Medicaid Behavioral Health Transformation Demonstration

Final Mid-Point Assessment Report

District of Columbia

Department of Health Care Finance

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Medicaid Behavioral Health Transformation Demonstration

Final Mid-Point Assessment Report

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Task & Deliverable

Task 7
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ACED	Application and Enrollment Data
ALOS	Average length of stay
ARC	Assessment and Referral Center
ARPA	American Rescue Plan Act of 2021
ASAM	American Society of Addiction Medicine
ASURS	Adult Substance Use Rehabilitative Services
CBO	Community-based organizations
CCR	College and Career Readiness
CIQN	Children's Integrated Quality Network
CMHC	Community mental health clinic
CMS	Centers for Medicare and Medicaid Services
CNMC	Children's National Medical Center
CON	Certificate of Need
CoRIE	Community Resource Information Exchange Technical Solution
CPEP	Comprehensive Psychiatric Emergency Program
CRISP	Chesapeake Regional Information System for our Patients
CRT	Community Response Team
CY	Calendar Year
DBH	Department of Behavioral Health
DCAS	DC Access System
DCMR	District of Columbia Municipal Regulations
Demonstration	Behavioral Health Transformation Demonstration
DHCF	Department of Health Care Finance
District	District of Columbia
DOC	Department of Corrections
DUR	Drug Utilization Review
DY	Demonstration Year
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Service
ENS	Encounter Notification Service
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FY	Fiscal Year
FQHC	Federally Qualified Health Center
FSMHC	Free Standing Mental Health Clinic
HCBS	Home and Community-Based Services
HIE	Health Information Exchange

HHA	Home Health Agency
ICTA	Integrated Care Technical Assistance
IMD	Institutions for Mental Diseases
KII	Key informant interviews
LOCUS	Level of Care Utilization System
MAP	Mental Health Access in Pediatrics
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MEIP	Medicaid EHR Incentive Program
MHRS	Mental Health Rehabilitation Services
MME	Morphine milligram equivalent
NSDUH	National Survey on Drug Use and Health
OCR	Office of Civil Rights
OUD	Opioid Use Disorder
PCP	Primary care provider
PDMP	Prescription Drug Monitoring Program
PHE	Public health emergency
PLP	Pharmacy lock-in program
PRTF	Psychiatric Residential Treatment Facilities
Q	Quarter
QIO	Quality Improvement Organization
QSOA	Qualified Service Organization Agreement
RFI	Request for Information
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SES	Supported employment services
SMDL	State Medicaid Directors Letter
SMI	Serious Mental Illness
SOR	State Opioid Response
STCs	Special Terms and Conditions
SUD	Substance Use Disorder
TAP	Treatment Assignment Protocol
TAY	Transition age youth
TREM	Trauma Recovery and Empowerment Model
TST	Trauma Systems Therapy
WITS	Web Infrastructure for Treatment Services
WM	Withdrawal Management
YA	Young adult

1. Executive Summary

State		District of Columbia
Demonstration Name		Behavioral Health Transformation
Project Number		11-W-00331/3
Approval Date for Demonstration		11/06/2019
Approval Period		01/01/2020–12/31/2024
Target Population		Medicaid beneficiaries with • Substance use disorder • Serious mental illness and/or serious emotional disturbance
Time Period of Data Analyzed for the Mid-Point Assessment		01/01/2020–12/31/2021 (Claims based monitoring metrics: 01/01/2020–03/31/2021; Mental health services availability assessment: 01/01/2019–12/31/2021)

Demonstration. The Centers for Medicare and Medicaid Services (CMS) approved the District of Columbia's (District) Section 1115(a) demonstration titled Behavioral Health Transformation (Demonstration) on November 6, 2019. The Special Terms and Conditions (STCs) of the Demonstration are effective from January 1, 2020 through December 31, 2024, unless otherwise specified.

The STCs authorized federal financial participation (FFP) for Medicaid State Plan services furnished to eligible individuals primarily receiving short-term treatment and withdrawal management services for substance use disorder (SUD), serious mental illness (SMI) and/or serious emotional disturbance (SED), in facilities that meet the definition of an institution for mental disease (IMD) for the full five-year period of the Demonstration.

The STCs granted temporary expenditure authorities for the first two years of the Demonstration, from January 1, 2020 through December 31, 2021, for SMI/SED and/or SUD non-State Plan services furnished during a stay in or outside an IMD setting to eligible individuals receiving treatment or assessed as needing treatment or recovery support services for approved conditions.

The waiver authority under the Demonstration also exempted beneficiaries receiving SUD treatment from $1 pharmacy co-payments for prescriptions associated with medication assisted therapy (MAT).

Mid-Point Assessment. American Institutes for Research (AIR), the independent assessor, conducted this Mid-Point Assessment (Assessment), as required by the STCs, to examine whether the District was making sufficient progress towards meeting its Demonstration milestones and monitoring metric targets in the first two years of the Demonstration. The Assessment used data on monitoring metrics and implementation of action items as well as stakeholder feedback to assess progress on each SUD and SMI/SED Demonstration milestone. For milestones at medium or high risk of not being met, AIR made recommendations for adjustments in Demonstration implementation plans or to pertinent factors the District can influence to support improvements.

Assessment of progress. The District conducted multiple rounds of rulemaking to implement the Demonstration. The Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH) issued a series of rules, memoranda, and transmittals to phase in most of the new services authorized under the waiver in January 2020, and the rest of the services during the February–October 2020 period.

Monitoring metrics. Based on progress made up to the Demonstration Year 2 (DY2) Quarter 2 (Q2) monitoring report that includes claims-based monitoring metrics for DY2Q1, the District met Demonstration targets on seven out of 13 (54%) SUD milestone-critical metrics tracked with monthly data. The District also met Demonstration targets on two of two (100%) SMI/SED milestone-critical metrics tracked with monthly data. AIR was unable to assess progress on monitoring metrics for three out of six SUD milestones and three out of four SMI/SED milestones, either because the critical metrics under those milestones were annual measures and had only a single data point to evaluate or because there were no critical metrics associated with the milestone. Given the timeline to complete the mid-point assessment, only baseline (DY1) data for the annual measures were available and trend analyses could not be completed. On the monthly measures, trend analyses were completed and results indicated that most access- and utilization-related monitoring metrics experienced sharp decreases by the end of DY1Q1 with the onset of the COVID-19 pandemic, but slowly increased over the subsequent quarters of the Assessment period.

Implementation plan action items. At the time of the Mid-Point Assessment, on the SUD Demonstration component, the District had completed:

- 14 of 17 (82%) milestone-related implementation plan action items; and
- 9 of 14 (64%) Health IT Plan action items

On the SMI/SED Demonstration component, the District had completed:

- 12 of 20 (60%) milestone-related implementation plan action items
- 3 of 4 (75%) Financing Plan action items
- 6 of 18 (33%) Health IT Plan action items

Two SMI/SED milestone-related ongoing action items and eight SMI/SED Health IT-related ongoing action items were in process at the time of the Assessment.

Stakeholder feedback. Most of the stakeholders interviewed (providers, provider associations, and Medicaid managed care organizations) expressed enthusiasm about the Demonstration and progress made. They typically agreed that the Demonstration had improved access to critical levels of SUD care and care across the continuum for SMI/SED care, while noting some concerns related to insufficient knowledge of Demonstration features, difficult certification requirements, care coordination/transition constraints, and provider shortages for certain types of services.

Provider availability assessment. There were two critical metrics under SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD. DHCF reported 797 SUD providers and 393 SUD providers for MAT in DY1. Since these are annual metrics and only baseline data are available, it cannot be assessed whether the Demonstration target of "consistent" had been met. The number of Medicaid-enrolled psychiatrists or other practitioners authorized to prescribe psychiatric medications decreased from 423 to 400 (5% decrease) between the 2019 initial mental health services availability assessment and the 2021 annual assessment. The number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients increased from 568 to 625 (10% increase) during the period. Provider shortages were noted for certain community-based services such as crisis stabilization services and intensive outpatient services.

Average length of stay (ALOS) in IMDs for SMI/SED services. The District met the requirement of a 30-day or less ALOS in IMDs for SMI/SED services at the time of the Assessment. Baseline data for SMI/SED Metric #19(a), Average Length of Stay in IMDs, identified the ALOS for an SMI/SED IMD stay during 01/01/2020–12/31/2020, the first year of the Demonstration, as 13.3 days.

Risk levels for milestones. Triangulating evidence available across the domains of monitoring metrics, implementation plan action items and stakeholder feedback, AIR assigned a "low" risk level of not meeting the targets for five of the six SUD milestones and three of the four SMI/SED milestones at the time of the Assessment. AIR also assigned a "low" risk rating for the SUD and SMI/SED Health IT Plans and the SMI/SED Financing Plan. AIR assigned a risk level of "medium" for one SUD milestone and one SMI/SED milestone:

- SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD
- SMI/SED Milestone 2, Improving Care Coordination and Transitioning to Community-Based Care

Recommendations. For ensuring sufficient provider capacity at critical levels of SUD care including MAT for OUD, AIR recommends that the District:

- Continue execution of relevant activities currently in process, including overlapping initiatives such as the Emergency Department MAT induction program funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Opioid Target Response grant and the Behavioral Health Rate Study that is reviewing reimbursement rates and potential for new/enhanced services.
- Develop a more detailed and up-to-date understanding of capacity relative to demand by combining provider and system capacity measures with diagnosis and utilization measures and incorporating other common measures of network adequacy such as time and/or distance to providers and appointment wait times.
- Consider modifying certain SUD provider certification requirements such as those related to Trauma Recovery and Empowerment Model (TREM) services and the Certificate of Need (CON) process for residential SUD treatment providers.
- Educate beneficiaries about the new benefits associated with the Demonstration such as the removal of the $1 copay for MAT and the availability of independent licensed behavioral health providers accepting Medicaid.

For improving care coordination and transitioning to community-based care, AIR recommends that the District:

- Complete the implementation plan action items related to requiring MCOs to implement procedures for coordinating managed care services with the provision of other Medicaid services, including behavioral health services, and issuing rulemaking and other policies for psychiatric hospitals and residential treatment settings regarding

the assessment of beneficiaries' housing situations and the requirement of contact within 72 hours post discharge.

- Continue execution of relevant activities in process such as strategic and financial support for increased functionality, provider engagement and information sharing in the health information exchange (HIE), particularly as it relates to care alerts, consent management, and the social needs referral tool. An assessment of the Integrated Care DC Program, which conducts provider webinars and coaching, could identify additional strategies it may take to support providers seeking to improve care coordination.
- Consider expanding the transition planning benefit by exploring, for example, whether it may help to expand the types of beneficiaries who are eligible, or the number of providers certified to offer the services.
- Hold hospitals and health plans accountable for care transitions through contractual requirements and financial incentives.

The District's response and next steps. The District concurs with the recommendations made by AIR and has outlined its next steps in Exhibits 61 and 62 of this report.

2. General Background Information

This section provides general background information on the District of Columbia's (District) Behavioral Health Transformation (Demonstration), including its goals. Section 3 describes the Centers for Medicare and Medicaid Services (CMS) requirements for the Mid-Point Assessment (Assessment) and the methodology used. Section 4 lists the District's Demonstration-related rulemaking. Section 5 discusses the internal and external factors that influenced Demonstration progress and need to be considered in the Assessment. Sections 6 and 7 assess progress in achieving each substance use disorder (SUD) milestone and serious mental illness (SMI) or serious emotional disturbance (SED) milestone, respectively. These sections also cover the progress on the SUD and SMI/SED Health IT Plans and the SMI/SED Financing Plan. Section 8 assesses the Demonstration's record in meeting the CMS requirement related to the average length of stay (ALOS) in institutions of mental diseases (IMDs) for SMI/SED services. Section 9 summarizes the findings from each component of the Assessment, assigns an overall risk rating for each milestone, and makes recommendations for improvement of each milestone found to be at medium or high risk of not being met. It also includes the District's response to the recommendations and next steps it proposes for Demonstration progress. Section 10 summarizes the District's capacity to provide SUD and/or SMI/SED services at the time of the Assessment. Section 11 lists the activities that the District proposes for improving Demonstration performance. Appendix A includes the Independent Assessor Description. Appendixes B and C list the SUD and SMI/SED milestones, milestone criteria, implementation plan action items, and monitoring metrics. Appendices D, E, and F provide stakeholder interview guides. Appendix G contains the beneficiary survey questionnaire.

2.1. Demonstration Name, Approval Date, and Time Period of Data Analyzed in the Assessment

On November 6, 2019, CMS approved the District's Section 1115(a) demonstration titled Behavioral Health Transformation (Demonstration) (Project Number: 11-W-00331/3).[1] The Demonstration's Special Terms and Conditions (STCs) enabled the District to receive federal financial participation (FFP) for inpatient, residential, and other services provided to otherwise-eligible Medicaid beneficiaries while residing in IMDs for diagnoses of SUD and/or SMI/SED. The STCs also allowed the District to provide community-based services designed to improve

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

behavioral health care for individuals with SUD or SMI/SED. This is the first Demonstration addressing both SUD and SMI/SED populations approved since the Secretary of Health and Human Services announced the SMI/SED opportunity via State Medicaid Directors Letter (SMDL) #18-011 on November 13, 2018.

The STCs under which the District operates the Demonstration are effective from January 1, 2020 through December 31, 2024, unless otherwise specified. The STCs authorize FFP for Medicaid State Plan services provided to individuals residing in IMD settings for the Demonstration's full five-year period. For the rest of the services, the STCs grant temporary expenditure authorities for 24 months, from January 1, 2020 through December 31, 2021, provided the District adheres to the terms of the relevant STCs.

Under the STCs, CMS requires the District to conduct an independent Mid-Point Assessment by January 1, 2022 and submit the Assessment to CMS no later than 60 days after that date (i.e., by March 1, 2022). This Assessment requires examination of progress toward meeting Demonstration milestones and performance targets, and recommendations for adjustments in the District's SMI/SED or SUD Implementation Protocols, SMI/SED Financing Plan, or other factors that can improve the Demonstration. As the independent assessor, American Institutes for Research (AIR) conducted the independent Mid-Point Assessment of the Demonstration as required in the CMS guidance for conducting the Assessment issued in October 2021.[2] The independent assessor description is provided in Appendix A. This Assessment report includes the methodologies used for examining Demonstration progress and assessing risk, limitations of those methodologies, the Assessment's findings, and AIR's recommendations for improving performance on medium and high risk milestones. The Assessment report also incorporates the District's responses to AIR's findings and recommendations. The implementation period analyzed for this Mid-Point Assessment is January 1, 2020–December 1, 2021. The most recent monitoring metrics data used for the Assessment are those reported in the Demonstration Year (DY) 2 Quarter 2 (Q) (DY2Q2) Monitoring Report, which covers the period April 1, 2021–June 30, 2021. Since the claims-based monitoring metrics are lagged by one quarter to allow time for provider submission and payment, most data in the DY2Q2 report cover the time period of January 1, 2021– March 31, 2021. The mental health services availability assessments cover the period up to December 31, 2021.

[2] In October of 2021, CMS provided guidance on the methodology for conducting the Mid-Point Assessment: *Medicaid Section 1115 SUD and SMI/SED Demonstrations Mid-Point Assessment Technical Assistance (Version 1.0), State Demonstrations Group (SDG), Center for Medicaid and CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), October 2021.*

2.2. Description of the Demonstration's Policy Goals

The three overarching goals of the Demonstration, which cover both SUD and SMI/SED populations, are:

1. Expand the continuum of Medicaid behavioral health services and supports in the District.
2. Advance the District's goals to improve outcomes for individuals with opioid use disorder (OUD) and other SUDs.
3. Support a more person-centered, integrated, and coordinated system of physical and behavioral health care for Medicaid beneficiaries.

The SUD component of the Demonstration aims for the District to 1) maintain and enhance access to OUD and other SUD services, and 2) continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SUD. The SMI/SED component of the Demonstration aims to: 1) maintain and enhance access to mental health services, and 2) continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SMI and SED.

The Demonstration authorizes the District to receive FFP for delivering high-quality, clinically appropriate treatment to beneficiaries: 1) diagnosed with SUD and receiving treatment while they are short-term residents in settings that qualify as IMDs, and 2) diagnosed with SMI/SED and receiving treatment while they are short-term residents in settings that qualify as IMDs. The Demonstration complements the District's efforts to implement models of care focused on increasing supports for individuals in home and community-based settings to 1) improve their access to SUD services at varied levels of intensity, and combat OUD and other SUDs among District residents; and 2) improve their access to SMI/SED services at varied levels of intensity. The services covered include crisis intervention, recovery support services, transition planning, supported employment services (SES), and related benefit changes. The Demonstration also eliminated the $1 copayment requirement for certain prescriptions associated with medication assisted treatment (MAT).

The SUD and SMI/SED implementation milestones are listed in the next two subsections. The milestone criteria under each component, associated action items, and monitoring metrics are provided in Appendixes B and C.

2.2.1. *SUD Implementation Milestones*

The SUD milestones approved in the STCs include:

1. Access to Critical Levels of Care for OUD and Other SUDs
2. Use of Evidence-based, SUD-specific Patient Placement Criteria
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities
4. Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD
6. Improved Care Coordination and Transitions Between Levels of Care

The components of the SUD Health IT Plan include:

1. Prescription Drug Monitoring Program (PDMP) Functionalities
2. Current and Future PDMP Query Capabilities
3. Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes
4. Master Patient Index / Identity Management
5. Overall Objective for Enhancing PDMP Functionality & Interoperability

Appendix B lists:

- milestone criteria, future state, timeline and action items associated with the SUD milestones in Exhibit B.1 and Health IT Plan in Exhibit B.2; and
- monitoring metrics corresponding to the SUD milestones, along with their description, measurement period, reporting frequency, Demonstration target, and an indicator of whether it is a critical metric in Exhibit B.3.

2.2.2. *SMI/SED Implementation Milestones*

Four SMI/SED milestones were approved in the STCs:

1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Improving Care Coordination and Transitioning to Community-Based Care
3. Increasing Access to Continuum of Care, including Crisis Stabilization Services
4. Earlier Identification and Engagement in Treatment, including through Increased Integration

In addition, there is a Financing Plan and a Health IT Plan.

Appendix C lists:

- milestone criteria, future state, timeline and action items associated with each SMI/SED milestone, Financing Plan, and Health IT Plan in Exhibit C.1; and
- monitoring metrics corresponding to the SMI/SED milestones, along with their description, measurement period, reporting frequency, Demonstration target, and an indicator of whether it is a critical metric in Exhibit C.2.

3. Methodology

This section starts with a listing of the CMS requirements for conducting the Mid-Point Assessment as specified in the STCs for the waiver. This is followed by a discussion of the data sources and analytic methods. The section also provides a discussion of the Assessment's methodological limitations.

3.1. State Requirements Per the Special Terms and Conditions for the Mid-Point Assessment

The Mid-Point Assessment Report requirements are outlined in Section IX.48 of the STCs for the waiver. CMS requires that in the design, planning, and conducting of the Assessment, the independent assessor must consult with key stakeholders, including but not limited to representatives of managed care organizations (MCOs), SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners. CMS requires that the elements of the Assessment include:

A. Examination of progress toward meeting each milestone and timeframe approved in the SMI/SED and/or the SUD Implementation Protocols, the SMI/SED Financing Plan; and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol and/or SUD Monitoring Protocol

B. Determination of factors that affected achievement of the milestones and performance measure gap closure percentage points to date

C. Determination of selected factors likely to affect future performance in meeting milestones and targets not yet met, and information about the risk of possibly missing those milestones and performance targets

D. For milestones or targets at medium or high risk of not being met, recommendations for adjustments to the District's SMI/SED or SUD Implementation Protocols or SMI/SED Financing Plan, or to pertinent factors the District can influence to support improvement

E. Assessment of whether the District is on track to meet the budget neutrality requirements

CMS requires that the Assessment also evaluate whether the District is meeting the requirement of 30 day or less ALOS in IMDs for SMI/SED services at the time of the Assessment, as specified in Section V.40 of the STCs. Stays in IMDs for SMI/SED services that exceed 60 days

are not eligible for FFP under the Demonstration. If the 30-day or less ALOS is met, the District may claim FFP for stays up to 60 days. If the District cannot show it is meeting the 30-day or less ALOS requirement for SMI/SED services within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for stays up to 45 days, until such time that the state can demonstrate it is meeting the 30-day or less ALOS for SMI/SED services requirement.

In October of 2021, CMS provided additional guidance on the methodology for conducting the Assessment. AIR has incorporated this guidance, which is provided in *Medicaid Section 1115 SUD and SMI/SED Demonstrations Mid-Point Assessment Technical Assistance (Version 1.0), State Demonstrations Group (SDG), Center for Medicaid and CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), October 2021.*

According to the October 2021 CMS guidance for conducting the Assessment, "CMS would consider this segment of the assessment [regarding budget neutrality] to be addressed through the state's ongoing quarterly budget neutrality reporting, CMS's reviews of those and other pertinent deliverables, and our continued coordination and collaboration with the state on necessary updates and revisions to such reporting. As such, a separate budget neutrality assessment is not necessary for the state's mid-point assessment." In accordance with this guidance, this Assessment does not cover budget neutrality.

3.2. Data Sources

AIR conducted the Assessment using multiple sources of quantitative and qualitative data available at the time. These include primary data collected through key informant interviews (KIIs) and surveys, as well as secondary data available in monitoring reports and other documents.

3.2.1. *Critical Metrics*

For each Demonstration milestone, CMS identified a subset of monitoring metrics ("critical metrics") the state must include in its Mid-Point Assessment. We included all identified critical metrics reported by DHCF in our assessment. The values of the critical metrics came from seven monitoring reports:

- DY1Q1 Quarterly Monitoring Report
- DY1Q2 Quarterly Monitoring Report
- DY1Q3 Quarterly Monitoring Report

- Revised DY1Q1-Q3 Quarterly Monitoring Reports
- DY1 Annual Monitoring Report (including a separate section for DY1Q4)
- DY2Q1 Quarterly Monitoring Report
- DY2Q2 Quarterly Monitoring Report

3.2.2. *Other Monitoring Metrics*

We also assessed the District's performance on several other monitoring metrics—not included in the critical metrics list but included in the approved monitoring protocol and reported in the monitoring reports listed in 3.2.1—to provide additional information about progress towards meeting milestones. For example, we analyzed SMI/SED utilization metrics, Metrics #13–#18, which are non-critical metrics under SMI/SED Milestone 3, to provide context to mental health service utilization changes under the Demonstration.

3.2.3. *Provider Availability Assessments*

AIR used the data reported in the monitoring reports for SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, to assess SUD provider availability in the District. To assess SMI/SED provider availability, AIR used the 2019 and 2021 Mental Health Services Assessment conducted by DHCF on 1/27/2022. Stakeholder feedback and data on implementation plan action items provided additional information on SUD and SMI/SED provider availability.

3.2.4. *Implementation Plan Action Items*

To assess whether the District completed the action items identified in the Implementation Plan, AIR reviewed documents describing progress towards Demonstration milestones, and conducted a series of KIIs with Demonstration implementation staff.

Document Reviews. AIR reviewed six types of key documents for the Assessment:

- briefing materials about the Demonstration
- District policy (e.g., rules, legislation, contract language, care agreements)
- Demonstration monitoring reports
- provider guidance documents (e.g., bulletins)

- DHCF's and Department of Behavioral Health's (DBH's) self-assessment of progress towards Demonstration milestones
- materials that describe relevant co-occurring initiatives (e.g., grant narratives, reports)

Key Informant Interviews with Implementation Staff. Over January–November 2021, AIR conducted 15 KIIs with the core Demonstration implementation teams at DHCF and DBH; one with DC Health, the agency that administers the District's PDMP; and two with the Chesapeake Regional Information System for our Patients (CRISP), the District's designated Health Information Exchange (HIE) entity. These interviews supplemented the information gathered in the document reviews regarding progress towards milestones; barriers and facilitators to completing action items associated with the milestones; and any modifications to Demonstration implementation protocols.

3.2.5. *Stakeholder Interviews*

AIR solicited feedback on the Demonstration from providers, provider associations, and Medicaid managed care plans in the District. We conducted:

- five interviews and two listening sessions representing 15 provider organizations
- two interviews representing two District provider associations
- two interviews representing two Medicaid managed care plans

The goals of the interviews and listening sessions were to assess stakeholders' awareness of completed action items and to understand whether the action items the District plans to complete as part of the Demonstration are having the intended effect on the milestones with which they are associated. We also solicited information on providers' recommendations on how the District might overcome any Demonstration challenges. The interview guides are provided in Appendixes D–F.

3.2.6. *Beneficiary Survey*

Over February 12, 2021–April 30, 2021, AIR conducted a survey of Medicaid beneficiaries with an SUD or SMI/SED diagnoses who were 21 years or older. The survey explored beneficiaries' awareness of, and experiences with, new or expanded services available under the Demonstration—particularly utilization of services undetectable in claims data, and barriers to accessing behavioral health services from the perspective of beneficiaries. The survey included questions on six major topics:

- awareness of, access to, and barriers to services

- care coordination and integration
- adherence to, and retention in, treatment
- perceptions of care
- COVID-19–related changes to health and health care
- perceived health status

The survey questionnaire is provided in Appendix G. Beneficiaries could complete the survey via phone or web. A subset of beneficiaries whose preferred language was Spanish or Amharic also received the option to complete a mailed survey questionnaire.

Survey responses were received from a total of 358 beneficiaries out of a stratified random sample of 2,158. The interviewer-administered phone survey option accounted for 94 percent (337) of responses received. Self-administered web-surveys (20) accounted for almost all the remaining six percent. One Spanish survey was completed and returned via mail.

3.3. Analytic Methods

AIR used quantitative and qualitative data analytic techniques and triangulated the data available to assess the District's progress in achieving Demonstration targets.

3.3.1. *Monitoring Metrics*

Our assessment of the monitoring metrics followed the approach outlined in the CMS Mid-Point Assessment Technical Assistance guidance document.

We first collected the monitoring metrics reported by DHCF in all available Monitoring Reports at the time of the Assessment, i.e., DY1Q1–DY2Q2 reports. Multiple observations were available for monthly and quarterly metrics, but only one for annual metrics (for DY1, the baseline). We graphically explored trends in the monitoring metrics, except those with only a single (annual) observation point.

We then evaluated the progress on each metric against the appropriate Demonstration target, by calculating the changes (absolute numbers and percentages) between the baseline and the mid-point. For monthly metrics, the baseline is the reporting period of the first monitoring report with data. Critical metrics per CMS guidance were evaluated, which consist of a subset of the claims-based metrics in the monitoring reports. There are no non-claims based metrics included in the critical metrics per CMS guidance, and therefore, these metrics were not accounted for in the Assessment. For example, all metrics associated with the Health IT Plan are

non-claims based and non-critical. For claims-based metrics, the first report with data is the DY1Q2 report and the value of claims-based metrics at baseline is the average of the values in the months of January to March 2020. The mid-point is the reporting period of the latest monitoring report, DY2Q2; the value of the claims-based metrics at mid-point is the average of the values in the months of January to March 2021.

We computed the absolute and percent change based on the following formula provided in the CMS guidance:

$$Absolute\ change = Value\ of\ metric\ at\ midpoint\ -\ Value\ of\ metric\ at\ baseline$$

$$Percent\ change = \frac{Value\ of\ metric\ at\ midpoint\ -\ Value\ of\ metric\ at\ baseline}{Value\ of\ metric\ at\ baseline}$$

For annual metrics, only one data point—the value for DY1 (Calendar Year [CY] 2020), the baseline—is reported in the monitoring reports available so far. Therefore, we were unable to compute change over time.

The SUD Monitoring Protocol and the SMI/SED Monitoring Protocol include the approved annual goals and overall Demonstration targets for each metric associated with each milestone. AIR measured progress as any movement toward the District's overall Demonstration target. If the District's target is to remain consistent with the baseline value, then no movement on the metric is considered progress.

SMI/SED Metric #19(a), Average Length of Stay in IMDs, is used for assessing whether the District met the 30-day or less ALOS in IMDs for SMI/SED services STC requirement and is an annual metric. Because the single data point available for the metric covered the entire first year of the Demonstration, AIR used its value to assess the whether the District met the STC requirement.

3.3.2. *Provider Availability Assessments*

For SUD services, we assessed provider availability based on data on two monitoring metrics under SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD:

- SUD Metric #13, SUD Provider Availability
- SUD Metric #14, SUD Provider Availability – MAT

Since these are annual metrics, we were unable to assess change over time.

For SMI/SED services, we assessed provider availability based on data reported in the 2019 and 2021 annual Mental Health Services Availability Assessments. We explored the counts for the following providers and service settings in CY2019 (December 2019 for enrollment, CY2019 for provider counts) and CY2021 (December 2021 for enrollment, CY2021 for provider counts) to assess the SMI/SED provider availability and changes over time:

- psychiatrists and other providers authorized to prescribe
- other certified/licensed practitioners authorized to independently treat mental illness
- Community Mental Health Centers (CMHCs)
- intensive outpatient services providers
- residential treatment facilities and beds
- inpatient facilities and beds
- IMDs
- crisis stabilization services
- Federally Qualified Health Centers (FQHCs) offering behavioral health services

3.3.3. *Implementation Plan Action Items*

All documents and KII notes are stored in an NVivo database. AIR began the analysis process by developing a start list of codes based on the milestones, evaluation driver diagram and research questions, and data-collection protocols. Next, we systematically coded the data using these codes. After data were coded, we identified themes by identifying and interpreting coding patterns.

3.3.4. *Stakeholder Interviews*

The stakeholder interview notes are also stored in an NVivo database. We used the same analytic techniques on the stakeholder interview notes as we did for the Demonstration documents and KIIs.

3.3.5. *Beneficiary Survey*

AIR analyzed beneficiary survey responses using frequency tabulations. We generated percentages applying survey weights that accounted for differential selection probabilities and unit non-response. In addition, we systematically reviewed and categorized open-ended text responses.

3.4. Assessment of Overall Risk of Not Meeting Milestones

The Mid-Point Assessment focused on examining progress and assessing risk under the Demonstration and providing recommendations for changes to implementation protocols where applicable. We used data triangulation as the overarching analytic framework. We analyzed each data source independently and treated each finding as one piece of evidence as related to the Assessment. Thus, individual findings may be complementary, contradictory, or confirmatory when compared to other data sources. We synthesized the data provided across data sources to develop a comprehensive overall assessment of the Demonstration's progress. The subsections that follow describe how we conducted the data analysis and integrated the findings to assess progress and assign risk ratings. We triangulated the data from the various sources under four domains per CMS guidance for the Mid-Point Assessment:

- monitoring metrics
- implementation plan action items
- stakeholder feedback
- provider availability assessment

3.4.1. *Monitoring Metrics*

We assessed the risk of not meeting the Demonstration target of monitoring metrics for each milestone. Exhibit 1 lists CMS-provided criteria for assigning milestone risk rating based on the performance of associated critical monitoring metrics. For each milestone, we assessed the percentage of critical monitoring metrics that moved in the expected direction relative to the annual goals and overall Demonstration targets. If 75 percent or more of the critical monitoring metrics associated with a milestone were moving in the expected direction relative to the annual goals and overall Demonstration targets, we assigned the milestone a risk rating of low. If 25–74 percent of the critical monitoring metrics were moving in the expected direction, we assigned the milestone a risk rating of medium. If fewer than 25 percent of critical monitoring metrics associated with a milestone were moving in the expected direction, we assigned the milestone a risk rating of high.

Exhibit 1: Definition of Milestone Risk Ratings for Monitoring Metrics

Milestone Risk Rating	Critical Monitoring Metrics Moving in the Expected Direction Relative to the Annual Goals and Overall Demonstration Targets for Milestone
Low	All or nearly all (75% or more) of the associated monitoring metrics
Medium	Most (25-74%) of the associated monitoring metrics
High	Few (less than 25%) of the associated monitoring metrics

Because the start of the Demonstration coincided with the COVID-19 public health emergency (PHE), we took into account the impact of the PHE on progress in achieving Demonstration targets, especially when the Demonstration targets were not met. The findings from the risk assessment of monitoring metrics were incorporated into our overall assessment of progress made on each milestone, rather than assigning the final risk rating of a milestone based on monitoring metrics performance alone.

Exhibits 2 and 3 provide the critical metrics for SUD and SMI/SED for the Assessment, respectively, based on which we assigned the milestone risk rating. According to the CMS guidance, for SUD Milestones 2 and 6 the District had the discretion to consider some metrics as critical. We evaluated all these optional metrics as critical. We considered the other monitoring metrics listed under the milestones in the monitoring protocols as non-critical metrics for the Assessment. For milestones associated with both non-critical and critical metrics, we evaluated critical metrics only when assigning risk ratings. If no metrics existed for a milestone, we evaluated progress based on available evidence from other Assessment domains, such as applicable questions from the beneficiary survey, provider feedback from the stakeholder interviews, and other information and data provided by DHCF on implementation plan action items.

Exhibit 2: Critical Metrics for Assessing Progress for the SUD Mid-Point Assessment

Metric #	SUD Monitoring Metric Name
Milestone 1. Access to critical levels of care for OUD and other SUDs.	
7	Early Intervention
8	Outpatient Services
9	Intensive Outpatient and Partial Hospitalization Services
10	Residential and Inpatient Services
11	Withdrawal Management
12	Medication-Assisted Treatment
22	Continuity of Pharmacotherapy for Opioid Use Disorder
Milestone 2. Use of evidence-based, SUD-specific patient placement criteria.	
5	Medicaid Beneficiaries Treated in an IMD for SUD
36	Average Length of Stay in IMDs
In addition, the District may consider the following metrics when assessing Milestone 2:	
7	Early Intervention

Metric #	SUD Monitoring Metric Name
8	Outpatient Services
9	Intensive Outpatient and Partial Hospitalization Services
10	Residential and Inpatient Services
11	Withdrawal Management
12	Medication-Assisted Treatment
Milestone 4. Sufficient provider capacity at each level of care.	
13	Provider Availability
14	Provider Availability – MAT
Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.	
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
27	Overdose death rate
Milestone 6. Improved care coordination and transitions between levels of care.	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605)
17(2)	Follow-up after Emergency Department Visit for Mental Illness (NQF #2605)
25	Readmissions Among Beneficiaries with SUD
In addition, the District may consider the following metrics when assessing Milestone 6:	
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge

[a] There are no critical metrics identified for Milestone 3 (Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications).

Exhibit 3: Critical Metrics for Assessing Progress for the SMI/SED Mid-Point Assessment

Metric #	SMI/SED monitoring metric name
Milestone 1.[a] Ensuring quality of care in psychiatric hospitals and residential settings	
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
In addition, to provide context, the District may consider the following metrics when assessing Milestone 1:	
1[b]	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)

Metric #	SMI/SED monitoring metric name
23[c,d]	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
Milestone 2. Improving care coordination and transitions to community-based care	
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care (PMH-20)
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)
7	Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)
10	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)
Milestone 3.[a] Increasing access to continuum of care including crisis stabilization services	
19[e]	Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)
Milestone 4. Earlier identification and engagement in treatment including through increased integration	
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

[a] Milestones 1 and 3 each have only one required critical metric, so the District should consider submitting additional evidence if the critical metric did not show progress. CMS will assess the critical metrics and other supporting evidence to make the final determination on the state's progress towards these milestones.

[b] In the technical specifications, Metric #1 is categorized as a recommended monitoring metric, so the state may not report this metric in its monitoring reports. The District has the option to report Metric #1 for the mid-point assessment to demonstrate progress toward Milestone 1.

[c] Metric #23 is required for state monitoring reports but is grouped under Milestone 4 in the technical specifications. The District has the option to use Metric #23 to demonstrate progress toward Milestone 1 for the mid-point assessment, but the District should retain this metric in Milestone 4 for the purposes of annual monitoring.

[d] Milestone 1 includes an aim to "demonstrate the capacity to address co-morbid physical health conditions" in settings "with on-site staff, telemedicine, or other partnerships with physical health providers" (SMDL #18-011, p. 15). To align Metric #23 with Milestone 1, the District should modify the calculation of the numerator and denominator to focus only on residential and inpatient settings. To modify the metric calculation, in Step 2 of the "Event/diagnosis definition," the District should limit the beneficiaries to those who have at least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder using any of the following code combinations:

BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set)

Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set

[e] The District must meet an ALOS in IMDs of 30 days for SMI/SED services at the mid-point assessment to receive federal financial participation.

3.4.2. *Implementation Plan Action Items*

For each milestone, we identified all action items specified in the SUD and SMI/SED Implementation Plans. Note that we did not assess progress for action items for which the Demonstration indicates "no action was needed" in the Implementation Plans. If there was no completion date identified in the Implementation Plan, we suggested one in consultation with the District based on the content of the action item. Based on the findings from the document reviews and KIIs, we assessed the progress of each action item taking into consideration four dimensions of completion status:

- Completed = Action item is discrete and there is clear evidence that the action item is complete.
- Ongoing = Action item reflects a series of activities with no scheduled end date (e.g., participation in working group) and the District is engaging in these activities.
- Open = Action item is discrete, and the District has not yet completed it.
- Suspended = The District has not completed the action item and has no plans to complete it.

For each milestone, we assessed the percentage of action items that were complete or ongoing at the Mid-Point Assessment. We used these findings to contextualize, and as needed adjust, the risk ratings based on the monitoring metric trends.

3.4.3. *Stakeholder Feedback*

The stakeholder feedback assessment of the District's progress towards the milestones is based on the findings from the provider interviews and listening sessions, interviews with provider associations, and interviews with the MCOs. We identified themes within and across data sources that reflect the proportion of stakeholders who identified risks related to meeting the milestone. We used these findings to contextualize, and as needed adjust, the risk ratings based on the monitoring metric trends.

3.4.4. *Provider Availability Assessments*

AIR used the data on SUD Milestone 4 for assessing SUD provider availability and we compared the change in availability between the 2019 and 2021 Mental Health Services Availability Assessments for assessing SMI/SED provider availability. We used data on implementation plan action items and stakeholder feedback to contextualize the findings.

3.4.5. *Risk Rating and Recommendations*

As described, we triangulated evidence from the monitoring metrics, implementation plan action items, and stakeholder feedback to assign a final risk level to a milestone. As directed by CMS, for those milestones with a medium or high risk level, we provide recommendations for Demonstration implementation improvements/modifications. Recommendations were developed based on AIR's assessment of Demonstration progress, taking into account all pertinent quantitative and qualitative evidence available at the time of the Assessment. We also discuss the rationale behind the recommendations.

3.5. Special Methodological Considerations and Limitations

The proposed methodology is based on CMS's Mid-Point Assessment requirements provided in the STCs, as well as the additional methodological guidance CMS provided subsequently. A challenge with the methodology is that the results for some milestones may not neatly fit into the risk rating rubric provided by CMS. For example, for a particular milestone, the monitoring metrics may indicate medium risk, but the District has completed all the associated implementation plan action items, all stakeholders contacted expressed high satisfaction with the Demonstration, and the pandemic adversely affected achievement of Demonstration targets for some of the monitoring metrics. In such cases, we assigned the final risk rating for that milestone based on a holistic assessment of the importance and relevance of the associated monitoring metrics, action items, and stakeholder feedback on achievement of that milestone. When assigning final risk ratings and developing recommendations, we gave due consideration to identified challenges to the Implementation Plan and achievement of Demonstration targets.

A special consideration in developing a risk rating was how to account for the changes in the Demonstration implementation timeline, activities, and outcomes resulting from the PHE, which coincided with the start of the Demonstration. AIR considered the fact that the STCs and Implementation Plan were developed before the onset of COVID-19, and the PHE may have necessitated revisions to some of the planning and affected progress. The team incorporated information collected from the DC government, as well as external stakeholders, on whether and how any action items were affected by the PHE. The trends in monitoring metrics were also reviewed to assess the PHE influence. See Section 5 for a detailed discussion of internal and external factors that may have influenced Demonstration progress.

4. Findings: Overview of Demonstration Policy Changes

Rulemaking and issuance of related provider guidance material are key components of the District's progress under the Demonstration. These policy changes address multiple action items in both the SUD and SMI/SED waiver implementation planning. In this section, we summarize the key policy changes that occurred during the Demonstration up to the Mid-Point Assessment.

DHCF issued a series of rules to align their Medicaid regulations with the Demonstration goals. These rules institute new regulations (Chapter 86 of Title 29 of the District of Columbia Municipal Regulations [DCMR]) that:

- establish Demonstration services as Medicaid-eligible
- define Demonstration services
- identify which Medicaid beneficiaries are eligible for Demonstration services
- identify the types of providers that can provide Demonstration services
- describe the circumstances under which Demonstration services are reimbursable

DHCF issued three comprehensive rules. The first rule (effective November 29, 2019) included regulations for Medicaid coverage of:

- psychosocial rehabilitation (Clubhouse) services
- trauma recovery empowerment model (TREM) services
- trauma systems therapy (TST) services
- recovery support services for SUD
- supported employment services (SES) for SMI
- inpatient and residential IMD services

The first rule also established independent licensed behavioral health providers (psychologists, licensed independent social workers, licensed professional counselors, and licensed marriage and family therapists) as eligible for Medicaid enrollment; and instituted zero cost sharing for MAT for SUD.

The second rule (effective April 24, 2020) included regulations for Medicaid coverage of crisis stabilization services (the Comprehensive Psychiatric Emergency Program [CPEP], Psychiatric

Stabilization Program, Youth Mobile Crisis Intervention Program, and Adult Mobile Crisis and Outreach Program) and SES for beneficiaries with SUD. The third rule (effective October 23, 2020) included regulations for Medicaid coverage of transition planning services.

Following issuance of these rules, DHCF released a series of memorandums and transmittals informing providers of:

- procedures for newly eligible providers to enroll in Medicaid to receive reimbursement for Demonstration services (Transmittal # 19–25; December 17, 2019)
- removal of the co-pay for MAT drug products used to treat SUD (Transmittal # 19–27; December 19, 2019)
- ICD-10 and CPT codes applicable to independent licensed providers' billing for Demonstration services (Transmittal # 19–28; December 23, 2019)
- reimbursement rates for Demonstration services (October 23, 2020)

DBH also issued a series of rules in support of the Demonstration. These rules describe Demonstration-related requirements for providers certified by DBH. The most comprehensive policy changes occurred to Chapter 63 of Subtitle A of Title 22 of the DCMR. In a series of rules (final rule effective date June 17, 2020), DBH revised this regulation as follows:

- include certification requirements for providers of TREM services and add TREM as a specialty service
- require all treatment providers to provide intake and assessment services
- require all residential treatment providers to provide on-site or facilitate access to all Food and Drug Administration (FDA)-approved medications used in MAT
- make recovery support services a core service for all treatment providers
- require providers to have naloxone on site
- require Level 1, 2.1, and 2.5 providers to assess client interest in and eligibility for supported employment services
- include language specific to discharge planning by residential treatment providers
- expand the list of provider types qualified to provide ASURS to be consistent with the newly eligible Medicaid providers

Other key policy changes DBH made to Subtitle A of Title 22 of the DCMR include:

- updating Chapter 34 (effective date January 14, 2020) to designate specific certification for TREM and TST to enable higher reimbursement rates for these services
- adding Chapter 37 (effective date February 7, 2020), which describes certification standards for supported employment services for SMI
- adding Chapter 65 (effective date September 28, 2020), which establishes certification requirements and service and eligibility standards for transition planning services for SUD and SMI/SED services during or following an inpatient or residential SUD treatment stay
- adding Chapter 80 (effective date October 7, 2020), which establishes certification requirements for crisis service providers

5. Findings: Internal and External Factors that Influenced Demonstration Progress

In this section, we discuss three internal and external factors that potentially influenced Demonstration progress in its initial years:

- managed care changes
- the COVID-19 PHE
- transition of waiver services to the State Plan

5.1. Managed Care Changes

The District transitioned a substantial number of Medicaid beneficiaries from fee-for-service (FFS) to managed care as of October 2020. The majority of the District's Medicaid beneficiaries was already enrolled in a contracted MCO prior to this transition; however, a small group of FFS beneficiaries was contributing disproportionately to the program costs. To better manage this subpopulation, DC identified a group of 17,000 FFS beneficiaries (largely adults with disabilities who were not dually enrolled in Medicare) who could be appropriately transitioned to managed care, with approximately one-quarter of this group having a behavioral health diagnosis. One goal of transitioning this group to managed care was to grant them access to case management services offered by the MCOs.

Although this transition resulted in few payment and service delivery changes for behavioral health services, it did pose an administrative hurdle for certain providers, such as home health agencies (HHAs). Some providers voiced concerns about the transition to managed care, indicating the rollout was implemented too quickly without sufficient information. For example, providers noted they had different relationships with different MCOs. This caused uncertainty because providers were not sure what the MCOs would pay for, what would be the reimbursement amounts, which services would be allowed, and so on. In addition, these types of changes often required redesign of infrastructure that affected providers' bottom line, requiring time to make appropriate adjustments. It is noteworthy that, despite the confusion and billing challenges, providers reported that the managed care transition had not impacted their implementation of Demonstration changes.[3]

[3] In October 2021, the District instituted emergency legislation to prevent disruption of services to Medicaid beneficiaries who were assigned to an MCO – one out of three full-risk MCOs that cover the majority of the District's Medicaid beneficiaries – whose contract was to be cancelled after a protest.

In addition, the transition of beneficiaries to managed care did shift certain behavioral health services from fee-for-service payment and delivery under Demonstration authority to coverage under managed care outside of the Demonstration. For example, because MCOs cover short IMD stays as an "in lieu of" benefit, the number of individuals with IMD stays covered under the Demonstration decreased after the transition. Similarly, the number of individuals whose $1 copay was eliminated or who used independent licensed BH practitioner services under the Demonstration decreased, as MCOs had already implemented these policies under existing authority.

Additional changes to managed care are scheduled to occur in the District. For fiscal year (FY) 2024, the District plans to include all behavioral health services, including Demonstration services, that were previously "carved out" of the MCO contracts. Stakeholders viewed this change positively. They were preparing for the administrative hurdles that would occur due to the change, but believed that, after the initial implementation period, MCO members would find it much easier to access services. Stakeholders also anticipated more robust provider networks and additional support from MCOs related to beneficiaries' overall wellbeing and connections to quality care.

5.2. The COVID-19 Public Health Emergency

The COVID-19 PHE had a substantial impact on the Demonstration. The implementing agencies (DHCF and DBH) were forced to divert resources from Demonstration implementation to address pressing public health concerns—for example, issuing flexibilities regarding telehealth and temporarily adjusting payment rates for providers. In addition, most providers experienced significant disruption from COVID-19, including:

- lowered census and patient loads
- revised or stopped visitation in inpatient facilities
- suspended transportation services from inpatient to community settings
- confusion about which provider is responsible for COVID testing when beneficiaries are transitioning care (e.g., on discharge or on admission)
- disruption to established or preferred methods for follow-up
- longer lengths of stay due to delays in care transition planning
- increased expenditures on cleaning services, transportation (e.g., for individual taxis rather than facility-based shuttles), and personal protective equipment

These disruptions are evident in the monitoring metric trends displayed in the sections that follow. A common pattern for the monitoring metrics was a sharp decrease in service utilization during periods when COVID-19 case rates were high (starting near the end of DY1Q1), followed by a slow return to pre-Demonstration rates. This trend was particularly pronounced for services that must be delivered in person (such as inpatient, partial hospitalization, and residential treatment services). Providers did take advantage of telemedicine, which contributed in particular to overall mental health service use quickly rebounding in 2020 to exceed pre-pandemic levels, but with mixed opinions. Providers appreciated that telemedicine created opportunities for reimbursement during a time when service volume would have otherwise been very low. However, some were skeptical about the efficacy of this treatment modality, particularly for the more intensive services. Beneficiaries' perspectives on telemedicine may differ from providers' perspectives. Around 40 percent of beneficiaries who participated in the survey reported using telemedicine to get help with their drug or alcohol use or mental health; and three-quarters of them strongly agreed or agreed that the telemedicine visit was as good as an in-person visit.

5.3. Transition of Waiver Services to State Plan

As part of the Demonstration STCs, the District is required to transition all but the IMD services to the State Plan (through a State Plan amendment and/or 1915(i) SPA application(s)) by January 2022. The District submitted for approval three State Plan amendments needed to satisfy this requirement. CMS has approved one as of the Mid-Point Assessment—the State Plan amendment allowing DHCF to enroll additional licensed providers to provide behavioral health services and removing services restrictions to allow diagnostic, assessment, and treatment services for Autism Spectrum Disorder. Of the two State Plan amendments still under CMS review, one will establish authority for supported employment services and the other will add the following services to the State Plan:

- Mental Health Rehabilitation Services (MHRS) (clinical care coordination, Clubhouse, recovery support services, and TREM)
- ASURS (Clubhouse, recovery support services, and TREM)
- transition planning services

This State Plan amendment also outlines the behavioral health stabilization services (CPEP, adult mobile crisis intervention and outreach, youth mobile crisis, and psychiatric residential crisis stabilization) and reimbursement rates.

In moving Demonstration services to the State Plan, the District refined some covered services. For example, the transition planning benefit, which currently must be provided within 30 days

prior to an individual being discharged, will allow benefit provision both 30 days prior and 30 days post discharge. These refinements reflect continued progress towards the Demonstration goal of expanding access to the full continuum of behavioral health care.

6. Findings: Assessment of Progress in Achieving the SUD Milestones

This section presents the progress the District has achieved in meeting each SUD milestone by the Mid-Point Assessment. This Assessment reports findings under each of three domains: monitoring metrics, implementation plan action items, and stakeholder feedback. This section includes tables and graphs depicting progress on monitoring metrics, narrative summaries of qualitative data collected on implementation plan action items, and stakeholder feedback. The section also includes an SUD provider availability assessment.

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

6.1.1. *Monitoring Metrics*

The District's progress in achieving SUD Milestone 1, Access to Critical Levels of Care for OUD and other SUDs, is assessed based on the change (increase, decrease, or consistent) in seven critical metrics from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 4 shows seven critical monitoring metrics' progress towards Demonstration targets under SUD Milestone 1. The Demonstration targets were increases for the six critical monthly metrics (#7–#12). Three of the six (50%) met their Demonstration targets. The seventh critical metric (#22) was an annual metric with a single data point; as noted, we excluded annual metrics from the Assessment as we cannot estimate change over time yet. ***Therefore, the overall risk rating for monitoring metrics under SUD Milestone 1 is Medium.***

The three metrics that did not meet their Demonstration target (early intervention, outpatient services, and MAT) were very likely affected negatively by the PHE. Overall, most of the SUD access-related monitoring metrics showed a sharp decline from the January 2020 level by the end of DY1Q1, which coincided with the onset of the pandemic. The movement towards pre-pandemic service utilization levels started at different points for different measures, with recovery starting as early as DY1Q2 for some measures.

An additional limitation is that two of the metrics have very small numbers, which does not allow for meaningful change to be evaluated. Early intervention (#7) is defined by a small number of procedure codes, two of which are covered by Medicaid in the District but are infrequently used by providers. Intensive outpatient and partial hospitalization (#9) represents a level of care that is covered, but is not fully reflected in metric results due to data limitations.

Even with complete data, intensive outpatient services are likely to have been underutilized as a result of COVID-19, as this level of care has primarily been offered as in-person group service.[4]

Exhibits 5 to 10 graphically depict the monthly trends in the monitoring metrics associated with access to critical levels of care for OUD and other SUDs for six of the measures (#7–#12). SUD Metric #22, Continuity of Pharmacotherapy for Opioid Use Disorder, the annual measure, has no associated trend graph.

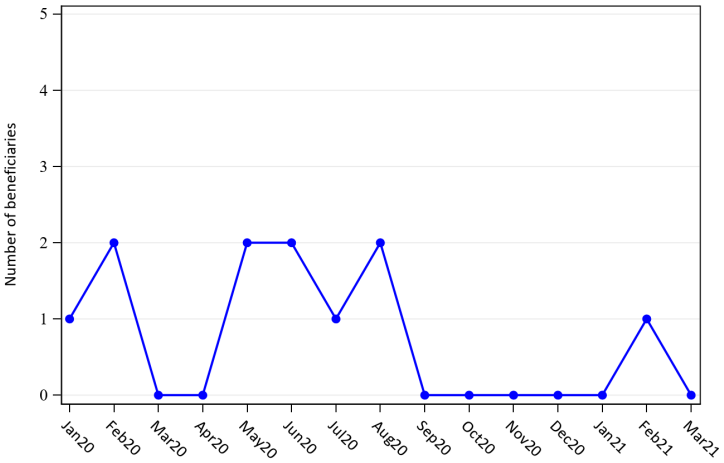
[4] DHCF is exploring ways to identify individuals receiving intensive outpatient/partial hospitalization services, which may include using clinical data from DBH on level of care assessments and/or counting the number of therapy hours billed in claims to compare against thresholds that define intensive outpatient/partial hospitalization. This additional effort is required because the services may be billed in the District using outpatient therapy codes that are also applicable to a lower level of care.

Exhibit 4: SUD Milestone 1 Monitoring Metrics – Access to Critical Levels of Care for OUD and Other SUDs

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
7	Early Intervention[(a)]	Month	Quarterly	1.0	0.3	-0.7	-66.7%	Increase	Decrease	Y	N	**Medium**
8	Outpatient Services	Month	Quarterly	2,537.3	2,132.3	-405.0	-16.0%	Increase	Decrease	Y	N	
9	Intensive Outpatient and Partial Hospitalization Services[(b)]	Month	Quarterly	3.3	5.0	1.7	50.0%	Increase	Increase	Y	Y	
10	Residential and Inpatient Services	Month	Quarterly	338.0	353.0	15.0	4.4%	Increase	Increase	Y	Y	
11	Withdrawal Management	Month	Quarterly	156.0	159.7	3.7	2.4%	Increase	Increase	Y	Y	
12	Medication Assisted Treatment	Month	Quarterly	2,091.7	1,988.3	-103.3	-4.9%	Increase	Decrease	Y	N	
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Year	Annually	46.1%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

Notes: [(a)]The small number of beneficiaries included in the metric makes it difficult to evaluate the progress based on the quantitative values. Exhibit 5 displays the trend of this metric. [(b)]The small number of beneficiaries included in the metric makes it difficult to evaluate the progress based on the quantitative values. Exhibit 7 displays the trend of this metric.

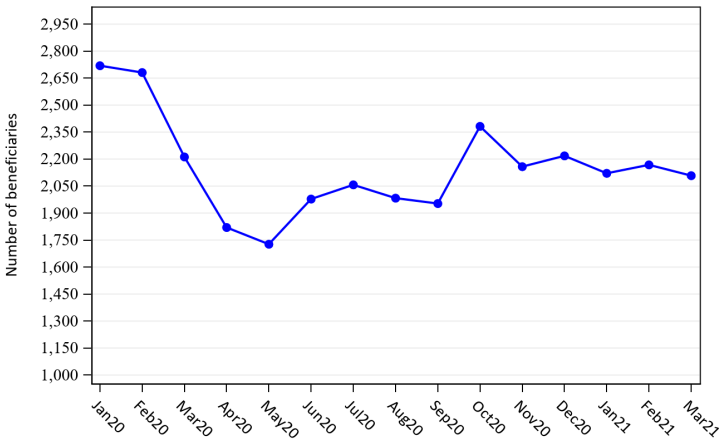
Exhibit 5: Trend of SUD Metric #7 – Early Intervention



Measure description: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.

Exhibit 5 shows that the average number of beneficiaries who used early intervention services was extremely low throughout the period of the Mid-Term Assessment, fluctuating between zero and two beneficiaries. The value of the metric at baseline (DY1Q1 average) is one and its value at mid-point (DY2Q1 average) is zero (0.33), for an absolute change of minus one (-0.67, or -67%). The metric did not meet the Demonstration target of an increase, but the small number of beneficiaries included in the metric makes it difficult to draw any meaningful conclusions.

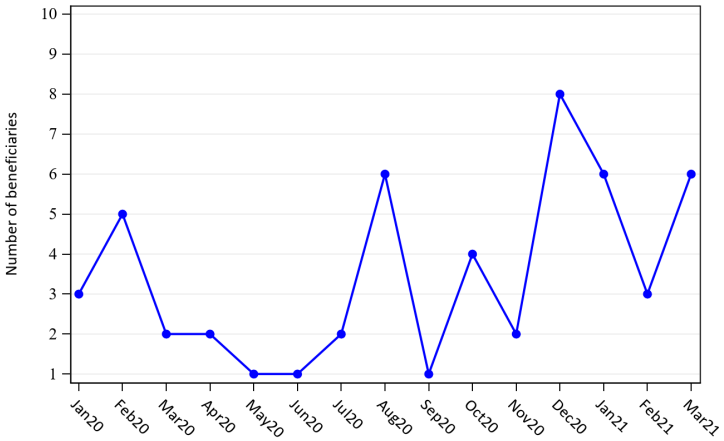
Exhibit 6: Trend of SUD Metric #8 – Outpatient Services



Measure description: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period.

Exhibit 6 shows that the number of beneficiaries who used outpatient services for SUD decreased sharply from February 2020, reaching its lowest point in May 2020. The number then increased and was consistent until a peak in October 2020. This was followed by an immediate decline, where service use remained consistent. The value of the metric at baseline (DY1Q1 average) is 2,537 and its value at mid-point (DY2Q1 average) is 2,132, for an absolute change of -405 (-16%). The metric did not meet the Demonstration target of an increase.

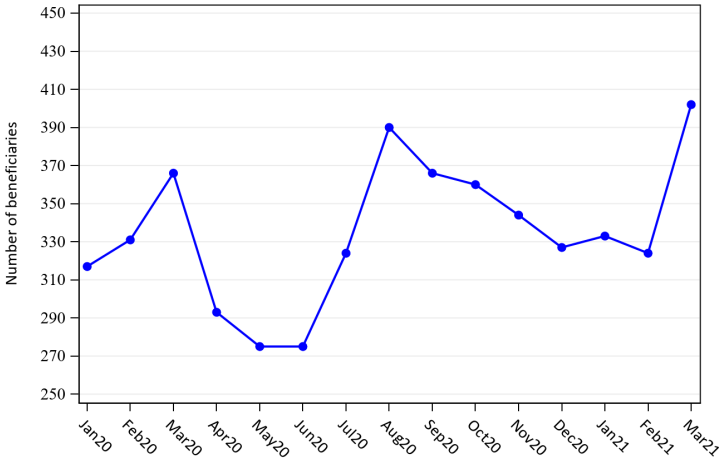
Exhibit 7: Trend of SUD Metric #9 – Intensive Outpatient and Partial Hospitalization Services



Measure description: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.

Exhibit 7 shows that the number of beneficiaries who used intensive outpatient and partial hospitalization services for SUD is very low, but with a jagged upward trend from January 2020 to March 2021. The value of the metric at baseline (DY1Q1 average) is three and its value at mid-point (DY2Q1 average) is five, for an absolute change of two (50%). The metric met the Demonstration target of an increase, but the small number of beneficiaries included in the metric makes it difficult to draw any meaningful conclusions.

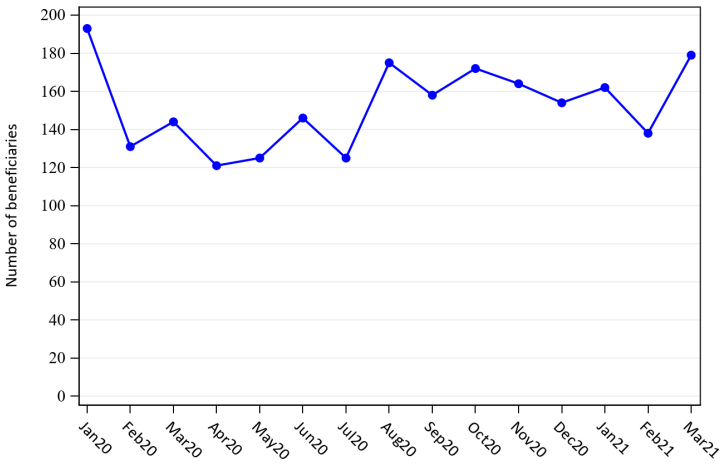
Exhibit 8: Trend of SUD Metric #10 – Residential and Inpatient Services



Measure description: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.

Exhibit 8 shows that the number of beneficiaries who used residential and inpatient services for SUD experienced a sharp reduction in March 2020 and reached the lowest point in May–June 2020. The number reached a peak in August 2020, and after a decline, had another sharp increase in March 2021. The decrease in 2020 Q4 may be attributable in part to a resurgence of the COVID-19 pandemic if individuals were reluctant or unable to obtain care in these settings. The value of the metric at baseline (DY1Q1 average) is 338 and the value of the metric at mid-point (DY2Q1 average) is 353, for an absolute change of 15 (4%). The metric met the Demonstration target of an increase.

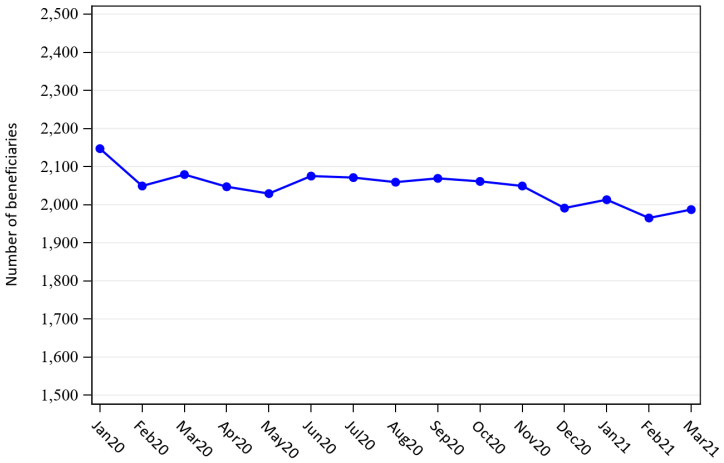
Exhibit 9: Trend of SUD Metric #11 – Withdrawal Management



Measure description: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.

Exhibit 9 shows that the number of beneficiaries who used withdrawal management services decreased during the first half of 2020. Even though the number of beneficiaries using withdrawal management services increased after the second half of 2020, the number in March 2021 was still below that at the beginning of the Demonstration. The value of the metric at baseline (DY1Q1 average) is 156 and its value at mid-point (DY2Q1 average) is 160, for an absolute change of four (2%). The metric met the Demonstration target of an increase.

Exhibit 10: Trend of SUD Metric #12 – Medication Assisted Treatment



Measure description: Number of beneficiaries who have a claim for MAT for SUD during the measurement period.

Exhibit 10 shows that the number of beneficiaries with a MAT claim for SUD experienced a small and steady reduction throughout the Demonstration thus far. The value of the metric at baseline (DY1Q1 average) is 2,092 and its value at mid-point (DY2Q1 average) is 1,988, for an absolute change of -103 (-5%). The metric did not meet the Demonstration target of an increase.

6.1.2. *Implementation Plan Action Items*

Exhibit 11: SUD Milestone 1 Implementation Plan Action Items - Access to Critical Levels of Care for OUD and Other SUDs

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A1.1	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.	December 31, 2021	Completed
SUD A1.2	Medicaid waiver and expenditure authority requested *(for intensive care delivered in an IMD setting)*.	June 3, 2019[(a)]	Completed
SUD A1.3	Medicaid waiver and expenditure authority requested *(for withdrawal management services delivered in an IMD setting)*.	June 3, 2019[(a)]	Completed

Note: [(a)]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date the waiver application was submitted.

All action items under SUD Milestone 1 are complete (Exhibit 11). Medicaid waiver and expenditure authority for coverage of intensive levels of care in residential and inpatient settings and coverage of medically supervised withdrawal management were requested on June 3, 2019 and granted by CMS with Demonstration approval on November 6, 2019.

DHCF leveraged the complementary efforts of its SUPPORT Act Section 1003 Planning Grant to conduct stakeholder engagement to assess SUD provider capacity and need, and to develop recommendations to strengthen the SUD system in ways that would result in a whole-person, population-based, integrated Medicaid SUD system that is comprehensive, coordinated, high quality, culturally competent, and equitable. More than 150 individuals participated in the contractor-convened interviews, focus groups, steering committee meetings, and community meetings. These participants included representatives from health and social service organizations, DHCF, DBH, DC Health, advocacy and professional groups, and community businesses, as well as individuals from the community at large. The assessment showed that this provider network is strong and well-supported compared to SUD service networks in similar urban markets. Services are well-distributed throughout the District and provide a full breadth of services across the SUD service continuum. However, this does not mean that DC

residents with SUD are always able to access the person-centered services they need, when and where they want them. The assessment identified several significant gaps across the American Society of Addiction Medicine (ASAM) levels of care and a range of service delivery challenges, that limit engagement in care, hinder care coordination, interfere with care transitions, and that ultimately reduce the effectiveness of the existing service network.

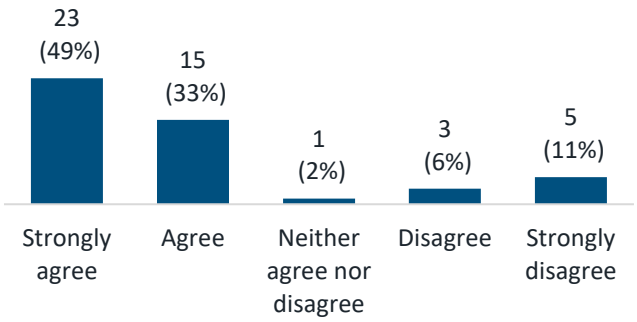
Many stakeholders cited that there were gaps in the availability, variety, and quality of intensive outpatient programs and recommended expanding:

- availability of intensive outpatient services that target specific segments of the SUD population (e.g., veterans, men-only, women-only, women with children)
- availability of intensive outpatient services that have different requirements and philosophies (e.g., sober and non-sober living, 12-step, SMART Recovery, faith-based or secular)
- training and technical assistance on evidence-based best practices for delivering high-quality intensive outpatient services

6.1.3. *Stakeholder Feedback*

From stakeholders' perspective, the District made progress in improving access to critical levels of care for OUD and other SUDs. Providers were aware of, and supported, waiver efforts to expand coverage of SUD services under Medicaid. In addition, most beneficiaries who responded to the survey reported they were able to access SUD services. Of the 14 percent (n=47) of survey respondents who said 'yes' when asked whether they felt they wanted/needed counseling or treatment for drug or alcohol use in the past 12 months, 81 percent (n=38) agreed or strongly agreed they were able to get the wanted/needed services (Exhibit 12).

Exhibit 12: Survey respondents who were able to get all the services they wanted or needed for counseling or treatment for drug or alcohol use



Note: Percentages are weighted. Percentages may not add up to 100 because of the "no response" category (not shown).

In addition, the availability of expanded coverage for IMD stays has expedited MCOs' contracting with SUD residential treatment providers in the District. MCOs were previously planning to pursue these contracts when the carve in of behavioral health services occurred.

Stakeholders identified several areas where they would like to see continued progress. Providers reported that the rates for these services should be reassessed to ensure they are high enough for financial sustainability. IMDs expressed frustration with the administrative complexity of receiving authorization and billing for these services. While not an issue for withdrawal management services (because those clinical episodes typically required stays fewer than 15 days), the need for patients to switch from managed care to FFS billing if their IMD stay exceeded 15 days posed an administrative burden. For other high acuity stays (e.g., ASAM 3.5 and 3.3), providers must receive MCO approval to admit an MCO patient; but then, if the patient stay ended up exceeding 15 days, providers had to void that pre-authorization and start the process over with the utilization management vendor for FFS patients.

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

6.2.1. *Monitoring Metrics*

The District's progress in achieving SUD Milestone 2, Use of Evidence-based, SUD-specific Patient Placement Criteria, is assessed based on the change (increase, decrease, or consistent) in eight critical metrics (six optionally critical) from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 13 shows the monitoring metrics' progress towards Demonstration targets under SUD Milestone 2. The two critical metrics are both annual, preventing evaluation of their progress at this stage. According to CMS guidance, the state may consider six metrics (already covered under SUD Milestone 1) when assessing SUD Milestone 2 (#7–#12). Three of these six metrics (50%) achieved their Demonstration targets of an increase. ***Therefore, the risk rating for monitoring metrics under SUD Milestone 2 is Medium.*** The PHE is considered a significant contributing reason why not all the SUD service utilization metrics met their Demonstration targets. Furthermore, as discussed under SUD Milestone 1, Metrics #7 and #9 are based on very small numbers of beneficiaries that make drawing meaningful conclusions difficult.

Exhibit 13: SUD Milestone 2 Monitoring Metrics – Use of Evidence-based, SUD-specific Patient Placement Criteria

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
5	Medicaid Beneficiaries Treated in an IMD for SUD	Year	Annually	1,837	N/A	N/A	N/A	Increase	N/A	Y	N/A	**Medium**
36	Average Length of Stay in IMDs	Year	Annually	11.4	N/A	N/A	N/A	No more than 30 days	N/A	Y	N/A	
7	Early Intervention[(a)]	Month	Quarterly	1.0	0.3	-0.7	-66.7%	Increase	Decrease	Y (optional)	N	
8	Outpatient Services	Month	Quarterly	2,537.3	2,132.3	-405.0	-16.0%	Increase	Decrease	Y (optional)	N	
9	Intensive Outpatient and Partial Hospitalization Services[(b)]	Month	Quarterly	3.3	5.0	1.7	50.0%	Increase	Increase	Y (optional)	Y	
10	Residential and Inpatient Services	Month	Quarterly	338.0	353.0	15.0	4.4%	Increase	Increase	Y (optional)	Y	
11	Withdrawal Management	Month	Quarterly	156.0	159.7	3.7	2.4%	Increase	Increase	Y (optional)	Y	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
12	Medication Assisted Treatment	Month	Quarterly	2,091.7	1,988.3	-103.3	-4.9%	Increase	Decrease	Y (optional)	N	

Notes: [a]The small number of beneficiaries included in the metric makes it difficult to evaluate the progress based on the quantitative values. Exhibit 5 displays the trend of this metric. [b]The small number of beneficiaries included in the metric makes it difficult to evaluate the progress based on the quantitative values. Exhibit 7 displays the trend of this metric.

6.2.2. *Implementation Plan Action Items*

Exhibit 14: SUD Milestone 2 Implementation Plan Action Items - Use of Evidence-based, SUD-specific Patient Placement Criteria

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A2.1	DBH will ensure assessments continue to be based on tools like the Treatment Assignment Protocol (TAP) and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary	June 30, 2021	Completed

The only action item for SUD Milestone 2 is complete (Exhibit 14). DBH added three new Assessment and Referral sites at community SUD providers. To ensure these and previous assessment and referral sites use tools such as the Treatment Assignment Protocol (TAP), DBH included the following language in the final rulemaking for 22A DCMR Chapter 63 (6328.1): "*All individuals seeking SUD services must be assessed and referred to a particular LOC* [level of care] *in accordance with the Department-approved assessment tool(s) and ASAM criteria.*"

6.2.3. *Stakeholder Feedback*

Providers uniformly indicated that decentralization of the intake, assessment, and referral process improved patient access to services, noting that it avoided having to send patients who presented at their provider of choice to the Assessment and Referral Center (ARC) prior to starting treatment. One provider said that decentralized intake had the largest impact of all waiver changes and that the change has been "dramatic"—enabling providers to reach patients in the community, offering patients more choice, and supporting integration of SUD and SMI/SED. One provider indicated that the process for being certified as an intake and referral center was onerous enough to prevent them from benefiting from the change, although they were developing the relevant services and strongly supported the policy. ARC-certified providers confirmed that the assessment tool they were required to use (the TAP tool) did not change; however, there were other tools they preferred for clinician-administered assessment that they were unable to align with the reporting requirements driven by the TAP structure.

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

6.3.1. *Monitoring Metrics*

There are no monitoring metrics associated with SUD Milestone 3.

6.3.2. *Implementation Plan Action Items*

Exhibit 15: SUD Milestone 3 Implementation Plan Action Items – Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A3.1	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.	June 30, 2021	Completed

The only action item for SUD Milestone 3 is complete (Exhibit 15). DBH included the following language in the final rulemaking for 22A DCMR Chapter 63 (6328.8): *"All providers shall offer all Food and Drug Administration ("FDA") approved forms of MAT to any client who meets the criteria for and selects MAT as part of their Plan of Care, in accordance with certification under this chapter or other Federal and District laws and regulations. If a provider is not certified to offer the client's choice of medication in accordance with this chapter or under any other Federal and District laws and regulations, then the provider shall refer the client to another provider able to offer MAT that meets the client's needs."*

6.3.3. *Stakeholder Feedback*

Stakeholder feedback suggests progress towards improved qualifications for residential treatment providers. The one residential treatment provider that participated in stakeholder interviews indicated they were compliant with the MAT requirements. This provider noted that they were in the process of becoming certified as an opioid treatment provider; in the meantime, they referred beneficiaries needing methadone to other providers.

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

6.4.1. *Monitoring Metrics*

The District's progress in achieving SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, is assessed based on the change (increase, decrease, or consistent) in two critical metrics from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 16 shows the monitoring metrics' progress towards Demonstration targets under SUD Milestone 4. Both the critical metrics are annual, preventing assessment of progress towards the Demonstration targets. ***Therefore, the risk rating for monitoring metrics under SUD Milestone 4 is Not Applicable.***

Exhibit 16: SUD Milestone 4 Monitoring Metrics – Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demonstration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
13	SUD Provider Availability	Year	Annually	797	N/A	N/A	N/A	Consistent	N/A	Y	N/A	N/A
14	SUD Provider Availability - MAT	Year	Annually	393	N/A	N/A	N/A	Consistent	N/A	Y	N/A	

6.4.2. *Implementation Plan Action Items*

Exhibit 17: SUD Milestone 4 Implementation Plan Action Items – Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A4.1	Medicaid waiver and expenditure authorities requested *(to exempt medications for MAT from the $1 co-payment otherwise associated with outpatient prescription medications; for intensive care in an IMD setting; for withdrawal management services delivered in an IMD setting.)*	June 3, 2019	Completed
SUD A4.2	The District will also work to improve future assessments of SUD provider capacity, especially the availability of MAT and 3.7-Withdrawal Management (WM) services.	December 31, 2021	Completed

Both action items under SUD Milestone 4 are complete (Exhibit 17). With submission of the Demonstration application on June 3, 2019, DHCF requested Medicaid waiver and expenditure authority to exempt medications for MAT from the $1 copayment otherwise associated with outpatient prescription medications, and to pay for intensive care and withdrawal management services in IMDs. CMS granted this request with Demonstration approval on November 6, 2019. Section 4 describes the policymaking related to these services.

As discussed under SUD Milestone 1, the District conducted an assessment of provider capacity as part of the Section 1003 SUPPORT Act Planning Grant. The District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment, which reported its final findings in February 2021, included analyses of utilization and claims data for all DBH-certified SUD providers, as well as interviews and focus groups with providers and community residents and meetings with stakeholders. The assessment identified gaps and service delivery challenges across the SUD service continuum and scope for system improvements and organizational capacity building. The results of the analyses showed that based on publicly available data at the time of review, there were 155 MAT waivered providers who prescribe medication to SUD clients, one provider of medically monitored high-intensity inpatient services (Level 3.7) and one provider of medically managed high-intensity inpatient services (Level 4.0) in FY 2019. To address access to MAT and Levels 3.7 and 4.0 of Care, DHCF is supporting DBH, DC Fire and

Emergency Medical Services, DC Health, and the Metropolitan Police Department in the implementation of the DC Stabilization and Sobering Center. The sobering center will allow first responders to direct patients intoxicated but not in need of emergency care away from hospital emergency departments (EDs) towards a more appropriate course of care for their medical needs. The sobering center will be staffed by health care experts who can monitor the patients' needs and lessen the demand at local hospitals. Discussions about potentially identifying more community locations (including the Stabilization and Sobering Center) to administer MAT based upon the policy promulgated July 28, 2020 by the United States Drug Enforcement Administration that permits Opioid Treatment Programs to implement mobile treatment sites are under way.

6.4.3. *Stakeholder Feedback*

Providers indicated that the District lacked sufficient provider capacity across the continuum of care for SUD services, especially for partial hospitalization and intensive outpatient services that bridge the transition between inpatient rehabilitation services and outpatient services. According to providers, there was a general shortage of SUD providers; and low salaries (driven by low reimbursement rates for SUD services) put them at a competitive disadvantage for attracting and retaining qualified personnel who had better paid opportunities elsewhere. These workforce recruitment and retention issues were exacerbated by the pandemic. While providers acknowledged that these issues were not unique to the District, they suggested that certification requirements in the District might contribute to the SUD workforce issues. For example, intensive outpatient services must be available six hours a day; providers indicated that this certification requirement is not financially viable at current reimbursement rates for this level of care.

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

6.5.1. *Monitoring Metrics*

The District's progress in achieving SUD Milestone 5, Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD, is assessed based on the change (increase, decrease or consistent) in four critical metrics from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 18 shows the monitoring metrics' progress towards Demonstration targets under SUD Milestone 5. There are four critical metrics. Three critical metrics are annual metrics, and one of them, the overdose death rate (#27), was not reported by DHCF due to data sharing constraints. Only one of the critical metrics is monthly (#23), and it achieved the Demonstration

target. Therefore, 100 percent of the applicable metrics met the Demonstration target and ***the risk rating for monitoring metrics under SUD Milestone 5 is Low.***

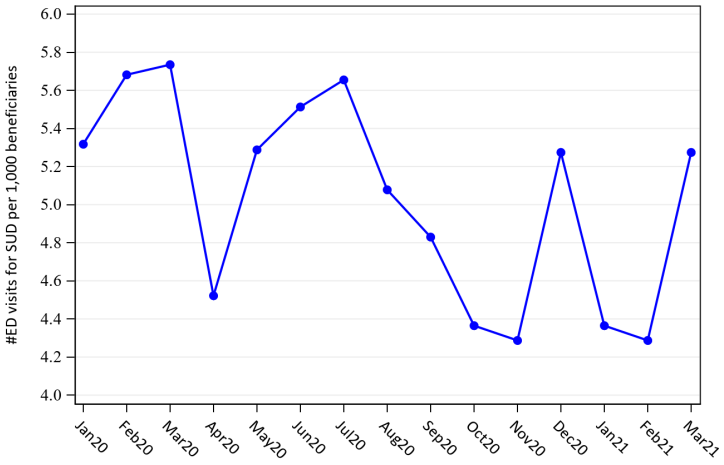
Exhibit 19 graphically depicts the monthly trend in ED utilization for SUD per 1,000 Medicaid Beneficiaries. The three annual measures have no associated trend graphs.

Exhibit 18: SUD Milestone 5 Monitoring Metrics – Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Year	Annually	10.8%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	Low
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Year	Annually	12.3%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Quarter	Monthly	5.6	4.6	-0.9	-16.8%	Decrease	Decrease	Y	Y	
27	Overdose death rate	Year	Annually	Not reported [a]	N/A	N/A	N/A	Decrease	N/A	Y	N/A	

Notes: [a]DHCF is working to have data sharing arrangements in place to be able to report this measure as soon as possible.

Exhibit 19: Trend of SUD Metric #23 – Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries



Measure description: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.

Exhibit 19 shows that the number of ED visits for SUD per 1,000 beneficiaries increased during the first quarter of 2020 but experienced a sharp decrease in April 2020. The number then fluctuated, peaking in July 2020, December 2020, and March 2021. The level in March 2021 is still below that at the beginning of the Demonstration. The value of the metric at baseline (DY1Q1 average) is 5.6 and its value at mid-point (DY2Q1 average) is 4.6, for an absolute change of -0.9 (-17%). The metric met the Demonstration target of a decrease.

6.5.2. *Implementation Plan Action Items*

Exhibit 20: SUD Milestone 5 Implementation Plan Action Items – Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A5.1	Activities funded through the SOR grant are ongoing.	Ongoing	Ongoing
SUD A5.2	DC Health will update and clarify relevant rulemaking, as necessary.	December 15, 2020[a]	Completed
SUD A5.3	DC Health's outreach efforts to encourage PDMP registration, utilization, and integration are ongoing.	September 21, 2020[b]	Completed
SUD A5.4	Medicaid waiver and expenditure authority requested.	June 3, 2019[c]	Completed
SUD A5.5	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for waiver services.	June 30, 2021	Completed
SUD A5.6	The District will evaluate the effectiveness of SOR grant activities	December 31, 2021	Open

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	to determine additional Medicaid changes through Demonstration amendments or other means.		
SUD A5.7	District efforts under the Medicaid State Plan and administration operations to enhance Adult Substance Use Rehabilitative Services (ASURS) and Mental Health Rehabilitation Services (MHRS) services and identify opportunities for system improvements are ongoing.	Ongoing	Ongoing

Notes: [a]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date the law passed. [b]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date that DC Health sent out reminder notices regarding PDMP registration. [c]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date the waiver application was submitted.

Overall, the District made good progress towards implementing comprehensive treatment and prevention strategies to address opioid use and OUD (Exhibit 20). Four out of the seven action items identified in the Implementation Plan are complete. The sections below summarize the District's progress.

Progress related to SOR grant activities. The District has recently procured a contractor to evaluate State Opioid Response (SOR) grant activities (SUD action item 5.6). The findings of this evaluation will be informative as several ongoing activities of the SOR grant align well with the Demonstration (SUD action item 5.1), including:

- an ED buprenorphine induction program
- a billing shift for peer-operated recovery support services programs and supported employment services from State Opioid Response (SOR) grant funds to Medicaid funds
- care management programs for individuals with long-term, serious SUDs
- housing application support for individuals in OUD programs

The District also leveraged SOR grant funds to expand access to naloxone kits for overdose reversal, with data as of December 2021 indicating progress on several fronts. Thirty-five pharmacies and 85 community-based organizations including three methadone clinics were receiving free naloxone kits to distribute to the public. The District conducted several

community-based naloxone trainings (34 trainings reaching 752 individuals in FY 2021), and outreach teams distribute naloxone kits as they connected with individuals in the community, particularly where there were recent overdose spikes. There are now 38 community naloxone trainers certified by DC Health. In addition, the District created a text line that residents can text to identify where free naloxone kits are available. While uptake of some of the SOR-funded programs (such as the ED induction program and billing for services previously funded through the SOR grant) was slower than agency staff would have preferred, staff were optimistic that these programs would become more embedded in the behavioral health delivery system in the District once grant funding ends.

To support the education and employment needs of individuals with substance use disorder, DBH used the SOR grant to fund the Department of Corrections (DOC) in FY 2021 to implement the College and Career Readiness (CCR) program. CCR provides pre-release employment training and preparation for individuals with opioid use disorder/stimulant disorder in the "LEAD Up!" beginning phase of this initiative. During this portion, 144 inmates in the DC Jail received services. Thirty of these participants were enrolled in high school to receive a diploma and 22 were enrolled in a post-secondary certification program. The "LEAD Out!" phase included 23 participants who have been recently released from jail. In this phase, these individuals received career readiness training (including life skills and digital literacy), resources for housing, continuing education, substance use programming, and cognitive behavior change instruction conducted by DOC staff. Twenty-two job referrals were made and 11 individuals secured employment.

Progress related to ASURS and MHRS. Section 4 of this report describes the rules relevant to SUD action items 5.2, 5.5, and 5.7, which institute District authority to certify and provide Medicaid payment for Demonstration services. The application and approval of the Demonstration waivers reflect completion of SUD action item 5.4. Implementation of some Demonstration services has been slower than expected. For example, the implementation of SES for SUD took longer than expected because the PHE made it difficult to hire and train new staff and there are a limited number of SES for SUD providers that are certified to provide these services with fidelity to the model. There were also added "administrative" burdens due to added requirements for transitioning the service from the waiver to the 1915i.

Progress related to the District's PDMP. Regarding the action items related to improving PDMP, as of March 16, 2021, DC law (23–251) requires all District prescribers and dispensers to query the PDMP prior to prescribing or dispensing an opioid or benzodiazepine for more than seven consecutive days and every 90 days thereafter, either while the course of treatment or

therapy continues, or prior to dispensing another refill after 90 days. Note that, although PDMP registration was required of all prescribers in the District prior to the Demonstration, not all prescribers were in fact registered. Thus, DC Health issued reminder notices related to this requirement to providers who were not registered for the PDMP. According to DHCF staff, prescriptions for Medicaid beneficiaries that exceed the morphine milligram equivalent (MME) limits decreased after the law was enacted.

6.5.3. *Stakeholder Feedback*

AIR interviews and the beneficiary survey suggested mixed awareness and feedback on the changes to ASURS and MHRS services among District stakeholders. Below we summarize stakeholder feedback on these services.

Crisis stabilization and mobile crisis outreach. Prior to the Demonstration, the interpretation of which crisis services were reimbursable varied across providers, and some patients were turned away from services because of perceived lack of reimbursement eligibility. Stakeholders noted that the Demonstration helped clarify the rules and reimbursement rates for crisis services, making it easier for patients to access these services. One stakeholder noted that the policy clarifications widened the range of crisis stabilization providers referring patients to their organization. One area where there are continued challenges is the mobile outreach services provided by child crisis providers. Two stakeholders noted that there are ongoing billing challenges for child crisis providers.

Recovery support services. A few stakeholders commented on peer recovery support services. One stakeholder—who had recently received a grant to support recruitment of peer recovery coaches—described being unsure how peer recovery support services were organized under the 1115 waiver, or how they differed from transition planning services.

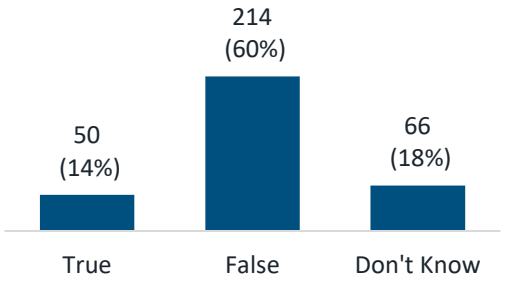
Supported employment services. Stakeholders reported that the SES were an important benefit but difficult to implement. One stakeholder had to terminate their SES program due to billing issues. Another noted that for SES to be effective, beneficiaries transitioning from residential treatment needed to be in a stable housing situation in the community, which was not always the case.

Behavioral health services provided by independent licensed providers. Several stakeholders spoke positively about independent licensed behavioral health providers being newly eligible to bill Medicaid for their community-based services. While one stakeholder was unaware of this new eligibility, others had begun integrating these providers into their organizations. One

stakeholder also said this new eligibility was helpful for both increasing community-delivered behavioral health care and embedding behavioral health clinicians into primary care settings.

Elimination of $1 copay for MAT. Providers aware of the elimination of the copay for MAT believed it was very helpful in reducing barriers for beneficiaries. However, beneficiary survey responses show that some beneficiaries were not aware that the copay had been removed (Exhibit 21). Fourteen percent (n=50) of beneficiary survey respondents reported that the following statement was true: "If my doctor prescribes medicine to help me stay off alcohol or drugs, I will have to pay for the medicine." An additional 18 percent (n=66) indicated they did not know if the statement was true or false. Of the 50 beneficiaries who said 'true,' 10 reported that they would have to pay between $2 and $10, five that they would have to pay between $11 and $50, and five that they would have to pay between $51 and $100.

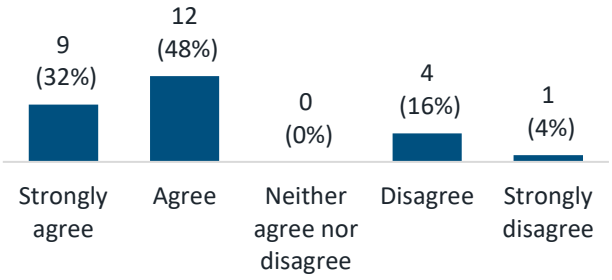
Exhibit 21: Survey respondents who believe they would have to pay for medicine their doctor prescribes to help stay off alcohol or drugs



Note: Percentages are weighted. Percentages may not add up to 100 because the "no response" category is not shown.

However, costs did not appear to be a major barrier to survey respondents' ability to access SUD-related prescriptions. Beneficiary survey respondents reported high access to prescription medicines for SUD. Of the eight percent (n=26) of survey respondents who said 'yes' when asked whether they felt they wanted/needed prescription medicine to help them detox or stay off drugs or alcohol in the past 12 months, 80 percent (n=21) agreed or strongly agreed that they were able to get the wanted/needed services (Exhibit 22).

Exhibit 22: Survey respondents who were able to get all the services they wanted or needed for prescription medicine to help them detox or stay off drugs or alcohol



Note: Percentages are weighted. Percentages may not add up to 100 because the "no response" category is not shown.

6.6. Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

6.6.1. *Monitoring Metrics*

The District's progress in achieving SUD Milestone 6, Improved Care Coordination and Transitions Between Levels of Care, is assessed based on the change (i.e., increase, decrease, or consistent) in 14 critical metrics (1 optionally critical) from baseline to mid-point compared to their applicable Demonstration targets.

Exhibit 23 shows the monitoring metrics' progress towards Demonstration targets under SUD Milestone 6. All metrics are critical, but all are annual, preventing estimation of any trend. Note that, although CMS guidance allows the state to consider Metric #16 when assessing Milestone 6, DHCF was unable to report this recommended measure due to staff constraints. Because we cannot evaluate the progress for annual metrics, ***the risk rating for monitoring metrics under SUD Milestone 6 is Not Applicable.***

Exhibit 23: SUD Milestone 6, Monitoring Metrics – Improved Care Coordination and Transitions Between Levels of Care

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
15.1	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Initiation of AOD Treatment - Alcohol abuse or dependence	Year	Annually	37.1%	N/A	N/A	N/A	Increase	N/A	Y	N/A	N/A
15.2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Initiation of AOD Treatment - Opioid abuse or dependence	Year	Annually	48.9%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
15.3	Initiation and Engagement of Alcohol and Other Drug	Year	Annually	31.1%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Initiation of AOD Treatment – Other drug abuse or dependence											
15.4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Initiation of AOD Treatment – Total AOD abuse or dependence	Year	Annually	33.5%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
15.5	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS	Year	Annually	4.8%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	measure]: Engagement of AOD Treatment - Alcohol abuse or dependence											
15.6	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Engagement of AOD Treatment - Opioid abuse or dependence	Year	Annually	14.6%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
15.7	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Engagement of AOD Treatment - Other drug abuse or dependence	Year	Annually	3.7%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
15.8	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]: Engagement of AOD Treatment - Total AOD abuse or dependence	Year	Annually	5.1%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission; NQF #1664]	Year	Annually	Not reported (a)	N/A	N/A	N/A	Consistent	N/A	Y (optional)	N/A	
17(1).1	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core	Year	Annually	9.9%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	Set; Adjusted HEDIS measure]: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)											
17(1).2	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]: Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Year	Annually	6.0%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
17(2).1	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]: Percentage	Year	Annually	69.9%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)											
17(2).2	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]: Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Year	Annually	58.3%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
25	Readmissions Among Beneficiaries with SUD	Year	Annually	0.1	N/A	N/A	N/A	Decrease	N/A	Y	N/A	

Notes: [(a)] DHCF was unable to report baseline data for this recommended measure due to staff constraints.

6.6.2. *Implementation Plan Action Items*

Exhibit 24: SUD Milestone 6 Implementation Plan Action Items – Improved Care Coordination and Transitions Between Levels of Care

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD A6.1	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for transition planning services.	June 30, 2021	Completed
SUD A6.2	DBH will develop additional training and technical assistance on clinical care coordination services.	June 30, 2021	Completed
SUD A6.3	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.	December 31, 2021	Completed

All three action items under SUD Milestone 6 are complete (Exhibit 24). As noted in Section 4, the third Demonstration rule implemented Medicaid billing for transition planning services, and the addition of Chapter 65 to DCMR 22A implemented provider certification requirements and service and eligibility standards for these services. The transition planning services connect individuals experiencing a behavioral health–related hospitalization or SUD residential treatment stay to continued treatment and support services ahead of their discharge, to promote recovery and prevent avoidable readmissions. One provider certified to provide transition planning services described delaying implementation of the service, in part due to referral challenges and COVID-19 restrictions that made the monitoring of individuals eligible for the transition planning service difficult. In addition, the criteria excluding beneficiaries enrolled in managed care created a relatively limited number of beneficiaries eligible for these services. DBH is working to increase utilization of transition planning services by improving care coordination through new and increased use of CRISP, including two-way communication, notifications/alerts, and expanding patient panels for distinct staff/providers.

The SOR grant may also support improved care coordination and transitions of care. Through the grant, awards have been made to seven organizations to provide care management services to individuals with OUD and multiple health/behavioral health needs. Grantee organizations

will have a strong focus on outreach to, and engagement with, potential clients and helping clients maintain connections to treatment. Services will be provided through the entirety of FY 2022.

To support the transition to whole person care, including increased capacity for care coordination, DHCF in partnership with DBH manages a five-year program, the Integrated Care DC Program. This technical assistance program, funded in part by the 1003 SUPPORT Act Provider Capacity Planning Grant, is designed to enhance capabilities to deliver person-centered care across the care continuum; use population health analytics to address complex medical, behavioral health, and social needs; and engage leadership to support value-based care. The multiple mechanisms through which the Integrated Care DC Program delivers technical assistance include individual practice coaching, webinar sessions, learning collaboratives, and a virtual learning community. The Integrated Care DC Program focuses on serving the practice transformation needs of seven priority groups:

- Health Home providers
- DBH providers
- FQHCs
- free standing mental health providers
- long-term services and supports providers, including home health agencies
- certified or waivered medications for MAT providers, including methadone providers
- specialty providers

Another strategy DHCF uses to facilitate integrated, coordinated care, is collaborating with stakeholders to identify opportunities for data sharing between SUD treatment providers and other health care providers. In September 2020, DHCF and DBH jointly published a Request for Information (RFI) to solicit information from consumer organizations, the provider community, health plans, and others regarding the pathway to integrate behavioral services more fully into the benefits offered through the District's Medicaid managed care program. Stakeholder comments included recommendations for data sharing. One recommendation was to require providers to exchange data in a standardized way, including potential investments in a shared analytic platform—with capabilities to support standard and ad hoc reporting, predictive analytics, statistical tools, risk stratification, trend analysis with data visualization tools; as well as general adoption of certified technology and assessments that comply with the CMS Interoperability final rule.

In addition, DHCF awarded CRISP, the District's designated HIE, a grant funded by the 1003 SUPPORT Act Provider Capacity Planning Grant to design, develop, and implement a consent management solution to facilitate behavioral health information exchange, including SUD data protected by 42 CFR Part 2, between District of Columbia Health Information Exchange (DC HIE) organizations. CRISP is in the pilot stage of adapting the regional HIE Consent Collaborative tool to DC provider workflows to support consent-based sharing of SUD information with treating providers and payers.

The pilot program supports providers in developing workflows for obtaining consent from beneficiaries to share their electronic health record (EHR) data via the HIE. In the first phase of the pilot program, the HIE would share directory information, such as whether the beneficiary has been in an SUD program. In the second phase of the pilot program, the HIE would support the exchange of clinical information. Approximately one dozen providers signed up to participate in the pilot. However, implementation has been slow as providers diverted resources to addressing the PHE, resulting in fewer face-to-face interactions with beneficiaries. CRISP is now in the process of developing a workflow to support consent capture for telehealth and is anticipated to complete work in 2022.

The Behavioral Health Integration Stakeholder Advisory Group, convened by DHCF and DBH, also provides input into strategies for better integrated coordinated care in the District. The advisory group consists of members representing consumers, caregivers, family-run organizations, consumer advocates and consumer advocacy organizations, consumer/peer-run organizations, providers offering behavioral health services across the continuum of care, provider organizations and provider trade associations, Medicaid MCOs and relevant subcontractors and representatives from other relevant District agencies. Members meet monthly to provide input into key decisions relating to the carve-in of behavioral health services into Medicaid Managed Care, identify potential issues and operational concerns, and provide solution-oriented feedback for consideration as part of a transparent behavioral health integration planning and implementation process.

6.6.3. *Stakeholder Feedback*

Many stakeholders viewed the District's decision to target transitions of care as part of its Demonstration as a move in the right direction. However, stakeholders uniformly noted that transitioning patients from residential and inpatient facilities to outpatient care remained difficult, and a significant weak point in the District's service delivery system. Several providers interviewed were unaware of the new transition planning service, as noted, and called for more

education on this benefit. For example, one outpatient provider expressed confusion about how and if it could be reimbursed for transition- and discharge-related services it provides for its patients during an inpatient stay, particularly if a patient was admitted for an extended period. Stakeholders also expressed concern that provider feedback was not fully considered in designing the transition planning benefit. These stakeholders expected the transition planning benefit to be broader in scope and that a larger group of Medicaid beneficiaries would be eligible for the service. Regardless of perspective on the new transition planning service, providers noted that support for care transitions was a routine part of their service delivery regardless of payment mechanism. The challenge in supporting care coordination and transitions, according to providers, was that the capacity of outpatient service providers did not meet the demand for step-down care. Multiple providers described scenarios where beneficiaries "fell through the cracks" because of the shortage of outpatient services and returned to residential and inpatient facilities as a result.

6.7. Health IT Plan

6.7.1. *Monitoring Metrics*

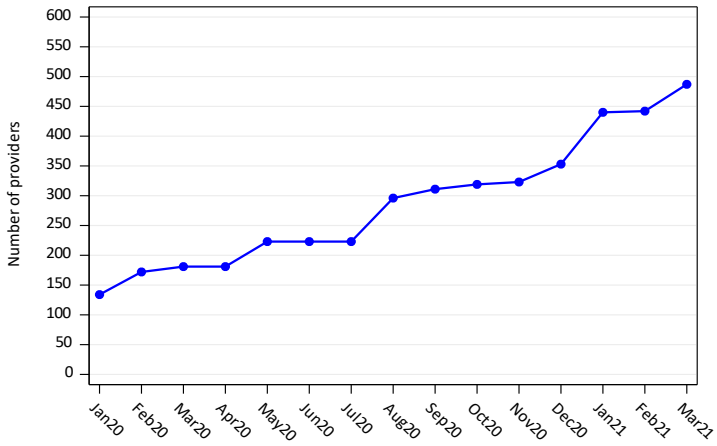
The District's progress in achieving the targets set under the Health IT Plan is assessed based on the change (i.e., increase, decrease, or consistent) in five non-critical metrics from baseline to mid-point compared to the applicable Demonstration targets. Exhibit 25 shows the monitoring metrics' progress towards Demonstration targets under the Health IT Plan. Although all five achieved the Demonstration target, we only assess risk based on critical metrics as defined by CMS guidance. **Therefore, the risk rating for monitoring metrics under the Health IT Plan is Not Applicable.**

Exhibits 26 to 30 graphically depict the monthly trend in the monitoring metrics associated with the Health IT Plan.

Exhibit 25: Health IT Plan Monitoring Metrics

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
Q1	Number of active DC HIE behavioral health provider users	Month	Quarterly	162.3	456.3	294.0	181.1%	Increase	Increase	N	Y	N/A
S1	Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE	Month	Quarterly	122.7	260.7	138.0	112.5%	Increase	Increase	N	Y	
S2	Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE	Month	Quarterly	2.3	7.0	4.7	200.0%	Increase	Increase	N	Y	
Q2	Number of behavioral health providers managed in provider directory	Month	Quarterly	61.3	149.3	88.0	143.5%	Increase	Increase	N	Y	
Q3	Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days	Month	Quarterly	53.7	75.0	21.3	39.8%	Increase	Increase	N	Y	

Exhibit 26: Trend of SUD Metric Q1 – Number of active DC HIE behavioral health provider users

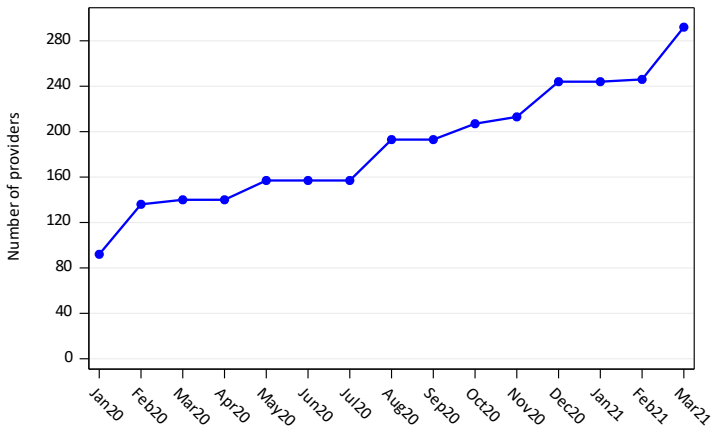


Measure description:Number of active DC HIE behavioral health provider users.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 26 shows that the number of active DC HIE behavioral health provider users experienced a steady increase throughout the Demonstration thus far. The number increased about fourfold between January 2020 and March 2021. The value of the metric at baseline (DY1Q1 average) is 162 and at mid-point (DY2Q1 average) is 456, for an absolute change of 294 (181%). The increase may be attributable to the fact that the HIE Connectivity grant provides technical assistance to connect nearly all Medicaid providers to HIE by 2022 and behavioral health providers were assigned priority for technical assistance. The metric met the Demonstration target of an increase.

Exhibit 27: Trend of SUD Metric S1 – Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE

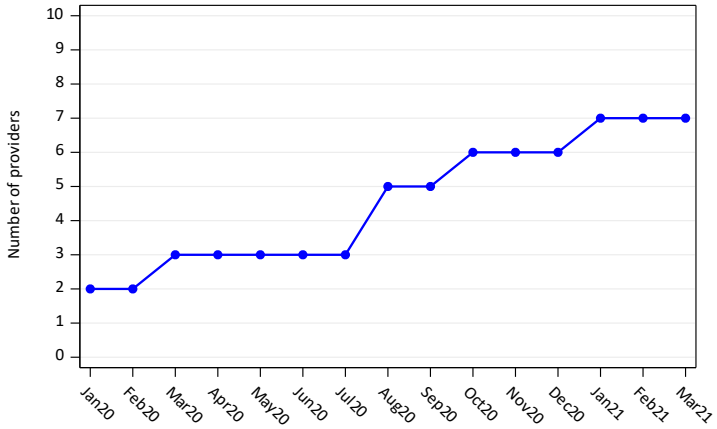


Measure description:Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 27 shows that the number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE increased steadily throughout the Demonstration thus far. The number increased by about threefold between January 2020 and March 2021. The value of the metric at baseline (DY1Q1 average) is 123 and at mid-point (DY2Q1 average) is 261, for an absolute change of 138 (113%). The metric met the Demonstration target of an increase.

Exhibit 28: Trend of SUD Metric S2 – Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE

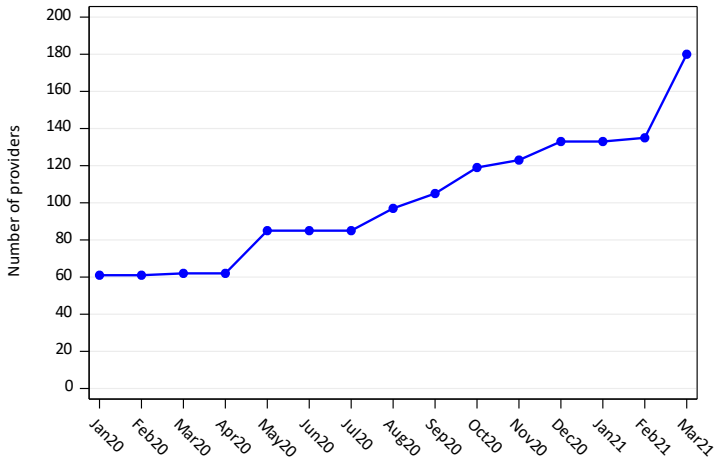


Measure description:Number of DC Medicaid-enrolled behavioural health care facilities/providers sending data to the HIE.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 28 shows that the number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE increased throughout the Demonstration thus far. The value of the metric at baseline (DY1Q1 average) is two and at mid-point (DY2Q1 average) is seven, for an absolute change of five (200%). Despite the growth, these numbers are small relative to the number of facilities/providers receiving data from HIE. The metric met the Demonstration target of an increase.

Exhibit 29: Trend of SUD Metric Q2 – Number of behavioral health providers managed in the provider directory

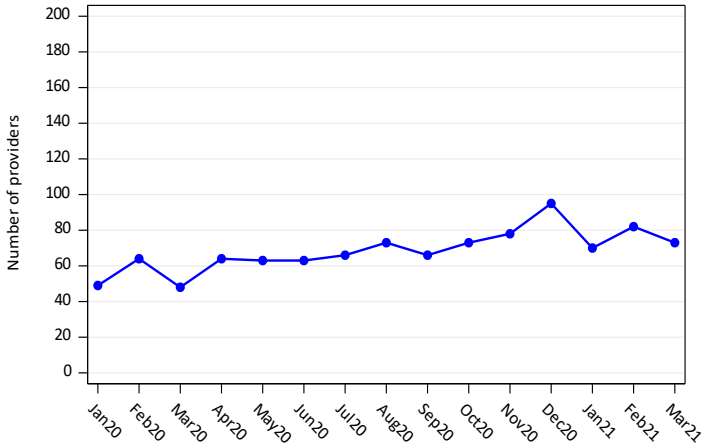


Measure description:Number of behavioural health providers managed in provider directory.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 29 shows that the number of behavioral health providers managed in the provider directory increased throughout the Demonstration thus far. The number increased about threefold between January 2020 and March 2021. The value of the metric at baseline (DY1Q1 average) is 61 and at mid-point (DY1Q1 average) is 149, for an absolute change of 88 (143%). The metric met the Demonstration target of an increase.

Exhibit 30: Trend of SUD Metric Q3 – Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days



Measure description:Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 30 shows that the number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days experienced a small but relatively steady increase throughout the Demonstration thus far. The value of the metric at baseline (DY1Q1 average) is 54 and at mid-point (DY2Q1 average) is 75, for an absolute change of 21 (40%). The metric met the Demonstration target of an increase.

6.7.2. *Implementation Plan Action Items*

The Health IT Plan included action items covering five milestone criteria:

- PDMP functionalities
- current and future PDMP query capabilities
- use of PDMP – supporting clinicians with changing office workflows / business processes
- Master Patient Index / identity management
- overall objective for enhancing PDMP functionality & interoperability

Exhibit 31: SUD Health IT Prescription Drug Monitoring Program (PDMP) Functionalities Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A1.1	DC Health will explore integration with RxCheck.	December 31, 2021	Completed
SUD HIT A1.2	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP.	December 31, 2019[(a)]	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A1.3	DC Health will integrate District Health Information Exchanges (HIEs) with the DC PDMP via Appriss.	December 31, 2021	Completed
SUD HIT A1.4	DC Health's work to enhance the analytic capabilities within the DC PDMP is ongoing.	Ongoing	Completed
SUD HIT A1.5	DC Health's academic detailing activities are ongoing.	Ongoing	Open
SUD HIT A1.6	DHCF's Pharmacy Lock-in Program (PLP) will remain in place.	March 23, 2012[b]	Completed
SUD HIT A1.7	DHCF's opioid-Morphine Milligram Equivalents (MME) limits will remain in place.	October 1, 2019[c]	Completed
SUD HIT A1.8	The District's Drug Utilization Review (DUR) Board will create and offer provider education seminars on safely prescribing opioids for chronic pain.	June 30, 2021	Completed

Note: [a]Implementation Plan did not include a timeline for completion. The evaluation team selected this date based on the timeline referenced in the action item. [b]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date the rule went into effect. [c]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date that the lowest limits went into effect.

Over the course of the Demonstration, the District made progress with increased integration of the PDMP, which directly integrates with RxCheck (Exhibit 31, SUD HIT A1.1, A1.2, and A1.3). To provide integration between the DC PDMP and District EHRs and the DC HIE, DC Health partnered with Appriss Health to provide a service called PMP Gateway. PMP Gateway is a web service that performs automated, multi-state queries to integrate patient-controlled substance prescription history within EHR systems. Many EHR vendors had completed the PMP Gateway integration development work to deliver controlled substance prescription data within their products/service offerings by the Mid-Point Assessment. DC PDMP began providing funding to DC facilities for licensing fees associated with EHR integration with the PMP Gateway in 2019 and has since seen the successful integration of 57 health care facilities.

DC Health has access to robust PDMP data analytics via a Tableau dashboard developed by Appriss as well as customizable dashboards for internal staff use. DC Health staff conduct various analyses of prescriber, prescription, pharmacy, and patient data using these tools. Quarterly, prescribers receive reports comparing their individual prescriber habits to those of

their peers. DC Health has no plans to further expand the PDMP's analytic capabilities; thus, we have assessed this action item (SUD HIT A1.4) as completed.

While DC Health conducted approximately 15 educational webinars with provider organizations and medical boards in 2021, academic detailing activities were postponed due to the PHE. Academic detailing activities are currently in the planning phase and scheduled to begin in mid-2022 (SUD HIT A1.5). The goal is to use PDMP data to conduct targeted outreach to prescribers for this additional educational support.

DHCF's rule regarding the pharmacy lock in program (PLP) has been effective since March 23, 2012 (SUD HIT A1.6). The rule authorizes the Drug Utilization Review (DUR) Board to access a report that identifies beneficiaries at risk of exceeding the customarily prescribed dosages or utilization of controlled substances. DHCF may restrict these beneficiaries to accessing prescriptions via only one pharmacy, a rule that has not changed since becoming effective.

DHCF issued a transmittal on August 30, 2018 notifying prescribers of the quantity and days' supply limits available without clinical prior authorization, phased in over one year. Patients receiving new prescriptions for opioids were subject to the limits starting October 1, 2018. Limits for pre-existing patient prescriptions were phased in over the course of a year (October 1, 2018–October 1, 2019) to allow patients to taper. Prescribing limits have not changed since the issuance of the transmittal (SUD HIT A1.7).

Exhibit 32: SUD Health IT Current and Future PDMP Query Capabilities Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A2.1	District stakeholders will continue collaborating to ensure the District's approach to patient matching increasingly meets the criteria for Level 4 of the Sequoia Project's patient matching maturity model, indicating "innovation, ongoing optimization, and senior management active involvement."	Ongoing	Completed

The Appriss vendor conducts the patient matching for providers accessing the DC PDMP via the EHR/HIE interface (Exhibit 32). The process involves:

- electronically standardizing the input data to identify similar records, such as individuals using different but similar names, different but similar addresses, or multiple individuals using the same address; and
- consolidating these patient records into a cluster of records for prescribing purposes.

Providers can alert DC Health if multiple records are combined incorrectly; however, this rarely occurs as the patient matching methodology is highly accurate.

Exhibit 33: SUD Health IT Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A3.1	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP.	December 31, 2019[(a)]	Completed
SUD HIT A3.2	Training and technical assistance for organizations utilizing HIE services is ongoing.	Ongoing	Ongoing

Note: [(a)]Implementation Plan did not include a timeline for completion. The evaluation team selected this date based on the language of the action item.

In 2020, DC PDMP staff conducted a series of webinars to educate providers on PDMP features (Exhibit 33). Topics included how to register for the PDMP, conduct queries to search for records, and interpret results. The webinars promoted awareness of delegate access, through which providers may have up to two delegates search the PDMP on their behalf. PDMP staff discussed Gateway integration, where health care facility EHR systems, HIE systems, and pharmacy management systems can integrate with the PDMP to streamline patient queries. The webinars assisted providers in obtaining and reviewing their quarterly Prescriber Report revealing their prescribing behavior in relation to other providers within their specialty. The sessions also included informational updates on PDMP-related legislation and spotlighted available resources on the DC PDMP website. As noted earlier, many providers have completed this integration.

Exhibit 34: SUD Health IT Master Patient Index / Identity Management Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A4.1	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.	Ongoing	Ongoing
SUD HIT A4.2	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.	Ongoing	Ongoing

The patient matching methodology action items (Exhibit 34) were discussed earlier in this section in reference to SUD HIT A2.1. Regarding SUD (Exhibit 35), DHCF staff have received access to the DC PDMP. This visibility complements the agency's other safe prescribing efforts such as the MME limits and the PLP. Agency staff report that additional visibility for agency pharmacists, pharmacy benefits managers and MCOs, would also be valuable. For example, it would be helpful to have real-time alerts to PBMs at the time of prescribing prior to dispensing. The District is exploring the potential for these types of alerts.

Exhibit 35: SUD Health IT Overall Objective for Enhancing PDMP Functionality & Interoperability Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SUD HIT A5.1	DC Health and DHCF will explore streamlining communication between these programs and the DC PDMP.	December 31, 2021	Ongoing

6.7.3. *Stakeholder Feedback*

The evaluation team did not solicit stakeholder feedback on changes to the PDMP functionality and interoperability because of the length of time allotted to each provider interview and listening session and the lower priority we assigned to the topic.

6.8. Provider Availability Assessment

SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, includes two critical annual measures on provider availability, both annual:

- SUD Provider Availability
- SUD Provider Availability – MAT

As reported in the DY2Q2 monitoring report, there were 797 SUD providers and 393 SUD providers for MAT in DY1. Because only a single data point is available, we cannot directly assess the progress in these metrics and whether the Demonstration target of "Consistent" set for the two metrics is met at the time of this mid-point assessment.

As described under SUD Milestones 1 and 4, the District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment identified perceived gaps across ASAM levels of care that worked together to limit engagement in timely, person-centered care, hinder care coordination, interfere with effectiveness of care transitions, and ultimately reduce the impact of the existing service network. Stakeholder interviews similarly revealed shortages in provider capacity at various levels of care, including care transitions services, recovery support services, and, particularly, intensive outpatient services. As discussed under the milestone assessments, the District is undertaking multiple strategies to address concerns related to provider availability, including a behavioral health rate study to assess provider reimbursement rates, which stakeholders believed to be a key challenge to expanding the number of Medicaid-enrolled SUD providers in the District.

7. Findings - Assessment of Progress in Achieving the SMI/SED Milestones

This section presents the progress the District achieved in meeting each SMI/SED milestone by the time of the Mid-Point Assessment, with findings reported under each of three domains: Monitoring Metrics, Implementation Plan Action Items, and Stakeholder Feedback. This section includes tables and graphs depicting progress on monitoring metrics, and narrative summaries of qualitative data collected on implementation plan action items and stakeholder feedback. The section also includes an SMI/SED provider availability assessment.

7.1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

7.1.1. *Monitoring Metrics*

The District's progress in achieving SMI/SED Milestone 1, Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings, is assessed based on the change (i.e., increase, decrease, or consistent) in three critical metrics (2 optionally critical) from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 36 shows the monitoring metrics' progress towards Demonstration targets under SMI/SED Milestone 1. Of the three critical metrics, two are optional according to CMS guidance. All three are annual metrics, and only one of them is reported by DHCF, preventing estimation of trends. ***Therefore, the risk rating for monitoring metrics under SMI/SED Milestone 1 is Not Applicable.***

Exhibit 36: SMI/SED Milestone 1 Monitoring Metrics – Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	Year	Annually	N/A[a]	N/A	N/A	N/A	N/A[a]	N/A	Y (optional)	N/A	**N/A**
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Year	Annually	81.0%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Year	Annually	Not reported [b]	N/A	N/A	N/A	Consistent	N/A	Y (optional)	N/A	

Notes: [a] DHCF indicated in SMI/SED monitoring protocol that this metric would not be reported. [b] DHCF is unable to report this measure due to unreliable lab data. DHCF will continue to explore ways to work with lab data.

7.1.2. *Implementation Plan Action Items*

Exhibit 37: SMI/SED Milestone 1 Implementation Plan Action Items – Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI A1.1	DHCF will develop and issue rulemaking and other policies as necessary. DHCF will also modify existing contracts as necessary.	December 31, 2021[(a)]	Completed
SMI A1.2	The District will develop and issue rulemaking and other policies as necessary.	June 30, 2021	Open

Note: [(a)]Implementation Plan did not include a timeline for completion. The evaluation team selected this date based on suggested date in the Implementation Plan future state column.

The rulemaking and other policies referenced in the implementation plan action items for SMI/SED Milestone 1 refer to utilization reviews and screenings and treatment for co-morbid physical health conditions, SUDs, and suicidal ideation (Exhibit 37). The District completed the action item regarding utilization review by issuing transmittal 19-31 (December 31, 2019). This transmittal educates providers about:

- how an IMD facility is defined (note there are no residential psychiatric facilities in the District)
- which Demonstration services qualify for IMD reimbursement (psychiatric hospitalization, SUD residential treatment, and withdrawal management)
- prior authorization requirements for receiving reimbursement for IMD stays associated with Demonstration services
- length-of-stay requirements (less than 60 days) for receiving reimbursement for SMI-related IMD stays associated with Demonstration services

Per the transmittal, FFS Medicaid utilization review is currently conducted through a contract with DHCF's Quality Improvement Organization (QIO). The current QIO, Comagine Health, uses the InterQual criteria for IMD authorizations and concurrent reviews.

The action item regarding policymaking for screenings and treatments for co-morbid physical health conditions, SUDs, and suicidal ideation had not yet been completed by the Mid-Point Assessment. While there is no formal policy regarding screening for, and providing access to,

treatment related to co-morbid physical health conditions, SUDs, and suicidal ideation, DHCF and DBH staff believe that approach is common practice for one psychiatric IMD in the District.

7.1.3. *Stakeholder Feedback*

Expanded coverage for IMD stays was less applicable to one psychiatric IMD in the District whose patients typically exceed the 60-day limit or otherwise do not qualify for Medicaid reimbursement. However, interviewees from this organization understood the value of shifting funding for shorter stays from local to Medicaid dollars.

As mentioned in Section 6.1.1, stakeholders expressed concern about the administrative burden associated with the utilization review processes for patients admitted to IMDs, given the different payment mechanisms associated with different lengths of stay. One stakeholder noted treatment delays due to prior authorization and the criteria for determining who will cover services in the IMD setting and for how long. However, two stakeholders reported a positive result of the utilization review policy changes. One health plan said that the utilization review policy changes for IMD admissions necessitated that the health plan enter into contract with the District's public mental health hospital, which in turn gave the health plan access to previously unavailable data on its members admitted to this hospital during their stay. This health plan noted that access to these data supports its care coordination efforts. The other stakeholder reacted positively to the introduction of a standardized patient assessment tool, as a way to focus the residential stay as one time-limited step for patients, with the goal of returning patients to the community.

7.2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

7.2.1. *Monitoring Metrics*

The District's progress in achieving SMI/SED Milestone 2, Improving Care Coordination and Transitioning to Community-Based Care, is assessed based on the change (increase, decrease, or consistent) in 10 critical metrics from baseline to mid-point compared to the applicable Demonstration targets.

Exhibit 38 shows the monitoring metrics' progress towards Demonstration targets under SMI/SED Milestone 1. All the critical metrics are annual metrics, preventing any trend estimation. ***Therefore, the risk rating for monitoring metrics under SMI/SED Milestone 2 is Not Applicable.***

Exhibit 38: SMI/SED Milestone 2 Monitoring Metrics – Improving Care Coordination and Transitioning to Community-Based Care

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Year	Annually	202.7	N/A	N/A	N/A	Decrease	N/A	Y	N/A	N/A
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Year	Annually	0.2	N/A	N/A	N/A	Decrease	N/A	Y	N/A	
7.1	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH): Percentage of discharges for which the child received follow-up within 30 days after discharge	Year	Annually	71.9%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
7.2	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH): Percentage of discharges for which the child received follow-up	Year	Annually	52.2%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	within 7 days after discharge											
8.1	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD): Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge	Year	Annually	71.0%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
8.2	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD): Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Year	Annually	55.6%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
9.1	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD): Percentage of ED visits for AOD abuse or dependence for which the beneficiary received	Year	Annually	9.9%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	follow-up within 30 days of the ED visit											
9.2	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD): Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Year	Annually	6.0%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
10.1	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD): Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit	Year	Annually	69.9%	N/A	N/A	N/A	Increase	N/A	Y	N/A	
10.2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD): Percentage of ED visits for mental illness for which the beneficiary received	Year	Annually	58.3%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
	follow-up within 7 days of the ED visit											

7.2.2. *Implementation Plan Action Items*

Exhibit 39: SMI/SED Milestone 2 Implementation Plan Action Items – Improving Care Coordination and Transitioning to Community-Based Care

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI A2.1	DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service.	June 30, 2021	Completed
SMI A2.2	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.	June 30, 2021	Open
SMI A2.3	DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service.	June 30, 2021	Completed
SMI A2.4	DHCF will develop and issue rulemaking and other policies as necessary to ensure psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations.	June 30, 2021	Open
SMI A2.5	DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service.	June 30, 2021	Completed
SMI A2.6	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.	June 30, 2021	Open

Three out of the six action items under SMI/SED Milestone 2 are complete (Exhibit 39). As discussed in sections 4 and 6.6.2, implementation of the new transition planning service is

complete (SMI A2.1, SMI A2.3, and SMI A2.5). The service includes an assessment of non-clinical needs, including housing, if not already assessed via other discharge planning efforts, but the transition planning service introduced under the Demonstration is conducted by the community-based provider rather than the psychiatric hospital or residential facility. The District has not yet issued rulemaking or other policies requiring that psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations (SMI A2.4). However, the District's HIE has developed a new tool, supported by grant funding, to allow providers to send and receive referrals related to social determinants of health, including housing insecurity. Requirements for MCOs to implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services are in process (SMI A2.2). As part of DHCF's five-year Medicaid reform effort, the scope of services in managed care contracts will be expanded to include all levels of behavioral health services currently carved out. DHCF released a new Request for Proposals (RFP) for managed care procurement for FY 2023 in November 2021. The behavioral health carve in is scheduled to occur in FY 2024. As of the Mid-Point Assessment, DHCF had not yet issued rulemaking or other policies regarding the contact requirement within 72 hours post discharge for psychiatric hospitals and residential treatment settings (SMI A2.6).

While not identified in the Implementation Plan, a notable effort to improve care coordination and transitions in the District is the "Improving Transitions of Care to Reduce Hospital Readmissions" project. DHCF issued a procurement for a contractor to conduct this project on April 22, 2021. The project will: 1) provide hospital transition of care and discharge data and workflow analysis, and an interactive dashboard for monitoring transitions of care and readmissions within the DC HIE; and 2) conduct a set of pilot interventions to improve transitions of care upon discharge as well as best-practice strategies to reduce 30-day all-cause hospital readmissions in the District. The contractor's transition-of-care pilots will focus in-depth on managing hospital discharges for individuals with multiple chronic conditions, particularly those with behavioral health conditions, to identify scalable best practices that can be successfully implemented in the District to reduce avoidable readmissions. At least one of the pilot sites must offer inpatient behavioral health services; and all pilots must engage at least one community-based behavioral health provider, as certified by DBH and/or as a Free Standing Mental Health Clinic (FSMHC). Findings from the pilots and recommendations on strategies to improve hospital discharge processes, transitions of care, and reduce 30-day all-cause hospital readmissions across the District will be summarized in a final report.

7.2.3. *Stakeholder Feedback*

Stakeholder feedback on the transition planning services is in Section 6.6.3. Regarding requirements that psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations during the discharge planning process, and that they follow up with beneficiaries 72 hours post discharge, stakeholder discussions confirmed that no policies regarding these topics had been issued under the Demonstration. Providers expressed no concerns about lack of policies regarding post-discharge follow-up, but noted that the Demonstration's approach to housing support falls short of their expectations, given that stable housing is often a precursor to long-term recovery.

7.3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

7.3.1. *Monitoring Metrics*

The District's progress in achieving SMI/SED Milestone 3, Increasing Access to Continuum of Care, Including Crisis Stabilization Services, is assessed based on whether the District met the requirement of 30-day or less ALOS in IMDs at the Mid-Point Assessment (#19, a critical annual metric). We also report trends in six SMI/SED Utilization Metrics (#13–#18), which are non-critical metrics under SMI/SED Milestone 3, to provide context to mental health service utilization changes under the Demonstration. The District's performance towards meeting Demonstration targets for these six non-critical metrics is reported in this section, but not included in calculating the risk rating for monitoring metrics under SMI/SED Milestone 3.

Exhibit 40 shows two types of monitoring metrics' progress towards Demonstration targets under SMI/SED Milestone 3. The only critical metric for risk rating is Metric #19 - Average Length of Stay in IMDs. This metric is broken down into two groups: ALOS for all IMDs (#19a) and ALOS in IMDs receiving FFP only (#19b). However, DHCF reports the same results for metrics #19a and #19b as all District IMDs receive FFP. There are three sub-groups reported within the ALOS metric: (1) ALOS in all populations, (2) ALOS among short-term stays (less than or equal to 60 days), and (3) ALOS among long-term stays (greater than 60 days). The Demonstration ALOS target of not more than 30 days is applicable only to the metrics identifying ALOS for all populations (#19a.1 and #19b.1), and not to the ALOS for short-term stays and long-terms stays. The Demonstration target is met for the two metrics on ALOS in all populations with the same ALOS of 13.3 days for both the metrics. ***Therefore, 100 percent of the applicable metrics achieved the Demonstration target, and thus the risk rating for monitoring metrics under SMI/SED Milestone 3 is Low.***

Four (#15–#18) of the six non-critical metrics that describe the District's trends in mental health service utilization (67%) achieved the Demonstration target. As with a similar SUD metric, intensive outpatient and partial hospitalization (#14) represents a level of care that is covered but is not fully reflected in metric results due to data limitations.[5] Exhibits 41 to 46 graphically depict the monthly trend in the six non-critical SMI/SED Utilization Metrics.

[5] DHCF is exploring ways to identify individuals receiving intensive outpatient/partial hospitalization services, which may include using clinical data from DBH on level of care assessments and/or counting the number of therapy hours billed in claims to compare against thresholds that define intensive outpatient/partial hospitalization. This additional effort is required because the services may be billed in the District using outpatient therapy codes that are also applicable to a lower level of care.

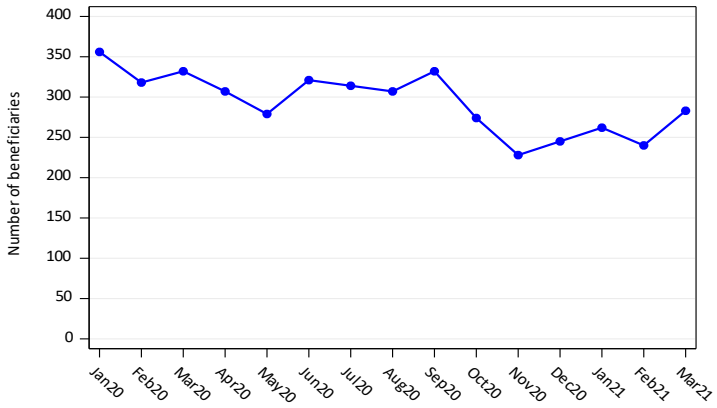
Exhibit 40: SMI/SED Milestone 3 Monitoring Metrics – Increasing Access to Continuum of Care, Including Crisis Stabilization Services

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
13	Mental Health Services Utilization - Inpatient	Month	Quarterly	335.3	261.7	-73.7	-22.0%	Increase	Decrease	N (Utilization metrics)	N	Low
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Month	Quarterly	642.7	572.3	-70.3	-10.9%	Increase	Decrease	N (Utilization metrics)	N	
15	Mental Health Services Utilization - Outpatient[(b)]	Month	Quarterly	21,946.7	23,776.7	1,830.0	8.3%	Increase	Increase	N (Utilization metrics)	Y	
16	Mental Health Services Utilization - ED	Month	Quarterly	110.7[(a)]	128.3	17.6	15.9%	Decrease	Increase	N (Utilization metrics)	N	
17	Mental Health Services Utilization - Telehealth	Month	Quarterly	878.3	4,431.3	3,553.0	404.5%	Increase	Increase	N (Utilization metrics)	Y	
18	Mental Health Services Utilization - Any Services	Month	Quarterly	22,551.3	26,344.0	3,792.7	16.8%	Increase	Increase	N (Utilization metrics)	Y	
19a.1	Average Length of Stay in IMDs: ALOS for all IMDs and populations	Year	Annually	13.3	N/A	N/A	N/A	No more than 30 days	N/A	Y	Y	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
19a.2	Average Length of Stay in IMDs: ALOS among short-term stays (less than or equal to 60 days)	Year	Annually	11.2	N/A	N/A	N/A	N/A	N/A	Y	N/A	
19a.3	Average Length of Stay in IMDs: ALOS among long-term stays (greater than 60 days)	Year	Annually	222.8	N/A	N/A	N/A	N/A	N/A	Y	N/A	
19b.1	Average Length of Stay in IMDs (IMDs receiving FFP only): ALOS for all IMDs and populations	Year	Annually	13.3	N/A	N/A	N/A	No more than 30 days	N/A	Y	Y	
19b.2	Average Length of Stay in IMDs (IMDs receiving FFP only): ALOS among short-term stays (less than or equal to 60 days)	Year	Annually	11.2	N/A	N/A	N/A	N/A	N/A	Y	N/A	
19b.3	Average Length of Stay in IMDs (IMDs receiving FFP only): ALOS among long-term stays (greater than 60 days)	Year	Annually	222.8	N/A	N/A	N/A	N/A	N/A	Y	N/A	

Notes: [a]This number was calculated based on updated baseline data provided by DHCF: 126 for January 2020, 101 for February 2020, and 105 for March 2020. The number based on the monitoring reports was 331.0. [b]Data limitations in computing this metric makes it difficult to evaluate the progress based on the quantitative values. Exhibit 43 displays the trend of this metric.

Exhibit 41: Trend of SMI/SED Metric #13 – Mental Health Services Utilization – Inpatient

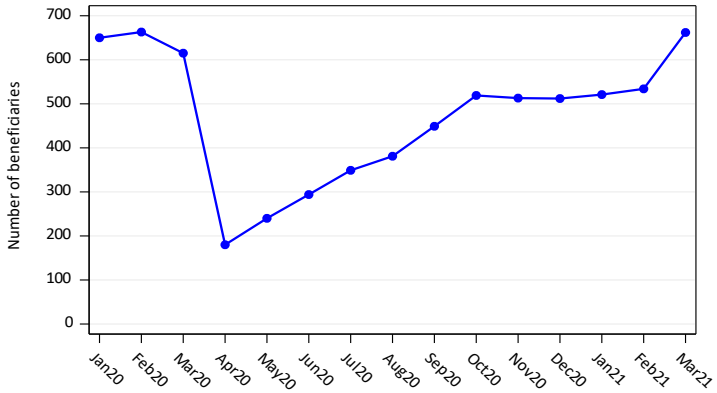


Measure description:Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 41 shows that the number of beneficiaries who used inpatient services related to mental health experienced a small but relatively steady decrease throughout the Demonstration thus far. The number decreased from 356 in January 2020 to 283 in March 2021. The value of the metric at baseline (DY1Q1 average) is 335 and at mid-point (DY2Q1 average) is 262, for an absolute change of -74 (-22%). The metric did not meet the Demonstration target of an increase.

Exhibit 42: Trend of SMI/SED Metric #14 – Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization

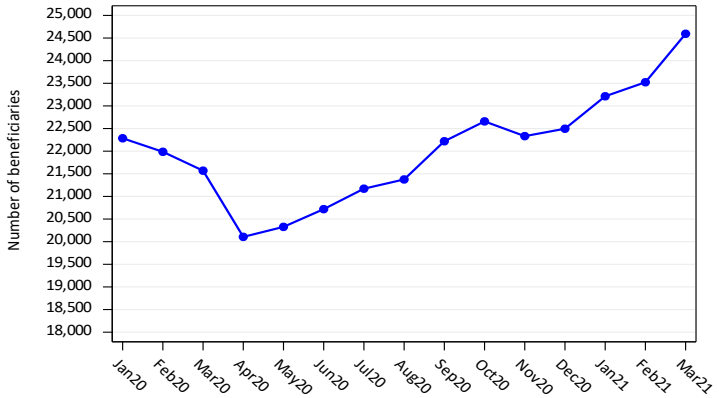


Measure description:Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 42 shows that the number of beneficiaries who used intensive outpatient and/or partial hospitalization services related to mental health experienced a sharp decrease in April 2020 but gradually increased thereafter. In March 2021, the number of beneficiaries using mental health related intensive outpatient and/or partial hospitalization services climbed again. The number increased from 650 in January 2020 to 662 in March 2021. This change in utilization pattern is likely driven by the PHE. The value of the metric at baseline (DY1Q1 average) is 643 and at mid-point (DY2Q1 average) is 572, for an absolute change of -70 (-11%). The metric did not meet the Demonstration target of an increase, but it reflects data limitations noted earlier that make it difficult to draw meaningful conclusions.

Exhibit 43: Trend of SMI/SED Metric #15 – Mental Health Services Utilization – Outpatient

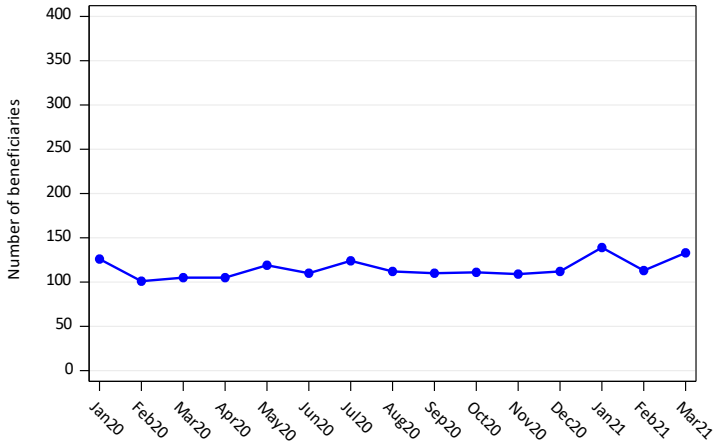


Measure description:Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 43 shows that the number of beneficiaries who used outpatient services related to mental health decreased during the first quarter of 2020 and gradually increased thereafter. The number increased from 22,285 in January 2020 to 24,594 in March 2021. This change in utilization pattern is likely driven by the PHE. The value of the metric at baseline (DY1Q1 average) is 21,947 and at mid-point (DY2Q1 average) is 23,777, for an absolute change of 1,830 (8%). The metric met the Demonstration target of an increase.

Exhibit 44: Trend of SMI/SED Metric #16 – Mental Health Services Utilization – ED

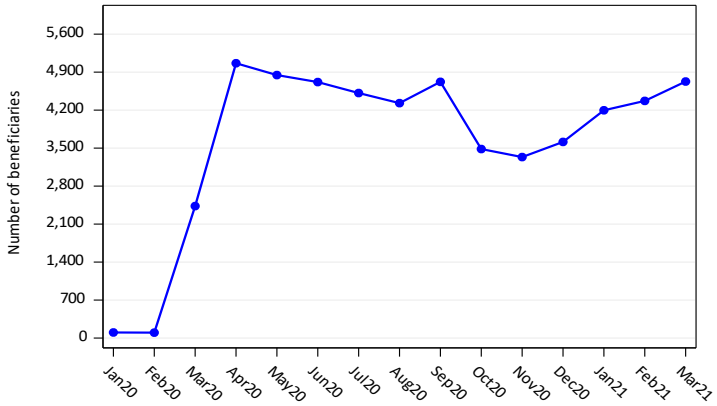


Measure description:Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 44 shows that the number of beneficiaries who used ED services for mental health remained steady. The number increased from 126 in January 2020 to 133 in March 2021. The value of the metric at baseline (DY1Q1 average) is 111 and at mid-point (DY2Q1 average) is 128, for an absolute change of 17 (16%). The metric did not meet the Demonstration target of a decrease.

Exhibit 45: Trend of SMI/SED Metric #17 – Mental Health Services Utilization – Telehealth

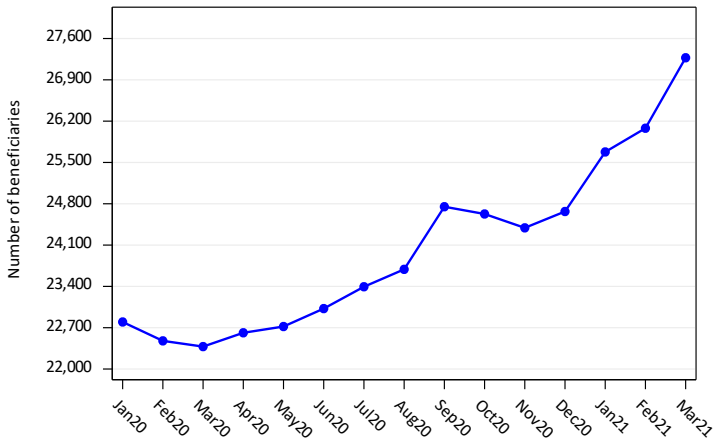


Measure description:Number of beneficiaries in the demostration population who used telehealth services related to mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 45 shows that the number of beneficiaries who used telehealth services related to mental health increased sharply in March and April 2020, before experiencing a gradual decrease during the remainder of 2020, and then increasing again from November 2020. The number increased from a mere 103 beneficiaries using mental health–related telehealth services in January 2020 to 4,727 beneficiaries using the services in March 2021. This change in utilization pattern is mostly driven by the PHE. For example, on March 12, 2020, the District issued a rulemaking authorizing home as an eligible originating site for telehealth services, to ensure continued access to behavioral health services. DHCF also clarified that any standards set forth in the regulations should also inform minimum program requirements implemented under the District's Medicaid managed care program. DHCF also temporarily authorized payment for audio-only telehealth services for the duration of the PHE and later made this change permanent. Many District IMD providers ceased admissions or decreased in-person patient volume to ensure the safety of their clients near the end of 2020 Q1. The value of the metric at baseline (DY1Q1 average) is 878 and at mid-point (DY2Q1 average) is 4,431, for an absolute change of 3,553 (405%). The metric met the Demonstration target of an increase.

Exhibit 46: Trend of SMI/SED Metric #18 – Mental Health Services Utilization – Any Services



Measure description:Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.

Note: This metric is not included in the risk rating because it is not a critical metric.

Exhibit 46 shows that the number of beneficiaries who used any services related to mental health increased steadily throughout the Demonstration thus far. The number increased from 22,797 in January 2020 to 27,274 in March 2021. The value of the metric at baseline (DY1Q1 average) is 22,551 and at mid-point (DY2Q1 average) is 26,344, for an absolute change of 3,793 (17%). The metric met the Demonstration target of an increase.

7.3.2. *Implementation Plan Action Items*

Exhibit 47: SMI/SED Milestone 3 Implementation Plan Action Items – Increasing Access to Continuum of Care, Including Crisis Stabilization Services

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI A3.1	DHCF will work with other District agencies to continually improve the data for future assessments.	Ongoing	Ongoing
SMI A3.2	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.	December 31, 2021	Completed
SMI A3.3	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	December 31, 2021	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	(sec.5006), section 1902(a)(83) and 42 CFR 438.10(h)(1)(vi).		
SMI A3.4	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.	December 31, 2021	Completed
SMI A3.5	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.	December 31, 2021	Open
SMI A 3.6	DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care.	December 31, 2021	Suspended

Three of the six action items for SMI Milestone 3 are complete, one is ongoing, and two are incomplete (Exhibit 47). The District made considerable progress in improving the Provider Lookup database (SMI A3.2 and A3.3). Information on providers accepting new patients was added to the Provider Lookup database in 2020. In addition, the CRISP DC Provider Directory allows CRISP users the ability to search for both people and organizations to assist in managing transitions of care. It displays contact information and allows providers to establish their own communication preferences (e.g., preferred method for receiving referrals and how best to reach that provider). The directory is updated periodically from multiple data feeds, including hospitals and credentialing organizations. In addition, CRISP users can control the information displayed for their organization and practitioners. It did not include data on patient acceptance at the Mid-Point Assessment, but issues regarding reconciliation of information from various sources (e.g., as reported by providers to DHCF's PDMS, by providers to MCOs, by MCOs to DHCF's enrollment broker) are under discussion, and the directory is being enhanced with a capability like that of the Master Patient Index. In addition, DC Health has expressed interest in a resident-facing provider directory, which also requires consideration of how to minimize conflicting information being made available to the public.

Regarding assessment and redesign of the EHR systems and practices of DBH, MHRS providers, SUD providers, and Saint Elizabeths Hospital, the District identified the EHR functionality needed to achieve their behavioral health delivery system's goals (SMI A3.4). This functionality is reflected in the Office of National Coordinator certified EHR systems. Thus, the District is encouraging behavioral health providers to adopt certified EHRs. DHCF is leveraging American Rescue Plan Act of 2021 (ARPA) funding for home and community-based services (HCBS) to provide incentive payments and technical assistance to support HCBS providers' adoption and use of digital health tools, including electronic health records, health information exchange, and telehealth, and will specifically target ASURS and MHRS HCBS providers.

The following bullets describe progress towards the three action items under this milestone that are incomplete.

- Improve the mental health service provider assessment data (SMI A3.1): The District has submitted two iterations of the mental health service provider assessment data to CMS thus far. Recognizing opportunities to improve the consistency and completeness of the data over time, DHCF is in the process of updating previous versions of the assessment and expects the data to continue to improve each iteration.
- Issue rulemaking and other policies to standardize the use of a patient assessment tool (SMI A3.5): The District plans to include these policies in the managed care procurement for FY 2023.
- Update certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care (SMI A3.6): The District recognizes that lack of intensive day treatment services was due to operating rules that are difficult to adhere to (e.g., open seven days a week), but believes the partial hospitalization programs helped address this service gap. There are no current plans to update the certification requirements for intensive day treatment services.

7.3.3. *Stakeholder Feedback*

Similar to perspectives on SUD provider availability, many stakeholders spoke of the limited availability of mental health providers and services as a significant challenge in the District. Multiple stakeholders thought the District selected the right levers to address these issues, but noted areas where availability of mental health providers and services continued to be a challenge, including partial hospitalization, intensive outpatient, crisis stabilization, and inpatient psychiatric services. Of note, two stakeholders considered the changes to funding for crisis services to be the main impact of the Demonstration; however, they believed that this

change has not impacted the availability or functioning of these services but may have stabilized their operations. Stakeholders acknowledged that the provider availability challenges reflect the fact that the field of behavioral health in general faces workforce shortages and that these shortages are exacerbated by lower reimbursement within Medicaid programs.

One stakeholder confirmed that providers continued to use the LOCUS tool required by DBH; however, this stakeholder noted that they also used additional tools that better meet their patient assessment needs and hoped to see DBH adopt different tools in the future.

7.4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration

7.4.1. *Monitoring Metrics*

The District's progress in achieving SMI/SED Milestone 4, Earlier Identification and Engagement in Treatment, Including Through Increased Integration, is assessed based on the change (increase, decrease, or consistent) in five critical metrics from baseline to mid-point compared to the Demonstration targets.

Exhibit 48 shows the monitoring metrics' progress towards Demonstration targets under SMI/SED Milestone 4. All critical metrics are annual metrics, preventing estimation of change over time. ***Therefore, the risk rating for monitoring metrics under SMI/SED Milestone 4 is Not Applicable.***

Exhibit 48: SMI/SED Milestone 4 Monitoring Metrics – Earlier Identification and Engagement in Treatment, Including Through Increased Integration

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
26	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries With SMI	Year	Annually	89.4%	N/A	N/A	N/A	Increase	N/A	Y	N/A	N/A
29.1	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Percentage of children and adolescents on anti-psychotics who received blood glucose testing	Year	Annually	39.6%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
29.2	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Percentage of children and adolescents on anti-psychotics who received cholesterol testing	Year	Annually	26.5%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	
29.3	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Percentage of children and adolescents on anti-psychotics who received blood glucose and cholesterol testing	Year	Annually	23.7%	N/A	N/A	N/A	Consistent	N/A	Y	N/A	

				Monitoring Metric Rate or Count								
#	Metric Name	Measurement Period	Reporting Frequency	At Baseline	At Mid-Point	Absolute Change	Percent Change	Overall Demon-stration Target	Directionality at Mid-Point	Critical Metric (Y/N)	Progress (Y/N)	Milestone risk assessment
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Year	Annually	77.7%	N/A	N/A	N/A	Increase	N/A	Y	N/A	

7.4.2. *Implementation Plan Action Items*

Exhibit 49: SMI/SED Milestone 4 Implementation Plan Action Items – Earlier Identification and Engagement in Treatment, Including Through Increased Integration

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI A4.1	Expenditure authority is requested under this demonstration to establish a new reimbursement methodology for CPEP and the Community Response Team (CRT) mobile crisis and outreach services to Medicaid beneficiaries to appropriately account for and value them.	June 3, 2019[(a)]	Completed
SMI A4.2	The District will develop and issue rulemaking and other policies as necessary to establish vocational supported employment services for adults with SMI.	December 31, 2021	Completed
SMI A4.3	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.	Ongoing	Ongoing
SMI A4.4	The District will develop and issue rulemaking and other policies as necessary regarding the enhanced reimbursement methodology for TST.	June 30, 2021	Completed
SMI A4.5	DBH is working to secure funding through Substance Abuse and Mental Health Administration's (SAMHSA's) Mental Health and Substance Abuse Prevention and Treatment Block Grants to promote improved transitions and integration of care for transition age youth (TAYs) and young adult (YAs) with co-occurring conditions.	9/30/2021[(b)]	Completed
SMI A4.6	A DBH workgroup is currently reviewing the findings and recommendations of the reports on	December 31, 2021	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	the District's child and adolescent public behavioral health system and their work will inform the development of an action plan.		

Note: [a]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the date the waiver application was submitted. [b]Implementation Plan did not include a timeline for completion. The evaluation team selected this date to reflect the end date of the most recent iteration of the grant.

Youth and young adults are not the primary focus of the Demonstration; however, a few services support these populations, including the TST treatment modality and crisis stabilization services. The District has completed five out of the six action items associated with SMI Milestone 4 (Exhibit 49). With the application and approval of the Demonstration, the District completed the action item to establish a new reimbursement methodology for CPEP and the CRT mobile crisis and outreach services (SMI A4.3). As described in Section 4, the payment, certification, and delivery policies associated with the CPEP (SMI A4.3), CRT mobile crisis and outreach (SMI A4.3), vocational supported employment services for SMI (SMI A4.2), and TST (SMI A4.4) services were implemented via DHCF and DBH rules and provider transmittals.

Several overlapping initiatives funded by local District dollars align with the Demonstration goals related to earlier identification and treatment for youth through increased integration.

- Via Mental Health Access in Pediatrics (MAP) funding, the District helps pediatric primary care providers better address their patients' mental health issues. The program offers primary care providers (PCPs) real-time phone access (Monday–Friday, 9am–5pm) to a team of mental health professionals (including psychiatrists, psychologists, social workers, and care coordinators). In addition to answering mental health–related inquiries about specific children (e.g., questions about community resources that would be appropriate for the family, medication questions), the DC MAP team provides education and technical assistance for PCPs about identifying and addressing mental health issues in primary care. DBH continues to support DC MAP through funding and regular contact with a DBH Program Officer, and continually attempts to engage more providers in using the service through personalized emails, phone calls, and letters to practice directors.
- Local District funding supports implementation of the HealthySteps model in pediatric primary care practices. HealthySteps supports families at pediatric well visits by funding

early childhood specialists. These specialists provide screenings, resources, and coaching, help parents deal with children's behavioral and developmental challenges, and coordinate and manage specialty care when needed. Several large pediatric primary care practices are implementing the model.

- In response to the need for increased training expressed by stakeholders, Integrated Care DC technical assistance offers provider coaching and webinar trainings on integrated care topics, including population health management and incorporation of evidence-based screening and interventions for behavioral health across Medicaid provider settings, including those within which youth and adolescents receive care.

During FYs 2020 and 2021, the District secured $12,598,512 from Substance Abuse and Mental Health Services Administration's (SAMHSA's) Substance Abuse and Prevention and Treatment SUD Block Grant. These funds were used to develop, implement, and ensure sustainability of specialized and evidence-based behavioral health programs for adults, adolescents, transition-aged youth, children, and their families. During FYs 2020 and 2021, the District secured 2,346,464 from SAMHSA's State Mental Health Bock Grant. These funds were used to develop and support community mental health services (such as peer services, the Clubhouse infrastructure, and DBH strategic planning and results-based accountability efforts).

DBH reviewed the findings and recommendations of the reports on the District's child and adolescent public behavioral health system, and incorporated some of them into their action plan.

7.4.3. *Stakeholder Feedback*

Stakeholder feedback on the crisis stabilization services and supported employment services is discussed in Section 6.5.3. Several stakeholders commented on the integration of physical and behavioral health services in the context of the newly Medicaid-eligible independent licensed behavioral health providers. Though stakeholders noted that this resulted in more behavioral health clinicians embedded in primary care settings, they also discussed ongoing challenges with linking physical and behavioral health care, particularly in post-acute, community settings.

Regarding services explicitly targeting children and young adults, stakeholders commented that it was too early to assess the effect of the new reimbursement methodologies for TST, but noted improved access as a result of recent delivery system changes outside the Demonstration. School behavioral health services were expanded in the District, which stakeholders believed increased youth access to mental health services.

7.5. Financing Plan

7.5.1. *Monitoring Metrics*

There are no monitoring metrics associated with the Financing Plan.

7.5.2. *Implementation Plan Action Items*

Exhibit 50: SMI/SED Financing Plan Implementation Plan Action Items

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI F1.1	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.	December 31, 2021	Completed
SMI F1.2	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	December 31, 2021	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	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.		
SMI F1.3	DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care.	December 31, 2021	Suspended
SMI F1.4	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.	June 30, 2021	Completed

Three of the four implementation plan action items under the SMI Financing Plan are complete (Exhibit 50). Discussion of implementation progress related to crisis stabilization (SMI F1.1) and other community-based services (SMI F1.2 and F1.4) is in Section 4. In addition to this initial progress, the District is currently conducting a Behavioral Health Rate Study to assess whether additional modifications are needed to reimbursement for, or the scope of, these services. As noted in Section 7.3.2, the District no longer plans to update certification regulations for intensive day treatment services.

7.5.3. *Stakeholder Feedback*

Discussion of stakeholder feedback on Demonstration changes to community-based behavioral health services is in Sections 6.5.3.

7.6. Health IT Plan

7.6.1. *Monitoring Metrics*

Please refer to section 6.7.1. for metric values and trends, as the same monitoring metrics related to the Health IT Plan are reported in both SMI/SED and SUD monitoring reports. Although all five of the non-critical health IT–related monitoring metrics achieved the Demonstration target, we only assess risk based on critical metrics as defined by CMS guidance. ***Therefore, the risk rating for monitoring metrics under the Health IT Plan is Not Applicable.***

7.6.2. *Implementation Plan Action Items*

Exhibit 51: SMI/SED Health IT Plan Implementation Plan Action Items – Closed Loop Referrals

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 1.1	Support CRISP DC Direct implementation; sustain collaborations with DCPCA/DCHA and District HIEs via the e-referral collaborative. Ensure that acute care hospitals, IMDs, community-based behavioral health providers (e.g., MHRS providers, free-standing mental health clinics), and primary care providers are incorporated into these discussions and have access to relevant technologies.	December 31, 2021	Completed
SMI HIT 1.2	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.	December 31, 2021	Completed
SMI HIT 1.3	Implement projects described in Section 1.1 and ongoing work with the DC Hospital Association.	December 31, 2021	Completed
SMI HIT 1.4	Execute current workplans and timeline for DCAS deployment and Community Resource Information Exchange Technical Solution (CoRIE) grant procurement. Continue efforts	December 31, 2021	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	to facilitate interoperability between systems.		

In partnership with DHCF, DBH has made substantial progress to ensure DBH certified providers are connected to the DC HIE and able to exchange HIPAA-compliant clinical information. All four action items related to closed-loop referrals are complete (Exhibit 51). DBH implemented several HIE participation requirements for certified providers (SMI HIT 1.3). In accordance with the requirements set forth in 29 DCMR 8608, IMD providers are required, as a condition of reimbursement for services authorized under Chapter 86, to "participate through a formal agreement with a registered HIE entity of the DC Health Information Exchange (DC HIE), defined in Chapter 87 of Title 29 of the DCMR." When a provider completes the SUD Attestation form and identifies that they are a substance use disorder treatment program as defined by 42 CFR Part 2, the provider also needs to execute a Qualified Service Organization Agreement (QSOA) with the HIE with which they have a participation agreement. In this event, only the provider's active patient list is shared with the HIE, to enable the practice to receive alerts on hospitalizations and access other physical health information. Enlightened, Inc.'s HIE Connectivity team will provide technical assistance, training, and onboarding support for the DC HIE to all eligible Medicaid providers that submit Medicaid claims to DHCF annually (SMI HIT 1.1). As of July 12, 2020, all IMDs had participation agreements with CRISP DC, receiving appropriate alerts on their patients. This includes the Psychiatric Institute of Washington and St. Elizabeths Hospital. As previously mentioned, additional capability for consent-based data exchange of 42 CFR Part 2 clinical information via the District's designated HIE is underway with the eConsent pilot project, anticipated for completion in 2022.

In addition, DBH promoted adoption of certified EHR technology to facilitate HIE connectivity and use (SMI HIT 1.2). As of February 2021, among the 47 behavioral health providers receiving technical assistance for HIE connectivity, 43 (92%) have a participation agreement in place with CRISP, enabling them to view key data (admits, transfers, discharges and Emergency Medical Service [EMS] transports, etc.); six organizations have full "bi-directional" connectivity and can both receive and share clinical and encounter data with the HIE among approved treating providers. The HIE does not support clinical referrals directly; however, they encourage providers to use secure, direct email when communicating with other providers.

The final data transition from a legacy system used to collect and manage public benefit application and eligibility data to the new District of Columbia Access System (DCAS) was

implemented in November 2021 (SMI HIT 1.4). As a result, all Medicaid beneficiaries are now able to interface with DCAS via the District Direct Resident Portal on a computer or mobile device. DC residents are able to use District Direct to perform key activities (such as apply for food, cash, and medical benefits; recertify and renew benefits; and submit changes of circumstances). The tool serves as a one-stop-shop for an integrated eligibility system, thereby improving the consistency and quality of the beneficiary data providers access to facilitate care coordination across public programs.

Another HIE effort under way is a tool to allow providers to send and receive referrals related to social determinants of health (SMI HIT 1.4). Development of this tool is supported by Community Resource Information Exchange Technical Solution (CoRIE) grant funding. The CoRIE grant is intended to enable greater integration of services to facilitate transitions of care and e-referrals from physicians and mental health providers to community-based supports. CoRIE supports whole system care by connecting health and social services through the DC HIE, enabling data sharing among health system stakeholders to address social determinants of health. The HIE's CoRIE tool has three main components:

- In collaboration with the DC primary care association, the HIE built a community resource inventory hosted in CRISP that providers can access to make referrals to community-based organizations (CBOs).
- CBOs will receive notification of a referral, with the option to accept or reject it.
- If a referral is accepted, the fact that the beneficiary has a relationship with the public program will be stored in the tool and shared with the provider.

The tool has been pilot-tested, but is not yet available to District providers and CBOs.

Exhibit 52: SMI/SED Health IT Plan Implementation Plan Action Items – Electronic Care Plans and Medical Records

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 2.1	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.	June 30, 2021	Open
SMI HIT 2.2	On an as-needed basis, DBH and DHCF will update program requirements to ensure care coordination programs are	Ongoing	Open

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	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.		
SMI HIT 2.3	Implement workplan and timeline for HIE connectivity grant including Children's National Medical Center (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.	December 31, 2021	Ongoing
SMI HIT 2.4	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.	December 31, 2021	Ongoing
SMI HIT 2.5	DHCF to implement workplan for the HIE Core Capabilities and Connectivity Grants to expand access to the Encounter Notification Service (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	December 31, 2021	Open

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	these efforts are successfully supporting consistent use of electronic alerts and workflow that uses alerts in an efficient manner that improves transitions of care.		

While the District has made good progress towards promoting adoption of certified EHRs among behavioral health providers and requiring connectivity to the HIE, few changes to policies or practices concerning exchanging electronic care plans have occurred during the Demonstration thus far (Exhibit 52). The HIE policy board's efforts to identify recommended policy changes are in process. In addition, the HIE is working on a screening tool to enable providers to view screening data at the site of care. The goal is to host those screening tools within the CRISP platform.

Exhibit 53: SMI/SED Health IT Plan Implementation Plan Action Items – E-consent

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 3.1	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.	December 31, 2021	Completed

Progress towards improvements to e-consent management (Exhibit 53) is discussed in Section 6.6.2.

Exhibit 54: SMI/SED Health IT Plan Implementation Plan Action Items – Interoperability of Assessment Data

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 4.1	Implement HIE Core Capabilities and Connectivity grant work plans 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.	September 30, 2021[(a)]	Open
SMI HIT 4.2	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.	Ongoing	Ongoing

Note: [(a)]Implementation Plan did not include a timeline for completion. The evaluation team selected this date based on the dates in the implementation plan action item text. The latest date is FY 2021.

As noted above, the District has achieved substantial progress with behavioral health providers adopting certified EHR technology and connecting to the HIE (Exhibit 54). The DC HIE Policy Board was established prior to the Demonstration (in 2012). The Board makes recommendations to the Mayor and Directors of several key District Government agencies regarding the District's HIE policies, mission, definition, vision, geographic scope, and functional scope of HIE operations; and how they should be coordinated with local and national efforts. Board members meet quarterly to develop these governance-related recommendations.

Exhibit 55: SMI/SED Health IT Plan Implementation Plan Action Items – Electronic Office Visits, Telehealth

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 5.1	Finalize DHCF telehealth rule for FFS. Implement MCO contract modifications to clarify telemedicine	June 30, 2021	Completed

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	payment policy. Clarify policies and continue to share best practices implementing telemedicine for SMI/SED.		

DHCF has issued updated guidance on telehealth, spurred in part by the pandemic (Exhibit 55). Most recently the agency issued rulemaking to extend certain provisions, including audio-only telehealth, beyond the end of the PHE. In addition, via the SOR grant, several behavioral health providers in the district are piloting a TeleMAT program, which builds on the phone-based MAT induction that occurred during the PHE. Early findings suggest that the volume of demand for TeleMAT is low; two pilot program grantees are exploring ways to combine their services to achieve feasible economies of scale.

Exhibit 56: SMI/SED Health IT Plan Implementation Plan Action Items – Alerting/Analytics

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 6.1	CRISP DC's work under the Core HIE grant is ongoing and will continue through 2023.	December 31, 2021	Ongoing
SMI HIT 6.2	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.	December 31, 2021	Ongoing
SMI HIT 6.3	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	December 31, 2021	Ongoing

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
	alerts for initial episodes of psychosis and training for providers to use alerts.		

The activities of the Core HIE and Capabilities grants along with the HIE Policy Board (Exhibit 56) are described earlier in this section.

Exhibit 57: SMI/SED Health IT Plan Implementation Plan Action Items – Identity Management

Action Item Number	Action Item Description	Date to be Completed	Current Status (Completed, Open, Suspended)
SMI HIT 7.1	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.	Ongoing	Ongoing
SMI HIT 7.2	Implement workplan and timeline for MEIP program support and technical assistance, the HIE Core Capabilities Grant, and the HIE Connectivity grant. Maintain and evolve data and information exchange standards for value-based purchasing initiates.	December 31, 2021	Ongoing

The District is actively monitoring changes to federal regulations regarding health data sharing and identity management (Exhibit 57). Following the Office of Civil Rights (OCR) Request for Information (RFI) regarding modification of HIPAA rules to improved coordinated care, HHS released a proposed rule: Proposed Modifications to the HIPAA Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement. The public comment period for the proposed rule closed on May 6, 2021. Neither the submitted comments nor the final

rule are publicly available yet. Therefore, no action is needed to ensure continued alignment between District and federal policies at this time.

Activities associated with the HIE Core Capabilities and Connectivity grants are described earlier in this section. Regarding the Medicaid Promoting Interoperability Program, formerly known as the Medicaid EHR Incentive Program (MEIP), the District has continued its partnership with eHealthDC, a DC Primary Care Association program, to provide free technical assistance to District Medicaid providers. This multi-year technical assistance program led by eHealthDC intends to:

- Assist staff and providers with better utilization of EHRs in accordance with the current practice workflows and program requirements.
- Provide exceptional Promoting Interoperability technical and on-site support to improve EHR utilization in weak performance areas to meet program requirements.

7.6.3. *Stakeholder Feedback*

Stakeholder perspectives on the use of health technology by mental health service providers were mixed. Stakeholders noted that behavioral health providers were slower to implement certified EHRs and connect to the HIE than other provider types in the District. These stakeholders appreciated that the DC government made technical resources available to providers and worked with the HIE to create functionality that is valuable to providers. For example, one provider noted that their clinicians found the HIE more useful and easier to navigate for obtaining patient data than Web Infrastructure for Treatment Services (WITS), which they found difficult to use. One stakeholder noted that concerns about sharing information were greater in the SUD and SMI/SED communities than in other areas of health, and expressed support for the current efforts to make consent management easier—particularly enabling beneficiaries to opt in or out with respect to sharing specific types of information.

In addition, stakeholders noted that using health information technology to exchange information required different workflows and expertise, which take time to get in place. Making full use of the HIE can be challenging for providers, requiring multiple types of positions/skills to extract and interpret data and then use it to make clinical improvements (e.g., follow up with patients admitted to the hospital). Stakeholders assumed larger providers implemented a specialty team for these activities.

According to stakeholders, use of telehealth for reaching beneficiaries with SMI/SED and SUD was a complex issue, with uptake of telehealth both facilitated and stymied by the pandemic.

On the one hand, this provider group saw significant expansion in telehealth and an increase in claims; but at the same time, they noted that it was not clear whether use of telehealth occurred because it was the clinically appropriate approach or because it was a necessity related to the pandemic. They also wondered which populations were reached or used telehealth services. This provider group suggested that—even while use of telehealth increased during the waiver period because beneficiaries with SMI/SED needed more support—some beneficiaries most in need (e.g., homeless) became more disengaged and harder to reach. They also noted that telehealth services could not overcome some aspects of the pandemic, particularly with respect to IMD services/SUD residential providers; these facilities were operating at less than full capacity and unable to make use of telehealth to provide services. This provider group further suggested that there was burnout and fatigue related to the pandemic and use of telehealth for delivering behavioral health services, contributing to already problematic workforce retention issues and making future use of telehealth less certain.

7.7. Provider Availability Assessment

Exhibit 58 shows the changes in availability of mental health services and providers in the District between the 2019 initial mental health services availability assessment and the 2021 draft annual mental health services availability assessment. Between the two assessments, the number of adult Medicaid beneficiaries (ages 21+) with SMI increased from 35,337 to 37,841.

With the Demonstration objective of increasing the availability of nonhospital, non-residential crisis stabilization services—including services made available through crisis call centers, mobile crisis units, observation/assessment centers—the District issued rulemaking and implemented new crisis stabilization reimbursement methodologies. The number of crisis stabilization units increased from 1 to 3 between the two availability assessments. The number of crisis call centers (1), mobile crisis units (2), crisis observation/assessment centers (1), and coordinated community crisis response teams (1) stayed the same.

The Demonstration also aimed to increase availability of ongoing community-based services—such as outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings. The Demonstration proposed to reimburse for behavioral health services provided to individuals with SMI/SED or SUD by psychologists and other licensed behavioral health providers practicing independently (in either a separate practice or hospital setting). Accordingly, the District issued rulemaking and implemented new coverage of community-based providers. The number of FQHCs that offer behavioral health services increased from 42 to 54 (29% increase). However, the number

of Medicaid-enrolled psychiatrists or other practitioners authorized to prescribe psychiatric medications decreased from 423 to 400 (5% decrease). Utilization of trauma-informed services and supported therapeutic employment services for individuals with SMI/SED was low, because of pandemic-related service delivery issues and staff shortages (e.g., vacant Employment Specialist positions). The District's plans for updating certification regulations for intensive day treatment services were suspended; no new providers were certified to deliver these services.

Between the period of the initial and the 2021 annual availability assessments, the number of licensed psychiatric hospital beds (psychiatric hospital + psychiatric units) available to Medicaid patients increased from 568 to 625 (10% increase), while the number of psychiatric hospitals (2) and the number Medicaid-enrolled psychiatric units in acute care hospitals (7) remained unchanged. Both the psychiatric hospitals in the District qualify as IMDs, one public and the other private. The District does not have psychiatric residential facilities.
Service utilization is expected to rise with the pandemic abating; and additional regulations, including those resulting from activities such as the behavioral health rate study, could improve provider availability across the continuum of SMI/SED care.

Exhibit 58: DHCF Mental Health Services Availability Assessment, 2019 Initial and 2021 Annual Assessment

Item	2019 Initial Assessment [a]	2021 Annual Assessment [b]
Number of adult Medicaid beneficiaries (18 - 20)	10,016	10,420
Number of adult Medicaid beneficiaries with SMI (18 - 20)	1,130	1,210
Number of adult Medicaid beneficiaries (21+)	171,023	189,785
Number of adult Medicaid beneficiaries with SMI (21+)	35,337	37,841
Percent with SMI (Adult)	20%	20%
Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Not available	Not available
Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	423	400
Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications Accepting New Medicaid Patients	Not available	353
Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Not available	Not available
Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	0	46

Item	2019 Initial Assessment [a]	2021 Annual Assessment [b]
Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	0	46
Number of CMHCs	0	0
Number of Medicaid- Enrolled CMHCs	0	0
Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Not applicable	Not applicable
Number of Providers Offering Intensive Outpatient Services	8	8
Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services	8	8
Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients[c]	8	8
Number of Residential Mental Health Treatment Facilities (Adult)	0	0
Number of Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult)	0	0
Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Not applicable	Not applicable
Total Number of Residential Mental Health Treatment Facility Beds (Adult)	0	0
Total Number of Medicaid- Enrolled Residential Mental Health Treatment Beds (Adult)	0	0
Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Not applicable	Not applicable
Number of Psychiatric Residential Treatment Facilities (PRTF)	0	0
Number of Medicaid- Enrolled PRTFs	0	0
Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Not applicable	Not applicable
Total Number of PRTF Beds	0	0
Number of Medicaid-Enrolled PRTF Beds	0	0
Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Not applicable	Not applicable
Number of Public and Private Psychiatric Hospitals	2	2
Public and Private Psychiatric Hospitals Available to Medicaid Patients	2	2
Number of Psychiatric Units in Acute Care Hospitals	7	7
Number of Psychiatric Units in Critical Access Hospitals (CAHs)	0	0
Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	7	7

Item	2019 Initial Assessment [a]	2021 Annual Assessment [b]
Number of Medicaid-Enrolled Psychiatric Units in CAHs	0	0
Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	7	7
Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Not applicable	Not applicable
Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	568	625
Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	568	625
Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	0	0
Number of Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	0	0
Number of Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Not applicable	Not applicable
Number of Psychiatric Hospitals that Qualify as IMDs	2	2
Number of Crisis Call Centers	1	1
Number of Mobile Crisis Units	2	2
Number of Crisis Observation/ Assessment Centers	1	1
Number of Crisis Stabilization Units	1	3
Number of Coordinated Community Crisis Response Teams	1	1
Number FQHCs that Offer Behavioral Health Services	42	54

Notes: [a]Date of assessment is 1/27/2022. Numbers reported are for CY2019 (December 2019 for enrollment; CY2019 for provider counts). [b]Date of assessment is 1/27/2022. Numbers reported are for CY2021 (December 2021 for enrollment; CY2021 for provider counts). [c] DHCF interpreted the second column labeled "Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services" in the mental health assessment template as "Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients".

8. Findings - Assessment of IMD ALOS Status for SMI/SED Services

AIR assessed the District's performance in meeting the 30-day or less ALOS in IMDs for SMI/SED services requirement at the time of the Mid-Point Assessment, as specified in Section V.40 of the STCs, based on the following metrics:

- SMI/SED Metric #19(a), ALOS for beneficiaries with SMI/SED discharged from an inpatient or residential stay in an IMD
- SMI/SED Metric #19(b), ALOS for beneficiaries with SMI/SED discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP)

As reported by SMI/SED Metric #19(a), Average Length of Stay in IMDs in the DY2Q1 monitoring report, the ALOS for beneficiaries with SMI/SED discharged from an inpatient or residential stay in an IMD for all IMDs and populations during 01/01/2020–12/31/2020 is 13.3 days. The numerator is 15,249, and the denominator is 1,149. The ALOS among short-term stays for SMI/SED beneficiaries (less than or equal to 60 days) is 11.2 days (the numerator is 12,798 [days times stays], and the denominator is 1,138 [stays]); the ALOS among long-term stays (greater than 60 days) is 222.8 days (the numerator is 2,451 [days times stays], and the denominator is 11 [stays]). The corresponding numbers for SMI/SED Metric #19(b) "Average Length of Stay in IMDs (IMDs receiving FFP only)" are the same as those for SMI/SED Metric #19(a) "Average Length of Stay in IMDs."

Therefore, the District met the STC requirement of 30-day or less ALOS in IMDs for SMI/SED services at the time of the Mid-Point Assessment.

9. Findings - Assessment of Overall Risk of Not Meeting Milestones

This section summarizes the findings from the milestone-level progress assessment, and assigns a final risk rating for each milestone. For each milestone with a risk level of medium or high, AIR provides recommendations for adjustments to the District's SUD or SMI/SED Implementation Protocols or Financing Plan, as applicable. The District's responses to the risk rating and recommendations are also included. These discussions are covered in separate subsections for SUD milestones and SMI/SED milestones. There is also a subsection on IMD ALOS status. The section concludes with next steps the District proposes for addressing deficiencies in or improving Demonstration performance, particularly in the areas that the Mid-Point Assessment identified as at risk of not meeting milestones.

9.1. SUD Milestones – Progress, Risks and Recommendations

Exhibit 59 lists the SUD milestones and associated summary of progress, risk level, recommendations and District's response, as applicable.

Exhibit 59: Summary of Mid-point Assessment of Overall Risk of Not Achieving SUD Demonstration Milestones

SUD Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs	100% (3/3)	50% (3/6)	Stakeholders provided positive feedback on the District's progress. However, they expressed frustration with the administrative burden of different payment for IMD stays depending on length of stay.	Low	N/A	N/A
Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria	100% (1/1)	50% (3/6)	Stakeholders provided positive feedback on the District's progress. Providers uniformly indicated that decentralization of the intake, assessment, and referral process improved patient access to services.	Low	N/A	N/A

SUD Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	100% (1/1)	N/A	Stakeholders provided positive feedback on the District's progress. A residential treatment provider that participated in interviews is in the process of becoming certified as an opioid treatment provider.	Low	N/A	N/A
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD	100% (2/2)	N/A	Stakeholders reported significant gaps in provider capacity for outpatient SUD services, particularly partial hospitalization and intensive outpatient services.	Medium	1. Continue execution of relevant activities currently in process 2. Develop a more detailed and up-to-date understanding of capacity relative to demand	Please see section 9.1.4

SUD Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
					3. Consider modifying provider certification requirements for certain SUD services 4. Educate beneficiaries about the new benefits associated with the Demonstration	
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	57% (4[(a)]/7)	100% (1/1)	Stakeholders reported mixed awareness and feedback on the changes to the ASURS and MHRS.	Low	N/A	N/A
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	100% (3/3)	N/A	Stakeholders reported that eligibility for the transition planning services was too narrowly defined. However, providers report	Low	N/A	N/A

SUD Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
			that the main challenge with care coordination and transitions is a lack of provider capacity.			
Health IT Plan	64% (9[(b)] /14)	N/A	No stakeholder feedback on changes to the PDMP functionality and interoperability was solicited.	Low	N/A	N/A

Notes: [(a)]Two additional ongoing action items are currently in process. [(b)] Three additional ongoing action items are currently in process.

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

Because the District met its target for three directly relevant monitoring metrics, completed all action items associated with this milestone, and received positive feedback from stakeholders, we assign **an overall risk rating of low** for SUD Milestone 1, Access to Critical Levels of Care for OUD and other SUDs. While there was progress in only three of the six critical monitoring metrics associated with this milestone, the three metrics that met the target (increase in intensive outpatient and partial hospitalization services, increase in residential and inpatient services, and increase in withdrawal management) are the most closely aligned with the three implementation plan action items for this milestone. The District completed all three of these action items by 1) issuing rules and distributing guidance related to coverage of, and payment for, these services; and 2) gathering stakeholder input into areas in need of additional improvement. Our discussions with stakeholders demonstrated that providers and MCOs are aware of, and see the value in, these coverage changes. In addition, the majority (81%) of beneficiary survey respondents reported they were able to access needed counseling or treatment services for drug or alcohol use.

The remaining three monitoring metrics for which the District did not meet their target (increase in early intervention, increase in outpatient services, and increase in MAT) align with components of access to critical levels of care for OUDs and other SUDs for which DHCF indicated that no action was needed. Coverage of outpatient services and MAT was available prior to the Demonstration. Thus, we assessed these monitoring metrics as less indicative of overall risk for this milestone.

9.1.2. *Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria*

We assign **an overall risk rating of low** for SUD Milestone 2, Use of Evidence-based, SUD-Specific Patient Placement Criteria. The two critical monitoring metrics for this milestone are not applicable because they are annual metrics, for which data to assess yearly change is not yet available. While CMS identifies several potential alternatives to the two critical metrics, none of those metrics provides enough specificity to clearly assess progress on the key action item for this milestone. The one action item the District planned to address during the Demonstration was to decentralize the assessment and referral process for SUD intake, and ensure providers newly certified to perform these assessment and referral services use the required tools. The District completed this action item via rulemaking. Providers were uniformly aware of and implementing this policy change and saw it as one of the most positive outcomes of the Demonstration thus far. Therefore, we assess the District as at low risk of not achieving SUD Milestone 2.

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

We assign the District **an overall risk rating of low** for SUD Milestone 3, Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment facilities. No monitoring metrics are applicable to this milestone; the one applicable action item is complete. According to regulations enacted during the Demonstration, all providers are required to provide MAT directly or refer beneficiaries to providers who offer MAT services. A residential treatment provider that participated in the stakeholder interviews indicated that they currently referred beneficiaries who need MAT and were in the process of obtaining the certification to provide it directly. Therefore, we assess the District as at low risk of not achieving SUD Milestone 3.

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

We assign the District **an overall risk rating of medium** for SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD. The two critical monitoring metrics for this milestone are not applicable because they are annual metrics, for which data to assess trends are not yet available. While the District completed both the action items associated with this milestone—exempt medications for MAT from the $1 copayment, and improve provider availability assessment—stakeholder feedback suggested that further progress was needed to achieve the milestone. The provider capacity assessment conducted under the Section 1003 SUPPORT Act Planning Grant by JSI in 2019 showed very few providers at critical levels of care (one provider at level 3.7 [medically monitored intensive inpatient services] and one provider at level 4.0 [medically managed high-intensity inpatient services]). Provider feedback indicated this lack of capacity was problematic for supporting beneficiaries as their SUD acuity evolves and noted that recruiting and retaining adequate numbers of providers was one of the most difficult challenges they faced.

Beneficiaries did not yet seem adequately aware of the policy change regarding removal of the $1 copay for MAT. Approximately one-third of beneficiary survey respondents either believed they would need to pay for prescriptions to detox or stay off drugs or alcohol, or were unsure about their cost-sharing responsibilities for these prescriptions.

Recommendations.

1. **Continue execution of relevant activities currently in process.** Several overlapping initiatives that are currently in process are aligned with the Demonstration's goal of

increasing the capacity of SUD providers. For example, the District has implemented an ED MAT induction program funded by SAMHSA's State Opioid Target Response grant. The program provides immediate access to the induction of buprenorphine at the ED and provides immediate access—either same day or next day—to FQHCs and other clinicians authorized to prescribe office-based MAT or deliver OTP services. This program expands access to MAT induction for beneficiaries experiencing opioid overdose. Continued program improvement and the planned expansion of this program to additional hospitals (it is currently delivered in two hospitals) will increase the District's capacity to deliver SUD services.

Another overlapping initiative currently in process that may help to expand SUD provider capacity is Phase One of the behavioral health rate study. Withdrawal management and medically managed intensive outpatient services, two levels of services for which there are very few providers, are included in this rate study. The findings from the rate study may provide the District with insights into additional strategies it can take to expand capacity to deliver these services.

2. **Develop a more detailed and up-to-date understanding of capacity relative to demand.** There are several data sources that identify the number of providers that offer SUD services in the District, including the annual critical Demonstration monitoring metrics for SUD Milestone 4 for which trends will be available next year, the quarterly data reported to CMS as part of the District's Section 1003 SUPPORT Act Provider Capacity Planning Grant, and the needs assessment conducted by JSI in 2019. Continued collection and reporting of these data will provide insights into whether capacity is improving over time. However, SUD providers are defined and measured differently across these reporting efforts. Therefore, we recommend identifying a strategy for standardizing SUD capacity measures to the extent possible, particularly for internal monitoring purposes.

   There are also several SUD utilization measures included in the monitoring metrics which identify the number of beneficiaries diagnosed with SUD who received treatment at various critical levels of care. However, a clear picture of the total demand for SUD services, both met and unmet, relative to supply is not readily available, which makes it

difficult to assess whether existing SUD provider and system capacity is sufficient to fully address beneficiaries' SUD needs.[6]

We recommend combining provider and system capacity measures with diagnosis and utilization measures to reflect capacity relative to beneficiaries' SUD treatment needs. For example, data on provider supply could be integrated with data on beneficiary demand (e.g., number of Medicaid beneficiaries, number of beneficiaries with SUD diagnoses, number of beneficiaries with SUD treatment), in total and by provider type/level of care, to construct ratio measures which could be tracked over time to assess trends. These ratio measures would be similar to some of the measures in the CMS-required annual provider availability assessment for the SMI/SED components of the waiver and those used to assess network adequacy. These relative measures would consider the supply, demand, and realized quantity of SUD services, and provide a fuller picture of the District's SUD service capacity.

It may also be useful to collect other common measures of network adequacy such as time and/or distance to providers, appointment wait times, beneficiaries' ability to receive an appointment as soon as needed, and percentage of providers accepting new patients.[7] The District likely has the data to construct some of these measures now (e.g., maximum time and/or distance between providers and beneficiaries and percentage of providers accepting new patients) and could compare these results with trends in Medicaid network adequacy policies/standards for behavioral health providers.[8,9]

3. **Consider modifying provider certification requirements for certain SUD services.** Implementing staff and community stakeholders noted that one challenge to increased availability of SUD services in the District is provider certification. Similarly, the extensive and specialized licensure required to become certified to offer TREM services is not financially sustainable given the reimbursement rate for these services according to stakeholders.

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[6] As reported in the National Survey on Drug Use and Health (NSDUH), of those with SUD in the District, 11.3 percent did not receive needed treatment within the past year compared with 7.1 percent nationally. SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2017 & 2018.

[7] The needs assessment conducted by JSI in 2019 found geographic variation by level of care in the distribution of SUD services across the District's 8 wards.

[8] It is the evaluation team's understanding that the Access Help Line and providers maintain this information for the purposes of intake, assessment, screening, and referral.

[9] See, for example: Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing and Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services.

For example, stakeholders noted that TREM services require two independently licensed clinicians to lead this specialized form of group therapy and thus is cost prohibitive. The TREM model dictates that two clinicians lead the groups, and two TREM-trained independently licensed clinicians are required for the agency to be certified to deliver this service. We recommend assessing whether there are opportunities to modify provider certification requirements to promote increased uptake by providers while still maintaining fidelity to the service model as specified by ASAM and other relevant professional bodies. Another strategy the District could pursue is to increase the payment for these services to reflect the actual costs of delivery. Results of the rate study that is in process may help to inform this potential strategy.

In addition, the District could assess whether changes to the Certificate of Need (CON) process for residential SUD treatment providers are warranted. Although DBH certifies these providers, current law in the District also requires a separate justification and DC Health approval via the CON. This additional process presents a barrier to provider entry in the District. While many other states have CON laws, research suggests that the removal of these laws improves access to providers.[10,11] In addition, some network adequacy regulations (e.g., Medicare Advantage) recognize the barriers imposed by state CON laws and lower requirements to accommodate this market challenge.[12]

4. **Educate beneficiaries about the new benefits associated with the Demonstration.** To increase beneficiaries' awareness that they will not have to pay for MAT if prescribed by their provider, we recommend additional outreach that educates beneficiaries about this new Medicaid benefit. To avoid confidentiality challenges associated with targeted outreach specific to beneficiaries with SUD, we recommend a widespread educational campaign. For example, SUD providers could hang posters at their site or include flyers with other appointment materials notifying beneficiaries that if they need MAT, it will be no cost to them. There could also be a broader education campaign about beneficiary costs within which zero-cost MAT is highlighted.

   If it has not yet occurred, it may also be helpful to educate beneficiaries about independent licensed behavioral health providers now accepting Medicaid. Beneficiary awareness of an expanded pool from which they could draw to seek care that is covered

[10] https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx
[11] David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," American Economic Journal: Economic Policy, February 2010.
[12] Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

by their insurance is vital to achieving the potential for expanded capacity through this Demonstration policy. The District Direct Resident Portal where individuals will be able to initiate and renew Medicaid benefits could be an effective place to disseminate this information.

The District's response.

1. **Continue execution of relevant activities currently in process.**
   In addition to the ED MAT induction program and the behavioral health rate study, efforts under way that align with the Demonstration's goal of increasing the capacity of SUD providers include:
   - Completing certification of an additional provider offering Level 3.7 services, currently in progress. The addition of this provider will expand the District's capacity to serve individuals who require withdrawal management services. The potential provider will add 20 beds for withdrawal management. The provider will also open another 40 beds for ASAM 3.1–3.5 services.
   - Working with partners in neighboring jurisdictions to serve individuals with SUD needs via providers outside of the District, without relying solely on single-case agreements that enable individual Medicaid beneficiaries to receive care delivered elsewhere. In particular, the District is seeking arrangements with Maryland and Virginia providers to treat District residents and expand capacity within the District's network.

2. **Develop a more detailed and up-to-date understanding of capacity relative to demand.**
   As noted in the recommendations, DHCF is reporting on several measures across overlapping initiatives to better understand SUD provider capacity. The differing specifications make it difficult to assess the results, both on their own and against each other. DHCF and DBH concur that a more holistic assessment of both the demand for and supply of SUD services, as well as SMI/SED services, is warranted. The agencies expect to devote additional analytic resources to this effort over the next year. However, the assessment will require appropriate context to avoid confusion given the number of measures already in place for different reporting requirements.

3. **Consider modifying provider certification requirements for certain SUD services.**
   With regard to the TREM, DBH will remind providers that although groups must have at least one TREM-trained independently licensed clinician lead the group, the required

second clinician can be a (less costly) TREM-trained Certified Addiction Counselor, and that TREM-trained peers can also participate in a supportive role. The TREM service will also be considered in the rate study to better assess reimbursement and assure it is sustainable.

DBH and DHCF concur that an assessment of CON policies for SUD residential treatment is warranted. DBH provides information for the determinations of need cited in CON analyses. The additional requirements that providers must meet for an approval by DC Health impose an unnecessary barrier to entry for new providers and delays in the availability of new capacity to serve District residents. While the CON remains current law in the District, DBH will continue to work with DC Health to provide financial and technical assistance to the providers seeking a CON. One provider has engaged in the process to date and the department has set up the process for at least five other programs/providers.

4. **Educate beneficiaries about the new benefits associated with the Demonstrations.** The District will consider additional options for beneficiary education on the topic of Demonstration benefits. For example, the *LIVE.LONG.DC* campaign that consolidates efforts for ending the District's opioid epidemic may present opportunities to further reinforce the availability of zero-cost MAT as part of its focus on prevention, harm reduction, treatment and recovery.

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

We assign SUD Milestone 5, Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD, **an overall risk rating of low**. The one applicable monitoring metric, ED utilization for SUD, decreased, which was the metric's Demonstration target direction. Four of the seven action items identified in the Implementation Plan are complete. Several District rules instituted Medicaid payment for, and created or updated requirements related to, multiple services across the care continuum that target beneficiaries with SUD.

The implementation plan action items that were not complete as of the Mid-Point Assessment relate to ongoing activities of the SOR grant. Some of these activities will completely transition to Medicaid billable services once the current iteration of SOR grant funding ends (e.g., the peer recovery support services programs). Other activities of the current SOR grant are synergistic

with Demonstration efforts (e.g., the ED induction program) and will continue outside the Demonstration. Future iterations of the SOR grant will provide an opportunity for District agencies and stakeholders to identify additional opportunities to further the Districts' goals related to the behavioral health delivery system, either within or in parallel to Demonstration efforts.

The District submitted State Plan amendments related to the ASURS and MHRS. Efforts to further refine these services are ongoing. For example, findings from the behavioral health rate study currently in process will inform further changes to the scope or payment for these services.

Regarding stakeholder feedback, there are areas for which implementation was challenging (e.g., billing for mobile outreach services by child crisis stabilization providers). However, stakeholders were generally aware of the changes relevant to their organizations and were particularly supportive of the changes that directly influence beneficiaries' access to care (such as clarification of reimbursement policies for crisis stabilization providers and removal of the copay for MAT).

Together, the monitoring metric, action item progress, and stakeholder feedback suggest that the District's risk of not achieving SUD Milestone 5 is low.

9.1.6. *Milestone 6: Improved Care Coordination and Transition Between Levels of Care*

We assign **an overall risk rating of low** for SUD Milestone 6, Improved Care Coordination and Transitions between Levels of Care. There are no applicable monitoring metrics for this milestone because all the applicable critical metrics are annual, for which trends are not yet available. The District completed all action items for this milestone by implementing a new transition planning service benefit, providing technical assistance for care coordination via the Integrated Care DC technical assistance program, and routinely soliciting stakeholder input into opportunities to improve data sharing to support care coordination. In addition, CRISP is developing an eConsent tool to permit sharing of 42 CFR Part 2 protected information via the HIE. While stakeholders uniformly expressed frustration with supporting beneficiary transitions between levels of care, particularly amidst the PHE, the primary challenge appeared to be lack of outpatient service capacity rather than the ability to bill for transition planning. Thus, we document those challenges under the risk rating for SUD Milestone 4, and assign SUD Milestone 6 a risk rating of low.

9.1.7. *Health IT Plan*

We assess **an overall risk rating of low** for the SUD Health IT Plan. There are no critical monitoring metrics for the Plan. While the District met the targets for all the non-critical monitoring metrics for the SUD Health IT plan, these metrics are not specific to PDMP functionality and use, which is the focus of the Plan. Therefore, we considered trends in these metrics as less applicable to progress for the SUD Health IT plan. The District made good progress with the relevant implementation plan action items. The PDMP fully integrates with certified EHRs and the HIE, via an external interface operated by Appriss. In addition, DC Health issued reminders regarding PDMP query requirements, and DHCF maintained policy protections associated with the pharmacy lock-in program and prescribing limits. No stakeholder feedback was solicited on the use or functionality of the PDMP. Based on the improved integration of the PDMP and associated policies regarding use and prescribing practices, we assign the SUD Health IT Plan an overall risk rating of low.

9.2. SMI/SED Milestones – Progress, Risks and Recommendations

Exhibit 60 lists the SMI/SED milestones and associated summary of progress, risk level, recommendations, and District's response, as applicable.

Exhibit 60: Summary of Mid-Point Assessment of Overall Risk of Not Achieving SMI/SED Demonstration Milestones

SMI/SED Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	50% (1/2)	N/A	Stakeholder feedback on utilization review requirements was mixed. Some are concerned about the administrative burden. Other stakeholders noted that there has been a positive impact on care coordination efforts.	Low	N/A	N/A
Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	50% (3/6)	N/A	Stakeholders reported that eligibility for the transition planning services was too narrowly defined and that care coordination and transitions continues to be a challenge. Stakeholders expressed	Medium	1. Complete implementation plan action items 2. Continue execution of relevant activities in process 3. Consider expanding the transition	Please see section 9.2.2

SMI/SED Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
			concerns about the limited housing support available under the Demonstration.		planning benefit 4. Hold hospitals and health plans accountable for care transitions	
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	50% (3[(a)]/6)	100% (2/2)	Many stakeholders spoke of the limited availability of mental health providers and services as a significant challenge in the District.	Low	N/A	N/A
Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	83% (5[(a)]/6)	N/A	Stakeholders reported positive feedback on increased integration of behavioral health in primary care as a result of the newly Medicaid-eligible licensed behavioral health professionals.	Low	N/A	N/A

SMI/SED Milestone	Percentage of fully completed action items (# completed /total)	Percentage of monitoring metric goals met (# metrics/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Financing Plan	75% (3/4)	N/A	Stakeholders reported mixed awareness and feedback on the changes to the ASURS and MHRS.	Low	N/A	N/A
Health IT Plan	33% (6[b]/18)	N/A	Stakeholder perspectives on the use of health technology by mental health service providers are mixed.	Low	N/A	N/A

Notes: [a] One additional ongoing action item is in process. [b] Eight additional ongoing action items are in process.

9.2.1. *Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings*

We assign SMI/SED Milestone 1, Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings, **an overall risk rating of low**. There are no critical monitoring metric trends available to assess progress towards this milestone. The first of the two action items under this milestone is complete. Immediately preceding the beginning of the waiver (December 31, 2019), the District issued a transmittal notifying providers of the utilization review requirements and processes associated with billing for Demonstration services in IMDs. The second action item was to develop and issue rulemaking and other policies as necessary to require psychiatric hospitals to conduct the required psychiatric and other medical screenings (e.g., screenings for co-morbid physical health conditions, SUDs, and suicidal ideation). The District had not yet issued any policies related to these screenings at the Mid-Point Assessment. It is our judgment, however, that this action item is less central to the goals of Milestone 1. There are criteria within Milestone 1 for which no action under the Demonstration was needed. These no action–needed items are all focused on improving psychiatric hospital quality via licensure, certification, and utilization review oversight policies and procedures, as is the case for the completed action item. Therefore, we assess the completed action item as more central to the milestone's goal than the incomplete action item and assign SMI/SED Milestone 1 an overall risk rating of low.

9.2.2. *Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care*

We assign SMI/SED Milestone 2, Improving Care Coordination and Transitioning to Community-Based Care, **an overall risk rating of medium**. No critical monitoring metrics are available to assess trends. Three out of the six action items under this milestone are complete, all three of which relate to implementation of the new transition planning service benefit. As discussed in previous sections, there is consensus among agency staff and District stakeholders that uptake of this benefit was slow because of the challenge COVID-19 restrictions pose to face-to-face transition planning and narrow beneficiary eligibility requirements. One of the incomplete action items—requirements for MCOs to implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services, including all behavioral health services—is actively in process, and the majority of the current MCOs contract with the Transitional Services Provider to provide the same service for their beneficiaries. The District will include more specific requirements for care management and hospital follow up, for youth and adults, in a new iteration of the managed care contracts for FY 2024. The remaining two incomplete action items relate to requirements to assess beneficiaries housing situations, and

to follow up with beneficiaries 72 hours post discharge for psychiatric hospitals and residential treatment settings. Because of the challenges with realizing the potential of the transition planning benefit and the incomplete status of these two action items, we assign SMI/SED Milestone 2 an overall risk rating of medium.

Recommendations.

1. **Complete implementation plan action items.** We recommend that the District continue to pursue completion of the following implementation plan action items because they have the potential to improve care coordination and transitions for beneficiaries:
    - require MCOs to implement protocols and procedures for coordinating managed care services with the provision of other Medicaid services, including all behavioral health services;
    - 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; and
    - develop and issue rulemaking and other policies as necessary to ensure psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations.

2. **Continue execution of relevant activities in process.** The District has developed a strong foundation of health IT infrastructure. We recommend continued strategic and financial support for increased functionality, provider engagement and information sharing in the HIE, particularly as it relates to care alerts, consent management, and the social needs referral tool. Over time, these improvements may enhance workflows for more comprehensive and efficient care transitions and coordination.

    The virtual learning, webinars, individual practice coaching, and learning collaborative offered by the Integrated Care DC program also have the potential to improve providers' care transition and coordination services. An evaluation of the program—such as identification of the number and type of providers participating, the practice changes participating providers implement as a result of their participation, and challenges to coordinating care—may help the District identify any additional strategies it may take to support providers seeking to improve care coordination for their patients.

3. **Consider expanding the transition planning benefit.** When moving the transition planning services from waiver authority to the State Plan, the District expanded the

services to be eligible for payment for the 30 days following discharge (under the waiver, the services were only eligible for payment during the 30 days prior to discharge). We recommend exploring whether additional changes to the services would improve uptake. For example, it may help to expand the types of beneficiaries who are eligible or the number of providers certified to offer the services.

4. **Hold hospitals and health plans accountable for care transitions.** Implementation of the action item to develop and implement a policy requiring hospitals to follow up with beneficiaries within 72 hours of discharge coupled with the existing care transition metrics identified as critical monitoring metrics represent an opportunity to assess hospital and health plan performance on care transitions. We recommend implementing accountability mechanisms for hospitals and health plans on the issue of care transitions. For example, once behavioral health services are carved in to MCO contracts, MCOs could be contractually required to address care transitions for beneficiaries experiencing a hospital or residential stay for SMI/SED in quality improvement plans. Another strategy that the District could explore is offering financial incentives for hospitals to achieve high performance on key measures of care transition.

The District's response.

1. **Complete implementation plan action items.** As noted in this report, the District is actively working to complete the action item on requirements for MCOs to implement protocols and procedures for coordinating whole-person care, including behavioral health services. Managed care contracts for FY 2024 will include a wide range of behavioral health services that were previously carved out and paid under FFS, giving MCOs greater responsibility for these benefits and lessening the need for separate coordination processes. In addition, MCOs will be required to provide in-house staffing of case management functions in an effort to avoid siloed physical and behavioral health processes that may result from subcontracting.

   For the action item regarding contacting beneficiaries within 72 hours post discharge for psychiatric hospitals and residential treatment settings, as well as the action item to ensure assessment of their housing situations, the District will issue transmittals or other provider guidance to ensure compliance.

2. **Continue execution of relevant activities in process.** The District concurs with this recommendation. In addition to the efforts cited, the District has awarded a contract to

improve hospital transitions of care and reduce hospital readmissions. The project will provide hospital transition of care and discharge data and workflow analysis, an interactive dashboard for monitoring transitions of care and readmissions with the DC HIE, and conduct a set of pilot interventions to improve transitions of care upon discharge, as well as best practice strategies to reduce 30-day all-cause hospital readmissions in the District.

The Integrated Care DC program began webinars and provider coaching in January/February 2021. As a result, the program does not yet have pre/post information available on participating providers receiving practice coaching and a comprehensive evaluation is unlikely to be useful at this time. DHCF has reviewed base year progress and drafted a report on lessons learned, which will be publicly shared after leadership review is completed.

3. **Consider expanding the transition planning benefit.** The District is currently exploring options for a potential expansion of this benefit to broaden eligibility criteria. We also agree that expanding the benefit to all engagement 30 days post-discharge is appropriate and will reduce the chance of readmission during this timeframe and increase the value of the program in the eyes of hospitals and promote their engagement with the service provider. The District does not believe that additional providers are required at this time. However, enhanced communication (e.g., with the current certified provider, DBH's new Integrated Care Team, and hospitals), along with better notification of admissions, is expected to increase utilization.

4. **Hold hospitals and health plans accountable for care transitions.** The District has implemented pay for performance programs for providers and health plans over the last several years, as well as Performance Improvement Project and other quality improvement efforts through its ongoing MCO oversight activities. In addition, as part of the integration of behavioral health care into MCO contracts, the District is considering performance metrics that may be appropriate for future monitoring efforts. For example, DBH currently works with its Core Service Agencies (which provide behavioral health care to a large number of District residents) to examine data on step-downs to the community for individuals with psychiatric hospitalizations, while DHCF reviews overall Medicaid program and MCO-level data on follow-up with a mental health practitioner after a hospitalization for mental illness.

With regard to financial incentives for hospitals, considerations include but are not limited to eligibility criteria (e.g., provider universe and metric specifications), payment amounts, and available funding. The design of any incentives must also consider whether they are to be implemented by MCOs within their capitated payments from DHCF and/or in FFS.

9.2.3. *Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services*

We assign SMI/SED Milestone 3, Increasing Access to Continuum of Care, Including Crisis Stabilization Services, an **overall risk rating of low**. The targets for all critical monitoring metrics were met. Average length of stay in IMDs for all populations is less than 30 days. In addition, three of the six non-critical but relevant monitoring metrics (utilization metrics) met the Demonstration target. Overall utilization of mental health services increased, as did utilization of outpatient and telehealth services. The two non-critical but relevant monitoring metrics that did not meet the Demonstration target of an increase are utilization of inpatient and intensive outpatient and partial hospitalization services. Utilization for these services decreased slightly. ED utilization for mental health services increased; however, the Demonstration target was a decrease for this metric. Given the restrictions on in-person congregation during the PHE, these trends make sense and will likely reverse as COVID-19 safety concerns wane. Three of the six implementation plan action items for this milestone are complete. These action items relate to improvements to health information technology tools (provider lookup database, provider directory, and EHR functionality) that support better visibility into available providers. Stakeholders noted that access to mental health service providers and services continued to be a challenge despite Demonstration efforts. However, because most monitoring metrics show clear progress regarding utilization and length of stay—even in the face of the PHE—and the District completed several action items that directly improve visibility into which providers and services are available, we assign SMI/SED Milestone 3 an overall risk rating of low.

9.2.4. *Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration*

We assign SMI/SED Milestone 4, Earlier Identification and Engagement in Treatment, Including Through Increased Integration, an **overall risk rating of low**. There are no monitoring metrics for which trends can be assessed as yet. Five of the six implementation plan action items associated with this milestone are complete. The District modified reimbursement methodologies for several services that facilitate clinical intervention prior to acute episodes of care (e.g., crisis stabilization services) or support youth and young adults with receiving targeted mental health services (e.g., TST). In addition, the District continues to look for

opportunities to address the behavioral health needs of children via alignment with other sources of District grant funding, such as the DC MAP program and local funding of HealthySteps. PHE service priorities prevented the District from using the SAMHSA mental health and substance abuse prevent treatment block grants to improve transitions and integrations of care for TAYs and YAs. However, stakeholders noted that school-based behavioral health initiatives in the District increased access for youth. Stakeholders identified general improvements in integrated care that resulted from new Medicaid eligibility for independent licensed behavioral health providers. Given the implementation plan action item progress related to early intervention, overall alignment of Demonstration goals with other District behavioral health initiatives targeting youth and young adults, and stakeholder perceptions of improved primary care integration as a result of Demonstration efforts, we assign SMI/SED Milestone 4 an overall risk rating of low.

9.2.5. *Financing Plan*

We assign the SMI/SED Financing Plan an **overall risk rating of low**. There are no monitoring metrics associated with the Plan. Three of the four implementation plan action items under this Plan are complete, which reflect key Demonstration activities related to policymaking for payment and certification of community-based mental health services. In addition, the District is currently conducting a Behavioral Health Rate Study to identify additional modifications to the scope or payment of behavioral health services in the District. Therefore, we assess the District as making good progress towards sustainability of Demonstration services and assign an overall risk rating of low to the SMI/SED Financing Plan.

9.2.6. *Health IT Plan*

We assign the SMI/SED Health IT Plan an **overall risk rating of low**. There are no applicable critical monitoring metrics to include in our assessment. The District made progress on implementing plan action items focused on promoting adoption of certified EHR technology and requiring connectivity to the HIE. Several action items are in process, such as development of electronic assessment and referral tools, and efforts to identify the appropriate policies and practices to support electronic exchange of care plan and other clinical data are ongoing. In general, stakeholders spoke positively about the District's health IT goals and efforts, which were in the early phases of working through implementation challenges at the Mid-Point Assessment. Overall, our assessment is that the District is at low risk to not achieving the milestones associated with the SMI/SED Health IT Plan. The District solidified a foundation for leveraging health IT for mental health service providers' care coordination. As the relevant technologies mature, and stakeholder and providers become more comfortable and skilled in using them, increased use to facilitate care coordination will likely occur.

9.3. IMD ALOS Status for SMI/SED Services – Progress, Risks and Recommendations

The District met the requirement of 30-day or less ALOS in IMDs for SMI/SED services, as specified in Section V.40 of the STCs. We found no risks as part of the Mid-Point Assessment and make no recommendations for improvement.

10. Findings - Assessment of the District's Capacity to Provide SUD and/or SMI/SED Services

The monitoring metrics indirectly provide an assessment of the magnitude of SUD and SMI/SED service needs in the District. SUD Metric #3, Medicaid Beneficiaries with SUD Diagnosis (monthly), showed a baseline (DY1Q1 average) count of 13,753 beneficiaries who received MAT or a SUD-related treatment service, with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period. The corresponding count at the time of the Mid-Point Assessment (DY2Q1 average) was 12,720 indicating a reduction of 8 percent. SMI/SED Metric #21, Count of Beneficiaries With SMI/SED (monthly), showed a baseline (DY1Q1 average) count of 37,382 beneficiaries with an SMI/SED diagnosis in the measurement period with an SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period. The corresponding count at the time of the Mid-Point Assessment (DY2Q1 average) was 36,962 indicating a reduction of 1 percent. These reductions may not mean that the need for SUD and SMI/SED services in the District decreased between the baseline and Mid-Point Assessment. It is likely a reflection of the reduction in the utilization of SUD and SMI/SED services among the District's Medicaid beneficiaries due to the pandemic. Almost all SUD and SMI/SED utilization metrics showed a sharp fall with the onset of the pandemic, and the utilization levels had not reached pre-pandemic levels for many of those metrics by the time of the Mid-Point Assessment, though there was movement towards the earlier higher levels.

A survey of a stratified random sample of adult Medicaid beneficiaries with a diagnosis of SUD or SMI/SED any time during the 15 months prior to the start date of sample construction (09/11/2019–12/11/2020), which AIR conducted between February 12, 2021–April 30, 2021, provides a glimpse into beneficiary perspectives on the District's capacity to provide SUD and SMI/SED services. Of the 14 percent (n=47) of 358 survey respondents who said 'yes' when asked whether they felt they wanted/needed counseling or treatment for drug or alcohol use in the past 12 months, 81 percent (n=38) agreed or strongly agreed they were able to get the wanted/needed services. Of the 51 percent (n=185) of survey respondents who said 'yes' when asked whether they felt they wanted/needed counseling or treatment for emotional or mental health in the past 12 months, 72 percent (n=134) agreed or strongly agreed they were able to get the wanted/needed services. For beneficiaries who felt they could not access wanted/needed services, the most frequently cited reason was COVID-19. Only four of the beneficiaries who felt they needed SUD services and 11 of the beneficiaries who felt they

needed mental health services reported they were unable to find a provider to take their Medicaid coverage. Five beneficiaries who said they needed SUD services and 21 beneficiaries who said they needed mental health services reported an inability to get an appointment as soon as needed. While in-person SUD and SMI/SED service utilization may have significantly decreased in the District because of the COVID-19 PHE, the beneficiary survey responses indicated many of them were able to take up the telemedicine services the District encouraged as an alternative. Around 39 percent of respondents (n=141) reported using telemedicine (health care visit over video or phone) to get help with their drug or alcohol use or mental health in the past 12 months. Of those, 80 percent (n=113) strongly agreed or agreed that telemedicine made it easier for them to see a health care provider.[13] These findings suggest that the DC Medicaid behavioral health care system was not perceived as severely lacking in capacity by Medicaid beneficiaries who needed SUD and SMI/SED services.

On the supply side, SUD Milestone 4 and the SMI/SED provider availability assessments provide data on the District's capacity to meet beneficiary behavioral health care needs. SUD Milestone 4 Monitoring Metrics, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, show that there were 797 SUD providers (SUD Metric #13) and 393 MAT providers (SUD Metric #14) in the baseline data of the Mid-Point Assessment (DY1 annual metric). Since there is only a single data point available for these metrics at the baseline, it is not possible to assess whether there has been an increase in the availability of SUD providers over time. However, the annual provider availability assessments show largely an increase in the overall availability of SMI/SED providers in the District between the baseline and Mid-Point Assessment. The number of FQHCs offering behavioral health services increased from 42 to 54. The number of licensed psychiatric hospital beds available to Medicaid patients increased from 568to 625. There are two psychiatric hospitals and seven acute care hospitals with Medicaid-enrolled psychiatric units in the District, but no psychiatric residential treatment facilities. The number of Medicaid-enrolled psychiatrists or other practitioners authorized to prescribe psychiatric medications decreased from 423 to 400 between the 2019 and 2021 provider availability assessments.

The providers and provider associations we interviewed reported shortages of providers across the continuum of SUD and SMI/SED care, with certain levels/types of care more affected than others. Insufficient availability of providers was reported as a continuing concern in the areas of intensive outpatient services, crisis stabilization services, and mobile outreach services, despite the Demonstration's explicit targeting of those services. Stakeholders also reported

[13] The survey did not explore the adequacy of beneficiaries' access to the tools needed for telemedicine.

insufficient outpatient provider capacity as a contributory factor in making care transition and care coordination a significant weak point in the District's SUD and SMI/SED service delivery system. Even non-clinical services such as recovery support services and employment support services were indicated as areas where provider shortages existed. While acknowledging COVID-19 PHE's role in aggravating provider capacity concerns, stakeholders cited certain licensing requirements, low Medicaid reimbursement rates, and high staff turnover as reasons behind provider shortages. Stakeholders did describe the new Medicaid reimbursement eligibility for independent licensed behavioral health providers as helpful in increasing provider availability for community-based behavioral health care and integration of behavioral health care with primary care.

The District's own information gathering efforts—such as the District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment—identified gaps in certain types of care and made recommendations for system improvements and organizational capacity building. The District is complementing Demonstration activities by leveraging additional resources (e.g., CMS SUPPORT Act Provider Capacity Planning Grant and SAMHSA SOR Grant) and following a multi-pronged strategy to address these gaps and move towards a more whole-person, population-based, integrated Medicaid behavioral health care system. These efforts include focused campaigns such as *LIVE.LONG.DC* targeting the District's opioid epidemic, improved coordination of DHCF and DBH activities, increased adoption of Health IT and data exchange among behavioral health care providers, and direct technical assistance to providers. The District is also currently conducting a behavioral health rate study to identify enhancements to reimbursement methods and service availability. With the transition of some of the waiver services into the State Plan from January 1, 2022 onwards, and the carving in of community-based behavioral health care services into Medicaid managed care in FY 2024, the District's capacity for adequate provision of coordinated behavioral health care is expected to further improve.

Overall, the information AIR reviewed to conduct the Mid-Point Assessment suggests there is sufficient capacity to provide most SUD and SMI/SED services in the District. The services for which additional capacity appears needed are in sub-acute care following or pre-empting inpatient or residential stays. Assessing the current state of evidence, we rated SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, as being at medium risk of not meeting the milestone at the time of the Mid-Point Assessment. On the SMI/SED services side, we rated SMI/SED Milestone 2, Improving Care Coordination and Transitioning to Community-Based Care, as at medium risk of not meeting the milestone. These

are areas where the District could take more steps to ensure sufficient capacity in needed services and specific recommendations are provided in Sections 9.1.4 and 9.2.2.

Differing specifications for provider availability metrics under various programs such as the Demonstration and SUPPORT Act Provider Capacity Planning Grant make it difficult for the District to reconcile and draw clear conclusions. Therefore, the District may need to acquire a more standardized and comprehensive view of SUD/SMI/SED provider availability. It will also be useful for the District to develop a more detailed and up-to-date understanding of capacity relative to demand for SUD/SMI/SED services.

The District's response. DHCF and DBH concur that a more holistic assessment of both the demand for and supply of SUD/SMI/SED services is warranted. Metrics currently used to meet various reporting requirements do not necessarily paint a cohesive picture and the agencies expect to devote additional analytic resources to this issue over the next year.

11. Next Steps

Exhibits 61 and 62 list the activities the District proposes to undertake for improving its performance on SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD, and SMI/SED Milestone 2, Improving Care Coordination and Transitioning to Community-Based Care, respectively, for which the assessor assigned a risk rating of medium.

Exhibit 61: Next Steps – SUD Milestone 4, Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

Recommendations	District's Next Steps
Continue execution of relevant activities currently in process	In addition to an ED MAT induction program and behavioral health rate study, efforts under way that align with the Demonstration's goal of increasing the capacity of SUD providers include: • Completing certification of an additional provider offering Level 3.7 services, currently in progress. • Working with partners in neighboring jurisdictions to serve individuals with SUD needs via providers outside of the District.
Develop a more detailed and up-to-date understanding of capacity relative to demand	DHCF and DBH expect to devote additional analytic resources over the next year to a more holistic assessment of the demand for and supply of SUD/SMI/SED services in the District.
Consider modifying provider certification requirements for certain SUD services	DBH will remind providers that independently licensed clinicians are not the only option for meeting TREM service requirements; in addition, this service will be considered in a rate study to assess reimbursement and sustainability. DHCF and DBH concur that an assessment of CON policies for SUD residential treatment is warranted. While the CON remains current law in the District, DBH will continue to work with DC Health to provide financial and technical assistance to the providers seeking a CON.
Educate beneficiaries about the new benefits associated with the Demonstration	The District will consider additional opportunities for beneficiary education on the topic of Demonstration benefits, including via the *LIVE.LONG.DC* campaign that consolidates efforts for ending the District's opioid epidemic.

Exhibit 62: Next Steps – SMI/SED Milestone 2 Improving Care Coordination and Transitioning to Community-Based Care

Recommendations	District's Next Steps
Complete implementation plan action items	The District is actively working to complete the action item on requirements for MCOs to implement protocols and procedures for coordinating whole-person care, largely via updated managed care contracts for FY 2024 that will include a wide range of behavioral health services previously carved out and paid under FFS. For the action item regarding contacting beneficiaries within 72 hours post discharge for psychiatric hospitals and residential treatment settings, as well as the action item to ensure assessment of their housing situations, the District will issue transmittals or other provider guidance to ensure compliance.
Continue execution of relevant activities in process	In addition to efforts cited in the recommendation, the District has awarded a contract to improve hospital transitions of care and reduce hospital readmissions. The District also expects to publicly share lessons learned from the Integrated Care DC program that offers technical assistance to providers on a variety of practice transformation issues.
Consider expanding the transition planning benefit	The District is currently exploring options for a potential broadening of eligibility criteria for this benefit. The District is also seeking to increase utilization of the benefit via enhanced communication among key entities and better notification of admissions.
Hold hospitals and health plans accountable for care transitions	As part of the integration of behavioral health care into MCO contracts, the District is considering performance metrics that may be appropriate for future monitoring efforts.

Appendix A. Independent Assessor Description

On November 22, 2019, the District of Columbia Office of Contracting and Procurement (OCP), on behalf of the Department of Health Care Finance, issued a solicitation for proposals from vendors qualified to complete an independent evaluation of the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration in accordance with criteria set forth by the Centers for Medicare & Medicaid Services. The statement of work for the independent evaluation was inclusive of a mid-point assessment to be developed and conducted by the vendor. Proposals were due to the District on December 20, 2019. After review by a Technical Evaluation Panel and OCP, AIR (formerly IMPAQ International) was selected as the independent evaluator and a contract was executed on May 14, 2020. In accordance with CMS guidance on the mid-point assessment, AIR has signed a "No Conflict of Interest" statement, included here.

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Advancing Evidence.
Improving Lives.

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Conflict of Interest Certification Form

Sponsor: District of Columbia, Department of Health Care Finance
Reference: Contract #CW82733
AIR Project Title: DC 1115 Waiver Evaluation
AIR Project Director: Rekha Varghese
AIR Internal Reference: Project # Q1065 / 2867

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

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

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

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

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

By: Jack Robinson

Title: Compliance Officer

Signature: 

Date: February 21, 2022

AIR Conflict of Interest Compliance Program

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

Identification of Conflicts of Interest

AIR's Corporate Conflict of Interest Compliance Program is designed to ensure that the company and its personnel are in compliance with the organizational and personal conflict of interest provisions in the Federal Acquisition Regulation (FAR) as well as any additional provisions required by a Request for Proposals (RFP) or issued contract such as conflict of interest requirements. Whenever AIR begins the proposal writing process in response to a Solicitation or RFP, AIR's Contract Administration Managers immediately review the RFP to see if it contains specific Organizational Conflict of Interest (OCI) or Personal Conflict of Interest (PCI) provisions.

If PCI requirements exist, the Contract Administration Manager assigned to proposal development will ensure that the appropriate personnel review, respond, prepare, and sign any requested PCI forms. If any potential, perceived, or actual personal conflicts of interest identified, AIR will make a full disclosure, in writing, to the Contracting Officer. Such disclosure will include a description of the actions AIR has taken or proposes to take to avoid, neutralize, or mitigate each reported conflict of interest. AIR will collaborate with the Contracting Officer to craft and implement a project-specific conflict-of-interest mitigation plan that ensures that all AIR's activities on the project are transparent and compliant.

For OCI requirements, the Compliance Officer's review will similarly look for specific forms in the RFP that may be required in addition to a more thorough review of the company's past contracts and relationships. The OCI review focuses on four primary forms of OCI:

- Unequal access to information
- Biased ground rules
- Impaired objectivity
- Procurement integrity

In all cases, the thorough review is designed to ensure compliance with FAR and RFP rules and to identify issues requiring disclosure and/or mitigation. AIR's Compliance Officer, Principal Contract Manager, Contract Administration Managers, and technical staff review AIR's contracts and other available data to determine if the nature of the work, personnel involved, clients, partners, subcontractors, or consultants present a conflict of interest. AIR further requires, via contractual documents at the time of proposal and at the time of award, all partners, consultants, and potential subcontractors to certify that they too have conducted a similar review with respect to an opportunity and can accurately represent that they do not have any PCIs or OCIs. Lastly, AIR conducts internal audits each time an RFP is identified for pursuit, and in accordance with any applicable procedures set forth in those RFPs that specifically require a conflict-of-interest review or certification. If an organizational conflict of interest is identified, AIR will make a full disclosure, in writing, to the Contracting Officer. Such disclosure will include a description of the actions AIR has taken or proposes to take to avoid, neutralize, or mitigate each reported conflict of interest. AIR will collaborate with the Contracting Officer to craft and implement a project-specific conflict-of-interest mitigation plan that ensures that all AIR's activities on the project are transparent and compliant.

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AIR Conflict of Interest Compliance Program

Key elements of internal audits conducted under AIR's Compliance Program, and practices in identifying PCIs and OCIs include, without limitation:

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

Avoidance, Neutralization, Mitigation, and Resolution Policies and Procedures

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

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

- Divest itself of, or reduce the financial relationship that AIR may have in another organization to a level that is acceptable to the Contracting Officer;
- Separate lines of business management or critical staff or consultants from working on the resultant contract;
- Ensure that the individuals who have potential conflicts of interest due to direct financial relationships to the organizations divest themselves of those relationships, or remove the individual(s) from the contract;
- Have the individuals who have potential conflicts of interest due to indirect financial relationships to the organizations divest themselves of those relationships or obtain approval from the Contracting Officer of an acceptable level which would allow the individuals to continue working on the contract, or remove the individual(s) from the contract;
- Remove or recuse a subcontractor or consultant, or other partner, and pursue alternative contracting strategies.

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

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

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AIR Conflict of Interest Compliance Program

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

Subcontractor & Partner Compliance

In addition to the requirements of subcontractors noted above, AIR takes additional steps to identify, avoid, neutralize, or mitigate apparent, potential, or actual conflicts of interest that our subcontractors or consultants may have. For example, if the subcontractor or consultant has no established procedures, AIR will require them to follow the procedures it uses to identify, evaluate, and disclose conflicts of interest, consistent with any terms of AIR's Prime Contract or RFP. Periodic review of this information helps AIR screen for possible conflicts of interest and ensure subcontractor compliance with the terms of their agreements.

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

Appendix B. SUD Milestones, Implementation Plan Action Items, Monitoring Metrics

Exhibit B.1 and Exhibit B.2 list the milestone criteria, future state, timeline and action items associated with the SUD milestones and Health IT Plan. Exhibit B.3 lists the monitoring metrics to the SUD milestones along with their description, measurement period, reporting frequency, Demonstration target and an indicator of whether it is a critical metric.

Exhibit B.1: SUD Milestones – Milestone Criteria, Future state, Timeline and Action Items

Milestone Criteria	Future State	Timeline	Action Item
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs			
Coverage of outpatient services	Already provided.	N/A	No action needed.
Coverage of intensive outpatient services	Already provided.	18 - 24 months	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.
Coverage of MAT (medications as well as counseling and other services)	Already provided.[14]	N/A	No action needed.
Coverage of intensive levels of care in residential and inpatient settings	Medicaid waiver and expenditure authority for intensive care delivered in an IMD setting is requested under this demonstration	N/A	Medicaid waiver and expenditure authority requested.
Coverage of medically supervised withdrawal management	Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this waiver.	N/A	Medicaid waiver and expenditure authority requested.
Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria			

[14] 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).

Milestone Criteria	Future State	Timeline	Action Item
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	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.	12 -18 months	DBH will ensure assessments continue to be based on tools like the Treatment Assignment Protocol (TAP) and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary.
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	Already implemented.	N/A	No action needed.
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	Already implemented.	N/A	No action needed.
Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	Already implemented.	N/A	No action needed.
Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities			
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the American Society of Addiction Medicine (ASAM) Criteria or other nationally recognized, SUD specific program standards regarding, in	Already implemented.	N/A	No action needed.

Milestone Criteria	Future State	Timeline	Action Item
particular, 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 ensure compliance with these standards	Already implemented.	N/A	No action needed.
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	Ensure residential treatment facilities offer MAT for all Food and Drug Administration (FDA)-approved types of medication on-site or facilitate access offsite.	12 -18 months	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.
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD			
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	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.	1. N/A 2. 18 - 24 months	1. Medicaid waiver and expenditure authorities requested. 2. The District will also work to improve future assessments of SUD provider capacity, especially the availability of MAT and 3.7-WM services.

Milestone Criteria	Future State	Timeline	Action Item
Residential and Inpatient Settings; Medically Supervised Withdrawal Management (WM)	Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this demonstration. Expanded services to include WM.		
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD			
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	Already implemented.	N/A	No action needed.
Expanded coverage of, and access to, naloxone for overdose reversal	Through the State Opioid Response (SOR), the District will distribute additional naloxone kits and conduct additional training.	N/A	Activities funded through the SOR grant are ongoing.
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	The District will implement legislative changes mandating that all controlled substance prescribers in the District register for the DC Prescription Drug Monitoring Program (PDMP). Additional information about the DC PDMP is included in Attachment A of the SUD Implementation Protocol. We summarized the criteria, future state, action items and timelines related to the Health IT Plan.	N/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 of the SUD Implementation Protocol. We summarized the criteria, future state, action items and timelines related to the Health IT Plan.
Other	Under this demonstration, the District proposes to expand the service continuum for SUD treatment, including: ▪ Crisis stabilization and mobile crisis outreach services ▪ Recovery Support Services ▪ Supported Employment Services pilot	1. N/A 2. 12 -18 months 3. 18 - 24 months 4. N/A	1. Medicaid waiver and expenditure authority requested. 2. DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for waiver services.

Milestone Criteria	Future State	Timeline	Action Item
	▪ Behavioral health services provided by independent and hospital affiliated psychologists and other licensed behavioral health providers ▪ Eliminate $1 copayment 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.		3. The District will evaluate the effectiveness of SOR grant activities to determine additional Medicaid changes through Demonstration amendments or other means. 4. District efforts under the Medicaid State Plan and administration operations to enhance Adult Substance Use Rehabilitative Services (ASURS) and Mental Health Rehabilitation Services (MHRS) services and identify opportunities for system improvements are ongoing.
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care			
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	Under this demonstration, the District proposes to add Medicaid reimbursement for transition planning services for individuals being discharge from residential and inpatient facilities.	12 - 18 months	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for transition planning services.
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	DBH provides additional opportunities for training and technical assistance on clinical care coordination services for SUD providers.	1. 12 - 18 months 2. 18 - 24 months	1. DBH will develop additional training and technical assistance on clinical care coordination services. 2. 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.

Exhibit B.2: SUD Health IT Plan – Milestone Criteria, Future state, Timeline and Action Items

Milestone Criteria	Future State	Timeline	Action Item
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Already implemented.	18 - 24 months	DC Health will explore integration with RxCheck.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Expanded DC PDMP-electronic health record (EHR) integrations with clinical organizations.	N/A	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP.
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	DC PDMP integrated with CRISP DC to track prescribing and facilitate query.	18 - 24 months	DC Health will integrate District Health Information Exchanges (HIEs) with the DC PDMP via APPRISS.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also "Use of PDMP" #2 below)		1. N/A 2. N/A 3. N/A 4. N/A 5. 12 - 18 months	1. DC Health's work to enhance the analytic capabilities within the DC PDMP is ongoing. 2. DC Health's academic detailing activities are ongoing. 3. DHCF's PLP will remain in place. 4. DHCF's opioid-MME limits will remain in place. 5. The District's DUR Board will create and offer provider education seminars on safely prescribing opioids for chronic pain.
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 about PDMP query)	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.	N/A	District stakeholders will continue collaborating to ensure the District's approach to patient matching increasingly meets the criteria for Level 4 of the Sequoia Project's patient matching maturity model, indicating "innovation, ongoing optimization, and senior management active involvement."

Milestone Criteria	Future State	Timeline	Action Item
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	Expanded DCPDMP-EHR Integrations and DC PDMP-HIE integrations will support workflow and business process improvements.	1. N/A 2. N/A	1. In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP. 2. Training and technical assistance for organizations utilizing HIE services is ongoing.
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	Already implemented.	N/A	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	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.	1. N/A 2. N/A	1. 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. 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.
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	All implemented programs will benefit from increased utilization of and integration with the DC PDMP.	18 - 24 months	DC Health and DHCF will explore Streamlining communication between these programs and the DC PDMP.

Exhibit B.3: Monitoring Metrics for SUD Milestones, by Milestone

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	Milestone 1	Month	Quarterly	Increase	N
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period.	Milestones 1 and 2	Month	Quarterly	Increase	Y for Milestone 1 O for Milestone 2
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment.	Milestone 1	Year	Annually	Increase	Y
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period.	Milestone 2	Year	Annually	Increase	Y
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	Year	Annually	No more than 30 days	Y
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.	Milestone 4	Year	Annually	Consistent	Y
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.	Milestone 4	Year	Annually	Consistent	Y
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle	Milestone 5	Year	Annually	Consistent	Y

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
		cell disease diagnosis, or in hospice are excluded.					
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Year	Annually	Consistent	N
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Year	Annually	Consistent	N
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Year	Annually	Consistent	Y
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of emergency department (ED) visits for SUD per 1,000 beneficiaries in the measurement period.	Milestone 5	Quarter	Monthly	Decrease	Y
27	Overdose death rate	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	Year	Annually	Decrease	Y

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: *Initiation of AOD Treatment*—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis *Engagement of AOD Treatment*—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Year	Annually	Increase	Y
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment SUB-3a: Patients who are identified with alcohol or drug disorder who receive a	Milestone 6	Year	Annually	Consistent	O (optional for the midpoint assessment purpose)

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
	[Joint Commission; NQF #1664]	prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.					
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported for within 7 and 30 days.	Milestone 6	Year	Annually	Consistent	Y
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported for within 7 and 30 days.	Milestone 6	Year	Annually	Consistent	Y
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Milestone 6	Year	Annually	Decrease	Y
3	Medicaid Beneficiaries with SUD Diagnosis (Screening)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement Period.	Assessment of need and qualification for SUD treatment services	Month	Quarterly	Increase	N

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period.	Assessment of need and qualification for SUD treatment services	Year	Annually	Increase	N
Q1	Number of active DC HIE behavioral health provider users	Number of active DC HIE behavioral health provider users.	Health IT	Month	Quarterly	Increase	N
S1	Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE	Number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE.	Health IT	Month	Quarterly	Increase	N
S2	Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE	Number of DC Medicaid-enrolled behavioral health care facilities/providers sending data to the HIE.	Health IT	Month	Quarterly	Increase	N
Q2	Number of behavioral health providers managed in provider directory	Number of behavioral health providers managed in provider directory.	Health IT	Month	Quarterly	Increase	N
Q3	Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days	Number of DC HIE behavioral health users who performed a patient care snapshot in the last 30 days.	Health IT	Month	Quarterly	Increase	N

Appendix C. SMI/SED Milestones, Implementation Plan Action Items, Monitoring Metrics

Exhibit C.1 lists the milestone criteria, future state, timeline and action items associated with each SMI/SED milestone, Financing Plan and Health IT Plan. Exhibit C.2 lists the monitoring metrics corresponding to the SMI/SED milestones along with their description, measurement period, reporting frequency, Demonstration target and an indicator of whether it is a critical metric.

Exhibit C.1: SMI/SED Milestones and Reporting Topics – Milestone Criteria, Future state, Timeline and Action Items

Milestone Criteria	Future State	Implementation Timeline	Action Item
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential 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	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.	N/A	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 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	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.	N/A	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

Milestone Criteria	Future State	Implementation Timeline	Action Item
licensing or certification and accreditation requirements			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	Stays for fee-for-service (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) 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.	N/A	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	Already implemented.	N/A	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	The District will require psychiatric hospitals to conduct the required psychiatric and other medical screenings.	12 - 18 months	The District will develop and issue rulemaking and other policies as necessary.
1.f Describe the state's approach to defining a 'short term stay for acute care in an IMD', as described above and as	N/A	N/A	N/A

Milestone Criteria	Future State	Implementation Timeline	Action Item
referenced in the State Medicaid Director Letter (page 12)			
1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	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.	N/A	No action needed.
Milestone 2: Improving Care Coordination and Transitioning 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	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.	1. 12 - 18 months 2. 12 - 18 months	1. DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. 2. 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.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available	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	1. 12 - 18 months 2. 12 - 18 months	1. DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. 2. DHCF will develop and issue rulemaking and other policies as necessary to ensure

Milestone Criteria	Future State	Implementation Timeline	Action Item
	supports, including housing, are to be assessed during the discharge planning process.		psychiatric hospitals and residential treatment settings assess beneficiaries' housing situations.
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	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.	1. 12 - 18 months 2. 12 - 18 months	1. DHCF and DBH will develop and issue rulemaking and other policies as necessary for the new transition planning service. 2. 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.
2.d Strategies to prevent or decrease lengths of stay in Emergency Departments (EDs) among beneficiaries with SMI or SED prior to admission	See Topic 3 for additional information on services that prevent the use of EDs, including non-hospital, non-residential crisis stabilization services.	N/A	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	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.	N/A	No action needed.
Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services			

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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 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	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).	1. N/A 2. 18 - 24 months 3. 18 - 24 months	1. DHCF will work with other District agencies to continually improve the data for future assessments. 2. 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. 3. 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).
3.b Financing plan – See additional guidance in Topic 5	See Topic 5 for additional information on the District's financing plan.	N/A	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	DBH plans to more systematically track open inpatient and crisis stabilization beds to facilitate more timely referrals.	18 - 24 months	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

Milestone Criteria	Future State	Implementation Timeline	Action Item
			will consider how to best improve tracking of bed availability.
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	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 Quality Improvement Organization (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.	18 - 24 months	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.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	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.	1. N/A 2. 18 - 24 months	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.
Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration			
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	As part of this demonstration, the District seeks to create a new reimbursement methodology for the Comprehensive Psychiatric Emergency Program (CPEP) and CRT mobile crisis and outreach services to more appropriately account for and value the services provided.	1. N/A 2. 18 - 24 months	1. 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.

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	As part of this demonstration, the District also seeks to provide vocational supported employment services to adults with SMI.		2. The District will develop and issue rulemaking and other policies as necessary to establish vocational supported employment services for adults with SMI.
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	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.	N/A	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	All Medicaid enrollees under 22 years of age will continue to be provided Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services without limitation and have access to Psychiatric Residential Treatment Facilities (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 Trauma Systems Therapy (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.	1. 12 - 18 months 2. N/A 3. 18 - 24 months	1. The District will develop and issue rulemaking and other policies as necessary regarding the enhanced reimbursement methodology for TST. 2. 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. 3. 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.

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	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.		
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	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.	N/A	No action needed.
Financing Plan			
5.a Increase availability of nonhospital, 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	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 demonstration also proposes adding coverage for psychiatric crisis stabilization services as a treatment alternative to psychiatric inpatient hospitalizations.	18 - 24 months	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

Milestone Criteria	Future State	Implementation Timeline	Action Item
			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.
5.b Increase availability of ongoing 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	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 TST—and	1. 18 - 24 months 2. 18 - 24 months 3. 12 - 18 months	1. 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. 2. DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care.

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	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.		3. 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.
Health IT Plan			
1.1 Closed loop referrals and referrals from physician/mental health provider to physician/mental health provider	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.	1. 18 - 24 months 2. 18 - 24 months	1. Support CRISP DC Direct implementation; sustain collaborations with DCPCA/DCHA and District HIEs via the e-referral collaborative. Ensure that acute care hospitals, IMDs, community-based behavioral health providers (e.g., MHRS providers, free-standing mental health clinics), and primary care providers are incorporated into these discussions and have access to relevant technologies. 2. 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.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	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.	18 - 24 months	Implement projects described in Section 1.1 and ongoing work with the DC Hospital Association.

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1.3 Closed loop referrals and e-referrals from physician/mental health provider to community-based supports	DC Access System (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.	18 - 24 months	Execute current workplans and timeline for DCAS deployment and CoRIE grant procurement. Continue efforts to facilitate interoperability between systems.
2.1 The state and its providers can create and use an electronic care plan	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.	12 - 18 months	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.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	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.	N/A	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

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			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	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), CNMC's HIE, 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.	18 - 24 months	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.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	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.	18 - 24 months	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.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	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 information across programs. Based on these data, in the event of a medical or social	18 - 24 months	DHCF to implement workplan for the HIE Core Capabilities and Connectivity Grants to expand access to the Encounter Notification Service (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

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	need–or emergency–providers with whom a client or beneficiary has a relationship will receive an alert.		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.
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).	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.	18 - 24 months	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.
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	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.	1. N/A 2. N/A	1. Implement HIE Core Capabilities and Connectivity grant work plans 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.

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	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.		2. 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.
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	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 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.	12 - 18 months	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.
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)	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	2020 - 2023	CRISP DC's work under the Core HIE grant is ongoing and will continue through 2023.

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	a formal Health Home or an informal arrangement with an MCO case manager. In fiscal year 2020, integration of Fire and Emergency Medical Service (EMS) data into the HIE will allow providers to be alerted via Encounter Notification Service (ENS) of ambulance visits, even if these Fire and EMS visits do not result in a transport or hospital encounter. Providing CRISP DC data to Fire and EMS providers at the point of care also has the potential to eliminate unnecessary or duplicative treatment plans.		
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	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.	1. FY2019 – FY2023 and FY2019 – FY2021 2. 18 - 24 months	1. 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. 2. 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

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			alerts for initial episodes of psychosis and training for providers to use alerts.
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	Per the Office of Civil Rights (OCR) Request for Information (RFI) in December 2018 on modifying HIPAA rules to improve coordinated care, 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.	N/A	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	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.	18 - 24 months	Implement workplan and timeline for MEIP program support and technical assistance, the HIE Core Capabilities Grant, and the HIE Connectivity grant. Maintain and evolve data and information exchange standards for value-based purchasing initiates.

Exhibit C.2: Monitoring Metrics for SMI/SED Milestones, by Milestone

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	Milestone 1	Year	Annually	Consistent	Y
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.	Milestone 1	Year	Annually	Consistent	O (optional for the midpoint assessment purpose)
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Year	Annually	Decrease	Y
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Year	Annually	Decrease	Y

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Year	Annually	Increase	N
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported for within 7 and 30 days after discharge.	Milestone 2	Year	Annually	Increase	Y
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported for within 7 and 30 days after discharge	Milestone 2	Year	Annually	Increase	Y
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported for within 7 and 30 days of the ED visit.	Milestone 2	Year	Annually	Increase	Y

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported for within 7 and 30 days of the ED visit.	Milestone 2	Year	Annually	Increase	Y
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	Year	Annually	Decrease	N
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	Year	Annually	Decrease	N
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Milestone 3	Month	Quarterly	Consistent	N
14	Mental Health Services Utilization - Intensive	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related	Milestone 3	Month	Quarterly	Increase	N

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
	Outpatient and Partial Hospitalization	to mental health during the measurement period.					
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Milestone 3	Month	Quarterly	Increase	N
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.	Milestone 3	Month	Quarterly	Decrease	N
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.	Milestone 3	Month	Quarterly	Increase	N
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Milestone 3	Month	Quarterly	Increase	N
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: (A) ALOS for all IMDs and populations, (B) ALOS among short-term stays (less than or equal to 60 days) and (C) ALOS among long-term stays (greater than 60 days).	Milestone 3	Year	Annually	No more than 30 days	Y
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	ALOS for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: (A) ALOS for all IMDs and populations, (B) ALOS among short-term	Milestone 3	Year	Annually	No more than 30 days	N

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
		stays (less than or equal to 60 days) and (C) ALOS among long-term stays (greater than 60 days).					
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.	Milestone 3	Year	Annually	Increase	N
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	Month	Quarterly	Increase	N
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.	Milestone 4	Year	Annually	Increase	N
26	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Year	Annually	Increase	Y
28	Alcohol Screening and Follow-up for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.	Milestone 4	Year	Annually	Increase	N
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: (A) Percentage of children and adolescents on	Milestone 4	Year	Annually	Consistent	Y

#	Metric Name	Metric Description	Milestone or Reporting Topic	Measurement Period	Reporting Frequency	Overall Demonstration Target	Critical Metric (Y/N/O)
		antipsychotics who received blood glucose testing, (B) Percentage of children and adolescents on antipsychotics who received cholesterol testing, (C) Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.					
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Year	Annually	Increase	Y

Appendix D. Round 1 Key Informant Interview Guides

Appendix D provides the Round 1 Key Informant Guides used for four group interviews. Section D.1 presents the guide for the Mental Health Services Key Informant Group. Section D.2 is the guide for the Substance Use Disorder Services Key Informant Group. Section D.3 is the Transition to Managed Care Key Informant Group. Lastly, Section D.4 is the Data Systems Key Informant Group.

D.1 Key Informant Interview Guide for Mental Health Services

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period leading up to the submission of your application to CMS for the 1115 waiver. Please focus on services for persons with SUD in Service Group 2, including IMD SUD residential, intake, assessment, and referral, medication assisted treatment, recovery support services, supported employment services, and other outpatient counseling.

1. From your perspective, what were the most significant needs and gaps with respect to SUD services in Service Group 2 for DC Medicaid beneficiaries prior to the Demonstration?

2. What were the biggest barriers to addressing these issues?

Topic 2. Changes Implemented as Part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the Demonstration. We have compiled a list of changes related to the delivery or payment for SUD services in Service Group 2 based on the District's Implementation Plans and other sources.

3. For each change, we'd like to hear about—
    - why this service is being targeted (the rationale for the change),
    - how much progress has been made on implementation to date, and
    - current or anticipated implementation challenges.

Changes related to expanding reimbursement or benefits for Service Group 2 under the Demonstration.
A. Reimbursement for residential and inpatient SUD treatment in IMDs and specifically reimbursement for short-term monitored withdrawal management delivered in an IMD
B. Reimbursement for transition management services, including for transition planning services for individuals being discharged from residential facilities
C. Removal of $1 copay for certain outpatient MAT prescriptions
D. Reimbursement for vocational and therapeutic supported employment for SUD
E. Reimbursement for independent licensed behavioral health clinicians providing SUD services

Demonstration-related changes intended to increase capacity.
F. Require assessment and referral services

Demonstration-related changes to improve quality.
G. Requirements for evidence-based assessment tools and practices
H. Require availability of MAT
I. Requirements to operationalize integrated, coordinated clinical care, particularly at care transitions a. Requirements for residential treatment settings to initiate contact within 72 hours of discharge with the beneficiary and community-based providers

4. Are there any other aspects of changes to the delivery or payment for Service Group 2 that we have not asked about?

Topic 3. Stakeholder Engagement

We are interested in how you have worked with plans and providers in rolling out the demonstration-related changes.

5. What type of stakeholder engagement (e.g., outreach, education, training, technical assistance) have you conducted with the following stakeholders related to demonstration-related changes focused on Service Group 2:
    a. Health plans
    b. Providers
    c. Beneficiaries
6. What, if any, other stakeholders have you involved in rolling out the demonstrated-related changes in Service Group 2?

Closing

7. Are you planning to make any changes related to Service Group 2 based on learnings from the first year of the Demonstration?
8. Before we end, is there anything else that you would like to share about the implementation of these Demonstration-related changes that we have not yet discussed?

Thank you for your time.

D.2 Key Informant Interview Guide for Substance Use Disorder Services

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period leading up to the submission of your application to CMS for the 1115 waiver. Please focus on services for persons with SUD in Service Group 2, including IMD SUD residential, intake, assessment, and referral, medication assisted treatment, recovery support services, supported employment services, and other outpatient counseling.

1. From your perspective, what were the most significant needs and gaps with respect to SUD services in Service Group 2 for DC Medicaid beneficiaries prior to the Demonstration?

2. What were the biggest barriers to addressing these issues?

Topic 2. Changes Implemented as Part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the Demonstration. We have compiled a list of changes related to the delivery or payment for SUD services in Service Group 2 based on the District's Implementation Plans and other sources.

3. For each change, we'd like to hear about—
    - why this service is being targeted (the rationale for the change),
    - how much progress has been made on implementation to date, and
    - current or anticipated implementation challenges.

Changes related to expanding reimbursement or benefits for Service Group 2 under the Demonstration.
F. Reimbursement for residential and inpatient SUD treatment in IMDs and specifically reimbursement for short-term monitored withdrawal management delivered in an IMD
G. Reimbursement for transition management services, including for transition planning services for individuals being discharged from residential facilities
H. Removal of $1 copay for certain outpatient MAT prescriptions
I. Reimbursement for vocational and therapeutic supported employment for SUD
J. Reimbursement for independent licensed behavioral health clinicians providing SUD services

Demonstration-related changes intended to increase capacity.
G. Require assessment and referral services

Demonstration-related changes to improve quality.
J. Requirements for evidence-based assessment tools and practices
K. Require availability of MAT
L. Requirements to operationalize integrated, coordinated clinical care, particularly at care transitions a. Requirements for residential treatment settings to initiate contact within 72 hours of discharge with the beneficiary and community-based providers

4. Are there any other aspects of changes to the delivery or payment for Service Group 2 that we have not asked about?

Topic 3. Stakeholder Engagement

We are interested in how you have worked with plans and providers in rolling out the demonstration-related changes.

5. What type of stakeholder engagement (e.g., outreach, education, training, technical assistance) have you conducted with the following stakeholders related to demonstration-related changes focused on Service Group 2:
    a. Health plans
    b. Providers
    c. Beneficiaries
6. What, if any, other stakeholders have you involved in rolling out the demonstrated-related changes in Service Group 2?

Closing

7. Are you planning to make any changes related to Service Group 2 based on learnings from the first year of the Demonstration?
8. Before we end, is there anything else that you would like to share about the implementation of these Demonstration-related changes that we have not yet discussed?

Thank you for your time.

D.3 Key Informant Interview Guide for Transition to Managed Care

Topic 1. Overview of Transition to Managed Care

We understand that the District transitioned a substantial number of Medicaid beneficiaries as of October 2020 and that these were largely adults with disabilities who are not dually enrolled in Medicare.

1. Can you provide an overview of the rationale behind the move and the selection of this group?
2. Did the Demonstration or related changes have any bearing on the transition? For example, how does the group of beneficiaries that were transitioned overlap or not with the beneficiaries targeted by the waiver?
3. What are the main service delivery or payment changes related to the transition? Are the services affected those covered or impacted under the Demonstration?
    3.1. For example, have there been any impacts on provider certification/payment processes when MCOs assume administration of SUD benefits?
    3.2. Were there services already covered by MCOs that were specifically targeted for expansion under the Demonstration?

Topic 2. Carve-out of Behavioral Services

Because the Demonstration is primarily focused on services for persons with SUD or SMI, we'd like to hear about the behavioral health services that are still covered on a fee-for-service basis (i.e., "carved out" of the MCO contracts).

4. Can you give an overview of the services that are still being provided on a FFS basis?
5. How does this set overlap with the set of services targeted under the Demonstration?
6. How do you think the overall transition to managed care and the carve-out of behavioral services will affect the achievement of the Demonstration goals?

Topic 3. Stakeholder Engagement

We are interested in how you have worked with plans and providers in rolling out the transition, particularly as there have been related changes from implementation of the Demonstration.

Let's start by talking about **plans**.

7. Have there been any challenges faced by the managed care plans with respect to the transition?
    7.1. What has worked well? What has worked less well in terms of plans' involvement?
    7.2. Has the Demonstration implementation affected the transition or vice versa?

Now let's talk about the roll-out to providers and their involvement in these changes.

8. Have there been challenges for the providers? We are particularly interested in providers serving SUD and SMI beneficiaries.
    8.1. What has worked well? What has worked less well for providers?
    8.2. How has the transition been experienced by different types of providers and settings?
    8.3. Has the Demonstration implementation had an effect on the transition or vice versa?
    8.4. Have there been any need for meetings or special communications?

Closing

9. Are you planning to make any additional changes related to the transition based on the initial transition or any overlap with the implementation of the Demonstration?
10. What are the most significant ways in which COVID-19 has influenced the transition to managed care?
11. Before we end, is there anything else that you would like to share about the transition and the interactions with the implementation of the Demonstration that we have not yet discussed?

Thank you for your time.

D.4 Key Informant Interview Guide for Data Systems

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period leading up to the submission of your application to CMS for the 1115 waiver.

1. From your perspective, what were the most significant needs and gaps with respect to health IT and data systems supporting delivery and payment for SUD, SMI, and SED services in for DC Medicaid beneficiaries prior to the Demonstration?
2. What were the biggest barriers to addressing these issues?
3. How did addressing these gaps play a role in the decision to apply for the 1115 waiver?

Topic 2. Demonstration-Related Strategies to Improve Health IT and Data Systems

The main focus of our discussion today is to understand the changes related to health IT and data systems that are being implemented as part of the Demonstration, specifically in terms of facilitating health IT adoption and interoperability. Because the Demonstration is primarily focused on services for persons with SUD or SMI, we'd like to hear primarily about strategies that would impact the delivery of and payment for behavioral health services.

4. Can you tell us about the strategies that have been used or are planned to motivate day-to-day use and utility of the District-wide Health Information Exchange in the Medicaid behavioral health system?
    - 4.1. Are there plans to expand the capabilities of the HIE?
    - 4.2. What about to expand use of the HIE among providers?
    - 4.3. How have providers responded to these efforts?
    - 4.4. What are some early successes and challenges that you have observed?
5. One of the goals of the Demonstration is to improve care coordination and transitions between levels of care. How do you envision using data systems to support those improvements?
    - 5.1. How have providers responded to these efforts?
    - 5.2. What are some early successes and challenges that you have observed?
6. What strategies are you using to expand use of the Prescription Drug Monitoring Program (PDMP)?
    - 6.1. How have providers responded to these efforts?
    - 6.2. What are some early successes and challenges that you have observed?
7. What changes are you planning to make to provider billing systems?
    - 7.1. How have providers responded to these efforts?

7.2. What are some early successes and challenges that you have observed?

Closing

8. What additional changes are being planned or strategies considered for expanding use of health IT in the District as part of the Demonstration?
9. Before we end, is there anything else that you would like to share about the use of health IT and data systems to support the goals of the Demonstration that we have not yet discussed?

Thank you for your time.

Appendix E. Round 1 Provider and Site Visit Interview Guides

Appendix E provides the Round 1 interview guides for providers (Section E.1) and site visits (Section E.2).

E.1 Provider Interview Guide

Topic 1. Background on organization

1. Please share a little about your title and responsibilities.
2. Please tell me a little about your organization.
    a. What are the main services that you offer?
    b. Are these services primarily offered for serious mental illness (SMI), serious emotional disturbance (SED), or substance use disorder (SUD)?
    c. What proportion of your clients are Medicaid beneficiaries?

Topic 2. Background and context for the Demonstration

We would like to start by asking you some questions about the period leading up to the submission of the District's application to CMS for the Demonstration.

3. From your perspective, what were the most significant needs and gaps in SMI, SED, and SUD services for DC Medicaid beneficiaries?
    a. How did these needs and gaps affect your organization and the delivery of services to beneficiaries with SMI/SED/SUD?
    b. What were the biggest barriers to addressing these issues?
4. What do you think of the Demonstration?
    a. Do you think the District has chosen the right levers or approaches to accomplish their goals?
    b. Are there other strategies they might have selected that might be more effective?
    c. Which strategies do you think will have the most impact on Medicaid beneficiaries?
5. How, if at all, has COVID-19 influenced your service delivery?

Topic 3. Changes implemented as part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the Demonstration that most affect how SMI/SED/SUD services are delivered at your organization.

6. What are the main changes in how you deliver services related to the Demonstration?

a. Please describe how these changes affect service delivery.
    i. From the perspective of your ability to deliver services, what are the positive and negative aspects of this change?
    ii. Have you/your staff received technical assistance in implementing changes?
    iii. How is it affecting beneficiaries and beneficiary access to behavioral health services?
    iv. How is it affecting provider participation and capacity?
    v. How is it affecting SMI, SED, and SUD quality of care and outcomes?
    vi. How effective have these changes been?
b. How has your contracting with health plans changed under the Demonstration?

7. Where are the areas that you have experienced the greatest challenges in implementing changes related to the Demonstration?

Topic 4. Implementation Progress and Impacts

Finally, we'd like to hear about your overall assessment of the Demonstration's progress and impact.

8. We also understand there are a number of other ongoing behavioral health initiatives in the District. Do any of these initiatives affect your organization or your clients?
    a. Which initiatives?
    b. How are they affecting your organization?
    c. How are they affecting your clients?
    d. To what extent are they similar to or conflicting with the Demonstration?
9. What is your overall assessment of the District's progress thus far?
    a. How effective have Demonstration-related changes been in improving behavioral health services?
    b. How do you see these impacts changing as the Demonstration activities continue?
10. What recommendations would you make for improving the Demonstration?

Closing

11. Before we end, is there anything about the implementation of the Demonstration thus far that I have neglected to ask?

E.2 Site Visit Interview Guide

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period prior to and leading up to the submission of the District's application to CMS for the 1115 waiver.

1. From your perspective, what were the most significant needs and gaps in SMI and SUD services for DC Medicaid beneficiaries?
    a. How did these needs and gaps affect your organization and the delivery of services to beneficiaries with SMI/SUD?
    b. What were the biggest barriers to addressing these issues?

2. Do you think the District has chosen the right levers or approaches to accomplish their goals?
    a. Are there other strategies they might have selected that might be more effective?

3. How, if at all, has COVID-19 influenced the demonstration or the behavioral health service delivery system?

Topic 2. Changes Implemented as Part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the demonstration that most affect how SMI/SUD services are delivered here at [NAME OF SITE].

4. What are the main changes in how you deliver services related to the waiver?

    a. Please describe how the change affects service delivery? From the perspective of your ability to deliver services, what are the positive and negative aspects of this change?
        i. How is it affecting beneficiaries and beneficiary access to behavioral health services?
        ii. How is it affecting provider participation and capacity?
        iii. How is it affecting SMI and SUD quality of care and outcomes?

5. *[If needed]*

    a. How has your approach to identification of and assessment of beneficiaries' need for behavioral health services changed?
        i. How effective have these changes been?

    b. How has the approach to care coordination and managing transitions between levels of care changed?

i. How effective have these changes been?
    1. How has your communication with other providers been affected?
    2. For beneficiaries that you provide care to, how has your understanding of the full range of services received changed?
    3. How has the referral process changed?

c. How has your approach to patient screening changed?
    i. How effective have these changes been?
    ii. Have you/your staff received technical assistance in implementing changes? [If yes], how helpful has the TA been? [If no], was it offered to your members?

d. How has reimbursement for the services your organization provides changed?
    i. Are those changes affecting your ability to provide services?
    ii. Do you see any changes from the beneficiary's perspective in access to services related to reimbursement changes?

e. How has contracting with plans changed under the demonstration?
    i. [if needed] how does this relate to/interact with transition from FFS to managed care that has taken place?

f. How has access to care for beneficiaries with SUD and SMI been affected?
    i. [if needed] how does this relate to/interact with transition from FFS to managed care that has taken place?

6. We also understand there are a number of ongoing health initiatives in the District. Do any of these initiatives affect the populations served by your members? Which initiatives? [if needed, ask which initiatives have largest impact to narrow down number]

   [FOR ANY INITIATIVES MENTIONED]:

   a. Are these the same beneficiaries targeted by the demonstration?
   b. How does this initiative affect your members?
   c. What are the interactions with the demonstration and your members' ability to support the demonstration's goals?

Topic 3. Implementation Challenges and Impacts

Finally, we'd like to hear about the challenges that your members have experienced, or are currently experiencing, in implementing changes related to the demonstration and your overall assessment of the demonstration's progress.

7. Where are the areas that [NAME OF SITE] has experienced the greatest challenges in implementing changes related to the demonstration?
    a. [*if needed*]: Can you tell me about why those areas have presented challenges? What would help overcome the challenges?

8. What is your overall assessment of the District's progress thus far?
    a. How effective have waiver-related changes been in improving behavioral health services?
        i. How have changes affected beneficiaries and beneficiary access to behavioral health services?
        ii. How have changes affected provider participation and capacity?
        iii. How have changes affected SMI and SUD quality of care and outcomes?
    b. How do you see these impacts changing as the waiver activities continue?

9. What recommendations would you make for improvement?

Closing

Before we end, is there anything about the implementation of the demonstration thus far that I have neglected to ask?

Thank you for your time.

Appendix F. Round 2 Key Informant Interview Guides

Appendix E provides the Round 2 Key Informant Guides used for three group interviews. Section F.1 presents the guide for the Health Plans Key Informant Group. Section F.2 is the guide for the Advocacy Organization Key Informant Group. Lastly, Section F.3 is the Health IT Stakeholders Key Informant Group.

F.1 Key Informant Interview Guide for Health Plans

1. Can you start by providing an overview of *[PLAN NAME]?*
   - How long have you contracted with DC Medicaid?
   - About how many enrollees do you have?
2. Now, could each of you please share a little about your position and responsibilities at *[PLAN NAME]* as well as how those responsibilities relate to the Demonstration?

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period leading up to the submission of the District's application to CMS for the 1115 waiver.

3. From your perspective, what were the most significant needs and gaps in SUD, SED and SMI services for DC Medicaid beneficiaries?
4. How did these needs and gaps affect *[PLAN NAME]*'s operations?
5. What were the biggest barriers to addressing these issues?
6. What do you think of the changes the District is making as part of the Demonstration?

   [IF UNAWARE OF THE CHANGES, SHOW SECONDARY DRIVERS]
   - Do you think the District has chosen the right levers or approaches to accomplish their goals?
     - Are there any strategies that you think are particularly important?
     - Are there any strategies that you think are unlikely to be effective?
     - What other strategies might be more effective?

Topic 2. Changes Implemented as Part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the Demonstration that most affect health plans and your operations.

7. What are the main ways in which the Demonstration is impacting *[PLAN NAME]*?

- What changes are affecting *[PLAN NAME]*?
- How is it affecting your operations?
- How is it affecting your enrollees and enrollees' access to behavioral health services?
    - What types of supports for enrollees have you implemented?
- How is it affecting your contracts and interactions with providers and provider networks?
    - What types of supports for providers have you implemented?
- How is it affecting your authorization of and payments for services?
- How is it effecting your approach to case management?

8. Where are the areas that *[PLAN NAME]* is experiencing or anticipating the greatest challenges in implementing changes related to the Demonstration?
    - Can you tell me about why those areas are presenting challenges?
    - What would help overcome the challenges?

Topic 3. Co-Occurring Initiatives

9. We understand that the District recently transitioned a substantial number of Medicaid beneficiaries from FFS to managed care as of October 2020 (largely adults with disabilities who are not dually enrolled in Medicare). This resulted in payment and delivery system changes but left many behavioral health services covered on a fee-for-service basis (i.e., "carved out" of the MCO contracts). How does this FY 2021 transition and these delivery system and payment changes impact *[PLAN NAME]*'s operations?
    - What are the changes in how you work with behavioral health providers? How are they affected by the changes?
    - What are the changes for beneficiaries, how are they affected?
10. How do you think the potential transition of additional populations to Medicaid managed care in the future (e.g., dually eligible beneficiaries) will impact the goals of the Demonstration?
11. How do you think the upcoming carve in of behavioral health services to managed care will impact the goals of the Demonstration?
12. We also understand there are a number of ongoing behavioral health initiatives in the District. Do any of these initiatives affect your organization?
    - Which initiatives?
        - How does this initiative affect you?
        - What are the interactions between this initiative and the changes you are making because of the Demonstration?

Topic 4. Implementation Challenges and Impacts

Our next and final topic that we would like to hear about is your overall assessment of the Demonstration's progress.

13. What is your overall assessment of the District's progress thus far?
    - How have changes affected beneficiaries and beneficiary access to behavioral health services?
    - How have changes affected provider Medicaid participation and capacity?
    - How have changes affected quality of behavioral health care and outcomes?
    - How have changes affected care coordination and care transitions?
    - How have changes affected the integration of behavioral health and physical health care?
14. How do you see these impacts changing as the Demonstration continues?
15. What challenges do you anticipate the District will face in achieving the goals of the Demonstration?
16. What recommendations would you make for improvements to the Demonstration?
17. How, if at all, has COVID-19 influenced the Demonstration or the behavioral health service delivery system?

Closing

18. Before we end, is there anything about the implementation of the Demonstration thus far that we have neglected to ask?

Thank you for your time.

F.2 Key Informant Interview Guide for Advocacy Organizations

1. To start, please provide an overview of your organization.
   1.1. How long have you been in existence?
   1.2. How many members do you have?
   1.3. What are the main ways your organization is involved in behavioral health services in the District?
   1.4. How have you been involved in the Demonstration thus far?
2. Now, could each of you please share a little about your position and responsibilities as well as any specific responsibilities related to the Demonstration?

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

We would like to start by asking you some questions about the period leading up to the submission of the District's application to CMS for the 1115 waiver.

3. From your perspective, what were the most significant needs and gaps in SUD, SED and SMI services for DC Medicaid beneficiaries?
4. How did these needs and gaps affect your organization's members?
5. What were the biggest barriers to addressing these issues?
6. What do you think of the changes the District is making as part of the Demonstration?

   [IF UNAWARE OF THE CHANGES, SHOW SECONDARY DRIVERS]

   - Do you think the District has chosen the right levers or approaches to accomplish their goals?
     - Are there any strategies that you think are particularly important?
     - Are there any strategies that you think are unlikely to be effective?
     - What other strategies might be more effective?

Topic 2. Changes Implemented as Part of the Demonstration

The main focus of our discussion today is to understand the changes that are being implemented as part of the demonstration that most affect your organization's members.

7. What are the main ways in which the waiver is impacting your members?
   - How has their approach to identification and assessment of beneficiaries' need for behavioral health services changed?

- How has the type of services they provide changed?
- How has their approach to care coordination and managing transitions between levels of care changed?
- How has their reimbursement for the services they provide changed?
    - Are those changes affecting their ability or willingness to provide services? Why or why not?
- How has their contracting with plans changed?
- How has their use of health information technology, such as the health information exchange, EHRs systems, and telehealth, changed?
- What types of changes do you think a beneficiary might notice?

8. Have your members received technical assistance in implementing changes?

    8.1. *[IF YES]* Who provided that TA? How helpful has the TA been?

    8.2. *[IF NO]* Was it offered to your members?

Topic 3. Co-Occurring Initiatives

9. We understand that the District recently transitioned a substantial number of Medicaid beneficiaries from FFS to managed care as of October 2020 (largely adults with disabilities who are not dually enrolled in Medicare). This resulted in payment and delivery system changes but left many behavioral health services covered on a fee-for-service basis (i.e., "carved out" of the MCO contracts). How does this FY 2021 transition and these delivery system and payment changes impact your members?
10. How do you think the potential transition of additional populations to Medicaid managed care in the future (e.g., dually eligible beneficiaries) will impact the goals of the Demonstration?
11. How do you think the upcoming carve in of behavioral health services to managed care will impact the goals of the Demonstration?
12. We also understand there are a number of ongoing behavioral health initiatives in the District. Do any of these initiatives affect your members?
    - Which initiatives?
        - How does this initiative affect your members?
        - What are the interactions between this initiative and the changes your members are making because of the Demonstration?

Topic 4. Implementation Challenges and Impacts

Our next and final topic that we would like to hear about is your overall assessment of the Demonstration's progress.

13. What is your overall assessment of the District's progress thus far?
    - How have changes affected beneficiaries and beneficiary access to behavioral health services?
    - How have changes affected provider Medicaid participation and capacity?
    - How have changes affected quality of behavioral health care and outcomes?
    - How have changes affected care coordination and care transitions?
14. How do you see these impacts changing as the Demonstration continues?
15. What challenges do you anticipate the District will face in achieving the goals of the Demonstration?
16. How, if at all, has COVID-19 influenced the Demonstration or the behavioral health service delivery system?
17. What recommendations would you make for improvements to the Demonstration?

Closing

18. Before we end, is there anything about the implementation of the Demonstration thus far that I have neglected to ask?

Thank you for your time.

F.3 Key Informant Interview Guide for Health IT Stakeholders

1. To start, can you please tell me about the HIE?
    1.1. What are the key services you provide to the District and its providers?
    1.2. What type and about how many providers are participating in the HIE?
    1.3. Do providers typically participate fully (for example, are participating providers sharing and accessing all the information and services that are available through the HIE)? If no, what level participation is most common?
    1.4. When did the HIE first become involved in the Demonstration?
    1.5. How has the HIE been involved in the Demonstration thus far?
2. What is your role in the HIE and relative to the Demonstration?

Topic 1. Background and Context for the 1115 Behavioral Health Waiver

3. How does the HIE help to facilitate the goals of the Demonstration?
    3.1. How does the HIE help to facilitate care coordination and transitions in care?
    3.2. How does the HIE help to facilitate the integration of behavioral health and physical health care?

Topic 2. Implementation Challenges and Impacts

4. What is your overall assessment of the District's progress in leveraging the HIE to achieve Demonstration goals thus far?
5. What strategies have been used or are planned to motivate day-to-day use and utility of the HIE in the DC Medicaid behavioral health delivery system?
6. What challenges to using the HIE in the DC Medicaid behavioral health delivery system have you heard about?
7. What strategies have been used to overcome these challenges?
8. What challenges do you anticipate the District will face in leveraging Health IT to achieve Demonstration goals?
9. What recommendations would you make for improvements to the Demonstration?
    - How can the Demonstration better leverage Health IT to achieve Demonstration goals?

Closing

10. Before we end, is there anything about the health IT aspects of the Demonstration that you would like to share that we have not talked about?

Thank you for your time.

Appendix G. Beneficiary Survey

Appendix G presents an example of the survey that beneficiaries completed.

DC Medicaid Health Care Survey

Survey Instructions

DC Medicaid is doing a survey to understand what you think of the program and what care you need. You may also know the program as fee-for-service Medicaid, DC Healthy Families or free health insurance from AmeriHealth Caritas, MedStar Family Choice, or CareFirst Community Health Plan. The goal is to help people who have DC Medicaid get the health care they need.
This survey will ask you some questions about what kind of services you need, if you have been able to get those services, and what you think of the services you have received. Answer each question by marking the box to the left of your answer.
You are sometimes told to answer follow up questions based on how you answer a question. When this happens, you will see an arrow with a note that tells you what question(s) to answer next, like this:

- ☐ Yes ➔ If Yes, answer question 1b ➔
- ☐ No

We have included a postage paid envelope that you may use to return the survey free of charge. After you have finished the survey, place it in the envelope that was provided, seal the envelope, and mail it to IMPAQ International (the company that is conducting the survey for DC Medicaid):
IMPAQ International
10420 Little Patuxent Pkwy, Suite 300
Columbia, MD 21044
If you want to know more about the survey, please call XXX-XXX-XXXX or email dhcf.waiversurvey@dc.gov.

Medicaid Enrollment

1. Are you currently enrolled in DC Medicaid? You may also know it as fee-for-service Medicaid, DC Healthy Families or free health insurance provided by AmeriHealth Caritas, MedStar Family Choice, or CareFirst Community Health Plan.
   ☐ Yes
   ☐ No
   ☐ I am not sure

Personal or Family Counseling

People can get counseling, treatment or medicine for many different reasons, such as:

- For feeling depressed, anxious, or "stressed out"
- Personal problems (like when a loved one dies or when there are problems at work)
- Family problems (like marriage problems or when parents and children have trouble getting along)
- Traumatic events (like an accident, a death in the family, domestic violence, or a violent attack)
- Needing help with drug or alcohol use
- For mental or emotional illness

Please think about these kinds of services as you answer the following questions.

2. In the last 12 months, have you felt you wanted or needed counseling or treatment for drug or alcohol use?
   ☐ No
   ☐ Yes ➔ **If Yes, answer question 2a** ➔

2a. Were you able to get all the services you wanted or needed related to counseling or treatment for drug or alcohol use?
   ☐ Strongly agree
   ☐ Agree
   ☐ Neither agree or disagree
   ☐ Disagree ➔ **If Disagree, answer question 2b** ➔
   ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 2b** ➔

2b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to counseling or treatment for drug or alcohol use? Please select all that apply.

☐ I did not know where to go.
☐ I did not have transportation to get there.
☐ The place was not open when I could get there.
☐ I could not get an appointment as soon as I needed one.
☐ I could not find a provider who would take my Medicaid.
☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed).
☐ Co-pay at office/clinic cost too much.
☐ Co-pay at the hospital cost too much.
☐ Co-pay for medicine cost too much.
☐ Another cost prevented me from getting the services I wanted or needed.
What cost?
☐ There was another reason I didn't get the services I wanted or needed.
What reason?

3. In the last 12 months, have you felt you wanted or needed counseling or treatment for a traumatic event?
☐ No
☐ Yes ➔ **If Yes, answer question 3a ➔**

3a. Were you able to get all the services you wanted or needed related to counseling or treatment for a traumatic event?
☐ Strongly agree
☐ Agree
☐ Neither agree or disagree
☐ Disagree ➔ **If Disagree, answer question 3b ➔**
☐ Strongly disagree ➔ **If Strongly Disagree, answer question 3b ➔**

3b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to counseling or treatment for a traumatic event? Please select all that apply.

☐ I did not know where to go.

- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed).
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  [ ]
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  [ ]

4. In the last 12 months, have you felt you wanted or needed counseling or treatment for emotional or mental health?

- ☐ No
- ☐ Yes ➔ **If Yes, answer question 4a ➔**

4a. Were you able to get all the services you wanted or needed related to counseling or treatment for emotional or mental health?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree ➔ **If Disagree, answer question 4b ➔**
- ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 4b ➔**

4b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to counseling or treatment for emotional or mental health? Please select all that apply.

- ☐ I did not know where to go.
- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed).
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  _____
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  _____

5. In the last 12 months, have you felt you wanted or needed emergency care without going to a hospital emergency room when you were having a crisis or needed urgent help related to drug or alcohol use or mental health?

- ☐ No
- ☐ Yes ➔ **If Yes, answer question 5a** ➔

5a. Were you able to get all the services you wanted or needed related to emergency care without going to a hospital emergency room when you were having a crisis or needed urgent help related to drug or alcohol use or mental health?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree ➔ **If Disagree, answer question 5b** ➔
- ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 5b** ➔

5b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to emergency care without going to a hospital emergency room when you were having a crisis or needed urgent help related to drug or alcohol use or mental health? Please select all that apply.

- ☐ I did not know where to go.
- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed)
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  _____
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  _____

6. In the last 12 months, have you felt you wanted or needed some place to go during the day to be with people, meet people who also want help with their drug or alcohol use or mental health, or connect with people for social support?

- ☐ No
- ☐ Yes ➔ **If Yes, answer question 6a ➔**

6a. Were you able to get all the services you wanted or needed related to some place to go during the day to be with people, meet people who also want help with their drug or alcohol use or mental health, or connect with people for social support?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree ➔ **If Disagree, answer question 6b ➔**
- ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 6b ➔**

6b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to some place to go during the day to be with people, meet people who also want help with their drug or alcohol use or mental health, or connect with people for social support? Please select all that apply.

- ☐ I did not know where to go.
- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed)
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  [ ]
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  [ ]

7. In the last 12 months, have you felt you wanted or needed prescription medicine to help you detox or stay off drugs or alcohol?

- ☐ No
- ☐ Yes ➔ **If Yes, answer question 7a ➔**

7a. Were you able to get all the services you wanted or needed related to prescription medicine to help you detox or stay off drugs or alcohol?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree ➔ **If Disagree, answer question 7b ➔**
- ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 7b ➔**

7b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to prescription medicine to help you detox or stay off drugs or alcohol? Please select all that apply.

- ☐ I did not know where to go.
- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed).
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  [ ]
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  [ ]

8. In the last 12 months, have you felt you wanted or needed prescription medicine for your mental health?

- ☐ No
- ☐ Yes ➔ **If Yes, answer question 8a ➔**

8a. Were you able to get all the services you wanted or needed related to prescription medicine for your mental health?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree ➔ **If Disagree, answer question 8b ➔**
- ☐ Strongly disagree ➔ **If Strongly Disagree, answer question 8b ➔**

8b. Which of the following, if any, was a reason that you did not get the services you wanted or needed related to prescription medicine for your mental health? Please select all that apply.

- ☐ I did not know where to go.
- ☐ I did not have transportation to get there.
- ☐ The place was not open when I could get there.
- ☐ I could not get an appointment as soon as I needed one.
- ☐ I could not find a provider who would take my Medicaid.
- ☐ COVID-19 (For example, I did not feel comfortable going out or the place I wanted to go was closed).
- ☐ Co-pay at office/clinic cost too much.
- ☐ Co-pay at the hospital cost too much.
- ☐ Co-pay for medicine cost too much.
- ☐ Another cost prevented me from getting the services I wanted or needed.
  What cost?
  [ ]
- ☐ There was another reason I didn't get the services I wanted or needed.
  What reason?
  [ ]

DC Medicaid, which is also called DC Healthy Families, is making some changes to the benefits that they offer. You may also know it as fee-for-service Medicaid or free health insurance provided by AmeriHealth Caritas, MedStar Family Choice, or CareFirst Community Health Plan. We want to understand whether people who have DC Medicaid know about these changes. The next set of questions will help us understand that.
Do you think the following statements are true or false?

9. If I were having crisis or urgent problem related to my drug or alcohol use or mental health, I would know how to get help without having to go to the emergency room (ER) or the hospital.

☐ Don't Know
☐ False
☐ True ➔ **If True, answer question 9a** ➔

9a. How would you get help?

10. If my doctor prescribes medicine to help me stay off alcohol or drugs, I will have to pay for the medicine.

☐ Don't Know
☐ False
☐ True ➔ **If True, answer question 10a** ➔

10a. About how much do you think you would have to pay?

11. I can get help finding a job through my health care providers. When thinking about your health care providers, please include doctors, nurses, counselors, case workers, and anyone else who helps you with your drug or alcohol use or mental health.

☐ Don't Know
☐ False
☐ True ➔ **If True, answer question 11a ➔**

11a. Have you used this help?

☐ No
☐ Yes ➔ **If Yes, answer question 11b ➔**

11b. How helpful was it?

☐ Very helpful
☐ Somewhat helpful
☐ A little helpful
☐ Not at all helpful
☐ Don't know

Care Coordination and Integration

Thinking about the services you have received from different health care providers or places for your drug or alcohol use or mental health, how often was each of the following statements true for you during the past 12 months? When thinking about your health care providers, please include doctors, nurses, counselors, case workers, and anyone else who helps you with your drug or alcohol use or mental health.

12. How often did you know whom to ask when you had questions about your counseling or treatment for drug or alcohol use or mental health?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always

13. How often were you given confusing information about your counseling or treatment for drug or alcohol use or mental health?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always

14. How often did you know what the next step in your care would be for your counseling or treatment for drug or alcohol use or mental health?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always

15. How often did the providers who help you with your drug or alcohol use or mental health know about the medical care you received for any physical health problems you have such as illness or injuries?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always
    - ☐ Does not apply; I do not have any physical health problems

16. How often did the providers who help you with medical care for your physical health problems, such as illness or injuries, know about the counseling, treatment or medicine you received for your drug or alcohol use or mental health?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always
    - ☐ Does not apply; I do not have any physical health problems

17. How often did you receive both physical health care (such as checkups and treatment for being sick) and help for your drug or alcohol use or mental health from the same provider or place?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always
    - ☐ Does not apply; I do not have any physical health problems

INPATIENT STAY EXPERIENCES

Our records indicate that you had a hospital visit for your drug or alcohol use or mental health in the past year.

18. Before you left the hospital, were you given information about how to get help in a crisis, or when urgent help was needed?
    - ☐ Yes, I was given all of the information I needed
    - ☐ I was given information but not all of my questions were answered
    - ☐ No, I was not given any information at all
    - ☐ Not sure
    - ☐ Not applicable. I did not have a hospital visit for this reason in the past year.

19. Have you been contacted by a health care provider since you left the hospital to discuss follow-up care?
    - ☐ Not Sure
    - ☐ No
    - ☐ Yes ➔ **If Yes, answer question 19a ➔**

19a. About how long after you left the hospital were you contacted to discuss follow-up care?
- ☐ Within 3 days
- ☐ Between 4 and 7 days
- ☐ Between 8 and 14 days
- ☐ Between 14 and 30 days
- ☐ More than 30 days
- ☐ Not sure

RESIDENTIAL REHABILITATION CENTER STAY EXPERIENCES

Our records indicate that you stayed in a rehab center for your drug or alcohol use in the past year.

20. Before you left the rehab center, were you given information about how to get help in a crisis, or when urgent help was needed?
    - ☐ Yes, I was given all of the information I needed
    - ☐ I was given information but not all of my questions were answered
    - ☐ No, I was not given any information at all
    - ☐ Not sure
    - ☐ Not applicable. I did not have a hospital visit for this reason in the past year.

21. Have you been contacted by a health care provider since you left the rehab center to discuss follow-up care?
    - ☐ Not Sure
    - ☐ No
    - ☐ Yes ➔ **If Yes, answer question 21a** ➔

21a. About how long after you left the rehab center were you contacted to discuss follow-up care?
- ☐ Within 3 days
- ☐ Between 4 and 7 days
- ☐ Between 8 and 14 days
- ☐ Between 14 and 30 days
- ☐ More than 30 days
- ☐ Not sure

Completing Treatment

How often was the following statement true for you during the past 12 months? When thinking about your health care providers, please include doctors, nurses, counselors, case workers, and anyone else who helps you with your drug or alcohol use or mental health.

22. I was unable to do what was necessary to follow my health care provider's treatment plans.

- ☐ Never
- ☐ Sometimes ➔ **If Sometimes, answer questions 22a and 22b ➔**
- ☐ Usually ➔ **If Usually, answer questions 22a and 22b ➔**
- ☐ Always ➔ **If Always, answer questions 22a and 22b ➔**

22a. When you were unable to do what the health care provider told you to do, how often was it because you could not pay for something, such as follow-up visits, medicine or supplies?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

22b. When you were unable to do what the health care provider told you to do, how often was it because you could not get an appointment you needed for follow-up care?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

Care Experiences

23. In the last 12 months, how much were you helped by the counseling or treatment you got?
- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ A lot

24. Does your language, race, religion, ethnic background or culture make any difference in the kind of counseling or treatment you need?
- ☐ No
- ☐ Yes ➔ **If Yes, answer question 24a** ➔

24a. In the last 12 months, was the care you received responsive to those needs?
- ☐ No
- ☐ Yes

25. In the past 12 months, have you used telemedicine (health care visit over video or phone) to get help with your drug or alcohol use or mental health?
- ☐ No
- ☐ Yes ➔ **If Yes, answer questions 25a, 25b, 25c, and 25d** ➔

When answering these next questions, please think about the telemedicine you used to get help with your drug or alcohol use or mental health. Tell us how much you agree or disagree with the following statements.

25a. The telemedicine visit was as good as an in-person visit.
- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree or Disagree
- ☐ Disagree
- ☐ Strongly Disagree

25b. Telemedicine made it easier for me to see a healthcare provider.
- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree or Disagree
- ☐ Disagree
- ☐ Strongly Disagree

25c. I find telehealth an acceptable way of receiving care.

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree

25d. I felt comfortable talking about my healthcare issues using telehealth services.

☐ Strongly Agree
☐ Agree
☐ Neither Agree or Disagree
☐ Disagree
☐ Strongly Disagree

How could the drug or alcohol use or mental health services you have received over the last 12 months be improved?

26. What have been some of the most helpful things about the drug or alcohol use and mental health services you have received over the last 12 months?

Health Status

26. In general, how would you rate your overall physical health?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

27. In general, how would you rate your overall mental health?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

28. In general, how would you rate your ability to keep from using drugs or alcohol?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

29. How much has your physical health been affected by COVID-19?
    - ☐ Not at all
    - ☐ A little
    - ☐ Somewhat
    - ☐ A lot

30. How much has your mental health been affected by COVID-19?
    - ☐ Not at all
    - ☐ A little
    - ☐ Somewhat
    - ☐ A lot

31. How much has your ability to keep from using drugs or alcohol been affected by COVID-19?
    - ☐ Not at all
    - ☐ A little
    - ☐ Somewhat

- ☐ A lot

32. Compared to 12 months ago, how would you rate your ability to deal with daily problems now?
    - ☐ Much better
    - ☐ Somewhat better
    - ☐ About the same
    - ☐ Somewhat worse
    - ☐ Much worse

33. Compared to 12 months ago, how would you rate your ability to accomplish the things you want to do now?
    - ☐ Much better
    - ☐ Somewhat better
    - ☐ About the same
    - ☐ Somewhat worse
    - ☐ Much worse

34. Compared to 12 months ago, how would you rate your problems or symptoms now?
    - ☐ Much better
    - ☐ Somewhat better
    - ☐ About the same
    - ☐ Somewhat worse
    - ☐ Much worse

35. Because of a physical, mental, or emotional condition lasting 6 months or more, do you have any difficulty working at a job or business?
    - ☐ Yes
    - ☐ No

Tell Us About You

36. What is the highest grade or level of school that you have completed?
    - ☐ Never attended school or only attended kindergarten
    - ☐ Grades 1 through 8 (Elementary)
    - ☐ Grades 9 through 11 (Some high school)
    - ☐ Grade 12 or GED (High school graduate)
    - ☐ College 1 year to 3 years (Some college or technical school)
    - ☐ College 4 years or more (College graduate)

37. What is your current employment status?

- ☐ Working for pay
- ☐ Unemployed – Not working for pay but looking for paid work
- ☐ Not working for pay but not looking for paid work

38. Are you Hispanic, Latino, or Spanish origin?
    - ☐ Yes
    - ☐ No

39. What is your race? Select all that apply.
    - ☐ White
    - ☐ Black or African-American
    - ☐ American Indian or Alaska Native
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Asian
    - ☐ Some Other Race

40. What is your current marital status?
    - ☐ Single, never married
    - ☐ Married or living with a partner
    - ☐ Separated, divorced, or widowed

41. What is your living situation today?
    - ☐ I have a steady place to live.
    - ☐ I have a place to live today, but I am worried about losing it in the future.
    - ☐ I do not have a steady place to live.

42. Please select whether this statement is often true, sometimes true, or never true for you and your household. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true

Thank you for taking the time to complete this survey. Your input is very valuable!

About the American Institutes for Research

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