	
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	<i>Current State:</i> 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 <i>2016 Access Monitoring Review Plan</i>,² and DC Health’s <i>2014 Community Health Needs Assessment</i>.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.
	<i>Future State:</i> 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).
	<i>Summary of Actions Needed:</i> 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)
	<i>Current State:</i> 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	
	<i>Future State:</i> See Topic 5 for additional information on the District’s financing plan.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> DBH does not currently systematically track the availability of inpatient and crisis stabilization beds.
	<i>Future State:</i> DBH plans to more systematically track open inpatient and crisis stabilization beds to facilitate more timely referrals.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	
<i>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.</i>	
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	<i>Current State:</i> 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: ○ Providing behavioral health support to address individual and community crises, community education, trauma informed care, de-escalation techniques, and grief assessment and referral; ○ 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; ○ 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> DBH, as part of its strategic planning, will identify ways to continue to promote physical and behavioral health integration. For children and adolescents specifically, DC MAP funding has been secured through, at least, fiscal year 2020.

Prompts	Summary
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> All Medicaid enrollees under 22 years of age are to be provided Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services without limitation. EPSDT services include periodic and inter-periodic assessments that consist of mental health (and substance use) screenings as required by the District's Periodicity schedule. Primary care physicians screening for mental health conditions are required to use a validated, brief mental health screen approved by DBH. Medicaid enrollees who screen positive for referral to mental health services are to receive timely access to an appointment for further assessment and treatment by a mental health provider. All Medicaid enrollees under 22 years of age also have access to Psychiatric Residential Treatment Facilities (PRTFs) outside of the District. In addition to services available through Medicaid, DBH supports several specialized services for District children and adolescents, including crisis stabilization. These include: • The Children and Adolescent Mobile Psychiatric Service (ChAMPS), in which a community-based provider provides on-site, immediate help to children facing a behavioral or mental health crisis whether in the home, school, or community. The goal of ChAMPS is to stabilize the young person and avert inpatient hospitalizations or placement disruptions for children involved in the foster care system. The ChAMPS teams also make follow up visits and connect families to needed support services; • Evidence-based practices as part of the treatment process that include: Child Parent Psychotherapy for Family Violence; Trauma Systems Therapy (TST); Parent Child Interaction Therapy; Functional Family Therapy (FFT); Trauma Focused Cognitive Behavioral Therapy; Multi-Systemic Therapy; Multi-Systemic Therapy for Youth with Problem Sexual Behavior; and Adolescent Community Reinforcement Approach (ACRA); • For Transition Age Youth (TAYs) and young adults (YAs), initiatives and service provision related to: reducing stigma around mental health; First Episode Psychosis; supportive independent housing; supported employment; the evidence-supported Transition to Independence Process (TIP); • DC Social, Emotional and Early Development (DC SEED) Project to address the highly specific, largely unmet needs of infants and young children (birth to 6 years old) who are at high imminent risk for or diagnosed with an SED. Major grant activities include developing early childhood competency in the provider network; evidence-based practice training, coaching, and ongoing consultation; strengthening of early childhood community partnerships; infusing early childhood component in existing services and supports; and establishment of a centralized early childhood telephonic referral and intake process; • High Fidelity Wraparound (HFW), which is an evidenced-based practice for children and youth with complex emotional and mental health needs who are at risk of out-of-home placement, a more restrictive school setting, or have had multiple inpatient placements; and

Prompts	Summary
	Professional training for providers who work with TAY population on better ways to connect and work with young adults. Despite the multitude of specialized services for children and adolescents available through Medicaid and DBH, the District's provider network is somewhat fragmented and can result in siloed care for young people with co-occurring disorders. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> See responses to Sections 4.a, 4.b, and 4.c.

Prompts	Summary
identification/engagement, integration, and specialized programs for young people	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> No action needed.
SMI/SED. Topic_5. Financing Plan	
<i>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.</i>	
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.	<i>Current State:</i> 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.
	<i>Future State:</i> As part of this demonstration, the District seeks to create a new reimbursement methodology for CPEP and for CRT mobile crisis and outreach services to more appropriately account for and value the services provided. The

Prompts	Summary
	demonstration also proposes adding coverage for psychiatric crisis stabilization services as a treatment alternative to psychiatric inpatient hospitalizations. <i>Summary of Actions Needed:</i> 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.	<i>Current State:</i> District residents can access community-based mental health services through several types of providers. Core service agencies (CSAs) serve as the main entry point for accessing the Mental Health Rehabilitation Services (MHRS) benefits, which include diagnostic assessment, medication/somatic treatment, counseling, day/rehab services, and community support. Free-standing mental health clinics (FSMHCs) also provide diagnostic assessment, medication/somatic treatment, and counseling services. As of July 2019, there are 51 CSAs and as of June 2019 there are 29 FSMHCs, 15 of which are also certified as a CSA. There are additional providers certified by DBH which deliver specialty mental health services such as Assertive Community Treatment (ACT), Community Based Intervention (CBI) for youth and children, and trauma-informed services, like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy. However, no providers are currently certified by DBH to provide intensive day treatment services. District stakeholders have identified regulatory requirements related to operations as the primary barrier to certification. In addition to CSAs, DHCF beneficiaries have access to 360 Medicaid-enrolled psychiatrists and advanced practice registered nurses with a behavioral health focus, 175 of whom billed DHCF in the past year. As indicated in the mental health services assessment, the District acknowledges that there is less than one psychiatrist/prescriber enrolled in Medicaid per 100 Medicaid beneficiaries with SMI. DHCF beneficiaries also have access to community-based services through federally qualified health centers. In fiscal year 2018, 41 FQHC locations billed for behavioral health treatment provided to DHCF beneficiaries.

Prompts	Summary
	<i>Future State:</i> 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. <i>Summary of Actions Needed:</i> DHCF and DBH will work with District stakeholders to assess a long-term sustainable plan to increase availability of on-going community-based services and services in integrated care settings for Medicaid beneficiaries throughout the District. This assessment will include a review of potential changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the District’s assessment of current availability of mental health services, specifically to increase the number of psychiatrists/prescribers enrolled in Medicaid. (Timeline: 18-24 months) DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care. (Timeline: 18-24 months) DBH and DHCF will develop and issue rulemaking and other policies as necessary regarding the proposed waiver services that increase access to community-based services. (Timeline: 12-18 months)

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”⁴ The HIT Plan should also describe, among other items, the: • Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and • Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education. Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. As outlined in the District’s State Medicaid Health IT Plan (SMHP),⁵ the District has a high level of electronic health record (EHR) adoption and health information exchange (HIE) needed to achieve the goals of the demonstration. DHCF and DBH are committed to leveraging health IT to facilitate integration of physical and behavioral health. Technology enables consistent data capture via certified EHRs so that providers can communicate with each other to access medical records for patients who have seen other providers. Data exchange based on structured information is critical to electronic care planning, care coordination, and integrating physical and behavioral health. DHCF and DBH agree that provider access to certified EHR technology is an important step towards a common infrastructure to exchange information, as permitted by patient consent. In addition, having a certified EHR is a requirement to participate in city-wide HIE via secure messaging and can facilitate access to complete clinical information for patients. Today, 89% of District providers utilize EHRs and there are several DHCF-funded programs in place to assist providers in exchanging referral information electronically. DHCF’s Medicaid EHR Incentive 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 <u>Interoperability</u>	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.	
<i>To assist states in their health IT efforts, CMS released <u>SMDL #16-003</u> 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.</i>⁷ <i>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.”</i>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	<i>Current State:</i> The District's State Medicaid Health IT Plan (SMHP) includes <i>improving transitions of care</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> Support CRISP DC Direct implementation; sustain collaborations with DCPA/DCHA and District HIEs via the e-referral collaborative. Ensure that acute care hospitals, IMDs, community-based behavioral
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	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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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>

	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> At present, electronic care plans are not shared using a consistent technology platform or standards-based approach.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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)	<i>Current State:</i> 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.

	<i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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)	<i>Current State:</i> 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. <i>Patient Care Snapshot</i> 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. <i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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. <i>Future State:</i> 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. <i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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	<i>Current State:</i> 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.
	<i>Future State:</i> 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.
	<i>Summary of Actions Needed:</i> 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 initiatives. (Timeline: 18-24 months)

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

Section 3: Relevant documents

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

ATTACHMENT A
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)
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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.
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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.
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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)
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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
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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)
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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.		
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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.
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	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.
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6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

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

Current State:

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

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

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

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

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

¹ See DCMR Title 22, Chapter 63, Section 6302.

² See DCMR Title 22, Chapter 63, Section 6326.

³ See DCMR Title 22, Chapter 63, Section 6334.

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

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

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

Future State:

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

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

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

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

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

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

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

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

Section II – Implementation Administration

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

Name and Title: Melisa Byrd, Senior Deputy Director and State Medicaid Director

Telephone Number: 202-442-9075

Email Address: melisa.byrd@dc.gov

Section III – Relevant Documents

Not Applicable.

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 medications 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, Apriss, 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 “<i>innovation, on-going optimization,</i>

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

¹ See: <https://sequoiaproject.org/resources/patient-matching/>

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

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

Section II. Implementation Administration

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

Name and Title: Melisa Byrd, Senior Deputy Director and State Medicaid Director

Telephone Number: 202-442-9075

Email Address: melisa.byrd@dc.gov

Section III. Relevant Documents

Not Applicable.

Appendix I – SUD Treatment Services and Qualified Practitioners

Medicaid SUD Treatment Services and Qualified Practitioners¹

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 Practitioners¹

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 Care¹

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.
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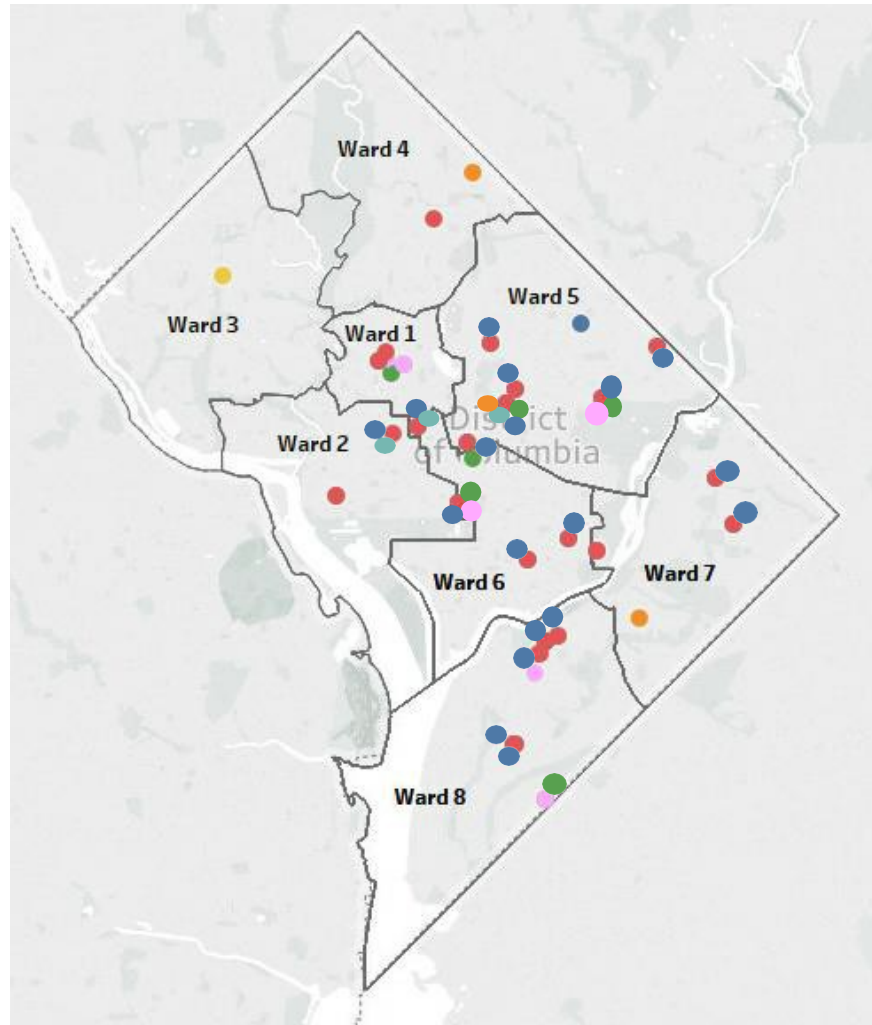
Appendix III – Certified SUD Providers by ASAM Level of Care Enrolled in Medicaid¹

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 Care¹



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.

Attachment B
Evaluation Design [Reserved]

Attachment C
Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management	Service to address the physical, behavioral, and any health-related social needs (HRSN) as applicable, consistent with 42 CFR 440.169.
Medication for Addiction Treatment Services	Services for all types of substance use disorder (SUD) as clinically appropriate, including coverage for all Food and Drug Administration (FDA) approved medications, with accompanying counseling.
30-day Supply of Prescription Medications	Prescription medications including prescribed over-the-counter drugs (OTC) (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.
Practitioner Office Visit	Visit where practitioner provides comprehensive and preventive health care services for persons who are enrolled in Medicaid to ensure that beneficiaries receive appropriate preventive, dental, mental health and specialty services.
Diagnostic services	Diagnostic, radiology, and laboratory services
Prescribed Drugs and Medication Administration	A drug which is required by any applicable federal or District of Columbia law or regulation to be dispensed only pursuant to a prescription drug order and is covered under the District of Columbia Medicaid State Plan. Such prescribed drugs will be administered to eligible individuals during the 60 or 90 days prior to the expected date of release, consistent with the applicable pre-release period, for the public institution.
Peer Support Services	Peer support services are supports that promote recovery, resiliency, engagement in treatment, socialization, self-sufficiency, self-advocacy, development of natural supports, and recognition of personal strengths in alignment with goals defined in the individual's person-centered care plan. These services are provided based on the expertise derived from an individual's lived experience and are delivered in coordination with the individual's care team. Peer support services are coordinated within the context of the comprehensive individualized plan of care and include: educational skill-building activities such as assisting with strategy development and coping skills and other activities to strengthen self-sufficiency and development of natural supports

	and therapeutic activities such as non-clinical activities that promote recovery, relationship building, and community living skills. Services may occur with the beneficiary alone or with significant support persons. Collateral contacts with family or other supports are allowed when they contribute to the beneficiary's treatment goals. A re-entry peer support specialist must be an individual: · With lived experience of incarceration and/or navigation of the juvenile justice system ; · Qualified to provide services in accordance with District law, under the supervision of a competent mental health professional (as defined by the District); and · Trained and certified in required District training for re-entry peer support specialists, including completion of continuing education requirements.
Other (Behavioral health clinical consultation services for individuals in youth correctional facilities)	Community-Based Intervention ("CBI"): Time sensitive, intensive, mental health intervention services delivered to children, youth, and their family and intended to prevent utilization of an out-of-home therapeutic resource by the consumer. Multi-Systemic Therapy ("MST"): An intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions.

Attachment D
Reentry Demonstration Initiative Implementation Plan [Reserved]

Attachment E
Reentry Demonstration Initiative Reinvestment Plan [Reserved]

Attachment F
Reentry Demonstration Initiative Final Reinvestments [Reserved]