Supporting Documentation:
MCAC Health System Re-Design (HSR) Subcommittee July 2025 Proposals
Compilation of Feedback from Housing, Nutrition, and Reentry Breakout Discussion Groups

Table of Contents

Section 1. Housing

A. Rent/temporary housing for up to 6 months and related utility assistance

Service Description:	• Participants discussed that DC Medicaid beneficiaries require a range of housing options including emergency, temporary, and long-term housing. • Participants suggested reviewing current long-term subsidized housing options to determine best approach for new DC Medicaid short-term benefit. • Participants suggested including case management, employment services, and vocational activities as paired housing supports particularly for a transitional living/enhanced shelter benefit, similar to Arizona's. • Participants discussed that on-site clinical coverage is not usually available in existing transitional housing programs but that referrals to clinical services is usually facilitated through case management. • Participants suggested employment services and other activities to promote long-term housing stability as paired housing supports particularly for a rent/temporary housing benefit, similar to Oregon's.
Beneficiary Eligibility Criteria:	• Participants suggested eligibility criteria include those at-risk of homelessness to help them remain in their current residences and reduce the number of newly unhoused beneficiaries. • Participants suggested reviewing E-RAP eligibility criteria.
Frequency:	• Participants discussed that CMS has limited frequency to a maximum of 6 months per demonstration period (i.e. 5 years).
Duration:	• Participants discussed that CMS has limited services to a maximum of 6 months.
Setting:	• Nothing was explicitly discussed.
Provider Staffing Qualifications:	• Participants suggested reviewing current training requirements for DC housing facilities and staff.
Staffing Ratio/Caseload:	• Participants discussed that increasing subsidized housing capacity remains a priority and suggested staffing requirements for a new DC Medicaid benefit do not inadvertently limit resources further.
Other Considerations:	• Nothing was explicitly discussed.

B. Short-term pre-procedure and/or post-hospitalization housing services (aka "medical respite")

Service Description:	• Short-term residential care for individuals who no longer require hospitalizations but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. Allow individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services. Includes interim housing with bed and meals and ongoing monitoring of the individual's medical and/or behavioral health conditions. (California definition)
	• DC's service description should consider:
	  ○ The role of care coordination and linkage to social service support and case management (e.g. housing), other medical services, and mental/behavioral health pathways; should be clear what the District intends to solve.
	  ○ Standard of care guidelines developed by respite organizations and the various medical support personnel needed to fulfill clinical standards.
	  ○ Beneficiary satisfaction with care (e.g. shared space vs private room), as well as the role of respite care in preventing beneficiary hospitalization.
	  ○ A participant suggested including enabling medical services, such as nursing care and medical care coordination, as allowable components within stabilization supports provided during medical respite care. The participant noted that while physician visits are currently reimbursable under Medicaid, essential enabling services provided within existing DC medical respite programs are not fully reimbursed but these services, including daily nursing care and medical coordination, are critical for the stability and recovery of individuals in medical respite.
	  ○ The participant emphasized the importance of distinguishing enabling medical services from general clinical services in the service description to ensure financial sustainability and appropriate care delivery. The participant suggested that language such as "enabling medical services (e.g. nursing and medical care coordination)" should be explicitly incorporated to support clarity during service implementation.
	• For behavioral health focused medical respite programs:
	  ○ A participant recommended that the step-down model transition clients from ASAM level 3.5 to 3.1 care, allowing for community engagement, such as employment or educational training, after 60 to 90 days. Support for women with children was highlighted, with daycare options noted as an important resource to address caregiving challenges.
	  ○ Several participants suggested extending program support for an additional 90 days post-transition from the respite facility. Partnerships with community-based organizations and key stakeholders were proposed to expand treatment coverage and services. Expanding residential treatment programs was also recommended to help reduce relapse and readmission cycles.
	  ○ Incorporating a peer-to-peer support program through Chapter 63 was proposed to enhance member engagement and positive outcomes.

Beneficiary Eligibility Criteria:	• Individuals who are post-hospitalization or at risk of hospitalization and meet the HUD definition of homeless or at risk of homelessness, have housing that would jeopardize their health and safety without modifications, or who live alone with no formal support. (California definition)

	• DC's beneficiary eligibility criteria should consider:
	  ○ Respite care for families (the whole unit being housed together), pregnancy, and immediate post-partum care needs.
	  ○ Those who have housing that would jeopardize their health and safety without modifications or those who don't have adequate housing for their health and safety, though this could be cost-intensive to provide relative to providing service to those without any form of housing.
	• For behavioral health focused medical respite programs:
	  ○ It was noted that eligibility should prioritize members in need of housing, reentry support, substance abuse treatment, mental health services, or nutrition assistance. Specific focus areas suggested included women with children, female-centered programs, and individuals with opioid addiction.

Frequency:	• As needed. One participant suggested review after 90 days.
Duration:	• Participants suggested general interest in more than six months of care with intensive care management based on clinical standards and wrap-around case management that provides pathways to long-term housing. • For behavioral health focused medical respite programs, participants suggested developing a two-year plan to support transitions from residential SUD treatment, with a focus on women with children and female-specific programs.
Setting:	• In-person setting to provide skilled nursing services and some medical treatment with options for specialty care or PCP visits via telehealth. • Participants recommended that supportive housing address medical, dental and substance abuse needs while providing temporary housing solutions.
Provider Staffing Qualifications:	• Participants recommended reviewing best practices from other states, current operations in the District, and District licensure guidelines.
Staffing Ratio/Caseload:	• Participants recommended reviewing best practices from other states, current operations in the District, and District licensure guidelines.
Other Considerations:	• A participant suggested that discharge planning begins at program entry to outline the scope and stages of care, addressing housing, medical conditions, and chemical dependency to reduce recidivism and improve outcomes. • Participants highlighted the need for additional beds to support clients with medical or mental health conditions. Limited space for individuals with substance use disorders and co-occurring medical needs was identified as a challenge, with structured care models proposed to address these gaps.

C. Housing navigation services

Service Description:	• Participants suggested aligning 1115 waiver housing navigation and pre-tenancy services with the existing Housing Supportive Services (HSS) benefit, including:
	  ○ Housing search, including identification of suitable supportive or transitional housing
	  ○ Identification of resources or income for housing (this being more challenging and intensive than HSS for low-income beneficiaries without a matched housing resource)
	  ○ Obtaining documents need to secure housing
	  ○ Assistance with housing applications and communication with prospective housing placements, including gathering clinical information to support placement in higher levels of care, such as assisted living and community residential facilities
	  ○ Assisting with move-in and transition needs, including food, clothing, and household furnishings (this could alternatively be covered in the separate one-time transition and moving costs 1115 service)
	  ○ Support with securing any supportive services that are needed, such as home health or assertive community treatment
	  ○ Assist with linking to resources and supports to address behavioral health, medical needs, and social determinants of health
	• Participants noted that housing navigation services are more intensive and time-limited than pre-navigation services because they are linked to care transitions and urgent supportive housing needs.
	• Several participants stated that care coordination for medical, behavioral health, and social needs is necessary and must be provided to enable housing search.
	• Several participants noted comprehensive assessment and intake are necessary to develop an appropriate housing plan.

Beneficiary Eligibility Criteria:	• Participants suggested a wide range of beneficiaries that would benefit from the service, including the following groups: Medicaid beneficiaries, unhoused/risk of homelessness, transfer from foster care, emergent housing, and care transitions. • Participants suggested that priority populations include individuals requiring reentry support, substance use treatment, or mental health services, with an additional focus on women with children and individuals recovering from opioid use.
Frequency:	• Participants noted that service intensity varies according to need, a minimum of weekly is likely needed but more frequent may be required to support very-low income or high acuity, for example, zero income or individuals that need long-term care.
Duration:	• Participants suggested that services would typically range from 30 to 90 days, with extensions up to 180 days based on individual circumstances, including: care transition, assistance with placement to higher levels of care, assistance for very low income, step-down services required for SUD recovery, medical necessity, and completion of the eligibility process.
Setting:	• Participants suggested aligning with existing HSS benefit which would include community and office-based.

	• Participants emphasized that services should be delivered in one of the following settings as part of discharge or transition planning: accredited community-based facilities with wrap-around services, medical respite facilities, residential (IMD) facilities
Provider Staffing Qualifications:	• Participants suggested that each program should include at least one Navigator, responsible for addressing SDOH-related needs, completing eligibility forms and reconsiderations, and implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines. • Participants also suggested care teams should include a physician or clinician to address additional health concerns and enhance service effectiveness. • Participants suggested professional experience should align with existing HSS benefit, including the role of individuals with lived experience.
Staffing Ratio/Caseload:	• Participants discussed how aligning with the existing HSS benefit may differ depending on the setting and intensity.
Other Considerations:	• Most group members suggested including an on-site physician or clinician within the program to address additional health concerns and enhance service effectiveness.

D. Pre-tenancy services

Service Description:	• Participants suggested aligning 1115 waiver housing navigation and pre-tenancy services with the existing Housing Supportive Services (HSS) benefit, including:
	  ○ Housing search, including identification of suitable supportive or transitional housing
	  ○ Identification of resources or income for housing (this being more challenging and intensive than HSS for low-income beneficiaries without a matched housing resource)
	  ○ Obtaining documents need to secure housing
	  ○ Assistance with housing applications and communication with prospective housing placements, including gathering clinical information to support placement in higher levels of care, such as assisted living and community residential facilities
	  ○ Assisting with move-in and transition needs, including food, clothing, and household furnishings
	  ○ Support with securing any supportive services that are needed, such as home health or assertive community treatment
	  ○ Assist with linking to resources and supports to address behavioral health, medical needs, and social determinants of health
	• Participants noted that pre-tenancy services that are not linked to a housing voucher resource may be more complex and time-intensive due to the shortage of appropriate housing for very low-income beneficiaries.
	• Several participants stated care coordination for medical, behavioral health, and social needs is necessary and must be provided to enable housing search.
	• Several participants noted comprehensive assessment and intake are necessary to develop an appropriate housing plan.

Beneficiary Eligibility Criteria:	• Participants suggested a wide range of beneficiaries that would benefit from the service, including the following groups: Medicaid beneficiaries, unhoused/risk of homelessness, transfer from foster care, emergent housing, and care transitions. • Participants suggested that priority populations include individuals requiring reentry support, substance use treatment, or mental health services, with an additional focus on women with children and individuals recovering from opioid use.
Frequency:	• Participants noted that service intensity varies according to need, a minimum of weekly is likely needed but more frequent may be required to support very-low income or high acuity, for example, zero income or individuals that need long-term care.
Duration:	• Participants noted that services would typically range from 30 to 90 days, with extensions up to 180 days based on individual circumstances.
Setting:	• Participants suggested aligning with existing HSS benefit which would include community and office-based.
Provider Staffing Qualifications:	• Participants suggested that each program should include at least one Navigator, responsible for addressing SDOH-related needs, completing eligibility forms and reconsiderations, and implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines. • Participants also suggested care teams should include a physician or clinician to address additional health concerns and enhance service effectiveness. • Participants suggested professional experience should align with existing HSS benefit, including the role of individuals with lived experience. • Participants suggested a nurse care manager for every 100 or more tenants with complex health needs to provide specialized support.
Staffing Ratio/Caseload:	• Participants discussed how aligning with the existing HSS benefit may differ depending on the setting and intensity.
Other Considerations:	• Nothing was explicitly discussed.

E. Tenancy-sustaining services

Service Description:	• Participants noted that 1115 waiver tenancy-sustaining services were largely aligned with the existing HSS benefit. • Participants noted that without a designated housing resource (matched voucher), assistance for individuals who are in danger of losing housing or need new placement may be more complex and time-intensive due to the shortage of appropriate housing for low-income beneficiaries. • Participants suggested that this service should be provided on a time-limited basis to prevent loss of housing to individuals not receiving HSS as a preventative service. • Participants noted that there are many housing units appropriate for high-need Medicaid beneficiaries that either fall outside the continuum of care (non-HUD CoC, non-Permanent Supportive Housing) or lack sustaining service funding, for example: 811 Capital Advance, HCV vouchers (DC Housing), Non-Elderly Disabled (NED), and nonprofits with affordable housing.

	○ Several participants suggested mapping these housing resources to explore whether 1115 housing services could expand housing options for Medicaid beneficiaries in care transitions. • Several participants stated care coordination for medical, behavioral health, and social needs is necessary and must be provided to enable housing to be maintained. ○ Participants suggested care coordination could be strengthened with CRISP/HIE to support better connection of health and housing supports. • Participants suggested housekeeping services may be necessary for high-need individuals to prevent loss of housing (for example to address behaviors such as hoarding or lack of hygiene that may result in eviction). • Several participants noted comprehensive assessment and intake are necessary to develop an appropriate housing plan.
Beneficiary Eligibility Criteria:	• Participants suggested a wide range of beneficiaries that would benefit from the service, including the following groups: Medicaid beneficiaries, unhoused/risk of homelessness, transfer from foster care, emergent housing, care transitions, and beneficiaries at risk of losing housing needing prevention services • Participants suggested that priority populations include individuals requiring reentry support, substance use treatment, or mental health services, with additional focus on women with children and individuals recovering from opioid use.
Frequency:	• Participants noted that service intensity varies according to need, a minimum of weekly is likely needed but more frequent may be required to support very-low income or high acuity, for example, zero income or individuals that need long-term care. • Participants also suggested individuals maintaining appropriate housing require fewer intensive services that are person-centered.
Duration:	• Participants noted that services would typically range from 30 to 90 days, with extensions up to 180 days based on individual circumstances. • Participants suggested that long-term tenancy-sustaining services are required to support beneficiaries with disabilities or histories of chronic homelessness and recommended extending services for up to 2 years or more. • Participants suggested long-term tenancy-sustaining services could be paired with affordable units to support beneficiaries with disabilities or histories of chronic homelessness.
Setting:	• Participants suggested aligning with existing HSS benefit which would include community and office-based.
Provider Staffing Qualifications:	• Participants suggested that each program should include at least one Navigator, responsible for addressing SDOH-related needs, completing eligibility forms and reconsiderations, and implementing preventative measures to maintain beneficiaries' program coverage and avoid lapses in deadlines. • Participants also suggested care teams should include a physician or clinician to address additional health concerns and enhance service effectiveness. • Participants suggested professional experience should align with existing HSS benefit, including the role of individuals with lived experience. • Participants suggested a nurse care manager for every 100 or more tenants with complex health needs to provide specialized support.
Staffing Ratio/Caseload:	• Participants discussed how aligning with the existing HSS benefit may differ depending on the setting and intensity.

Other Considerations:	• Nothing was explicitly discussed.

F. One-time transition and moving costs

Service Description:	• Participants noted that some providers offer gift cards to support services not covered by Medicaid, with furniture considered a covered expense and limited local funding available for additional resources. • Participants stated that there is limited funding available to support these costs currently and that it is often a barrier to housing Medicaid residents. • Participants commented on intersecting household and nutrition needs at the time of housing transition and considerations for combining this with other benefits, such as home modification or pantry stocking would be helpful. • The group discussed the inclusion of relocation support to help beneficiaries with moving expenses, including for housed individuals that are vulnerable and need to move for accessibility reasons.
Beneficiary Eligibility Criteria:	• Participants suggested that eligibility for all populations under consideration for 1115 would be helpful, however, some suggested prioritizing certain high-need individuals such as Medicaid beneficiaries with mental illness or those in temporary housing who need emergency housing assistance. • It was noted that both mental and physical health considerations should be incorporated into the application process, as these factors can create barriers to accessing or securing stable housing (for ex. linkage to in-home supports like MHRS or EPD, or home modifications), and a comprehensive screening or assessment in the home is necessary to ensure that the individual is adequately served. • Participants discussed ensuring access to housing services under the waiver for all Medicaid members in need, including individuals receiving services through DBH, Behavioral Health, SUD programs, children, and individuals with disabilities. • Participants considered refining eligibility criteria to better support individuals with complex care needs, reduce social risk factors, and improve access to essential services.
Frequency:	• Participants suggested that caps on eligibility and services should be operationalized in a way that is easy to manage by providers offering the service, and participants emphasized that services should be available as long as there is a demonstrated need while ensuring proper coordination to prevent inefficiencies or resource waste.
Duration:	• Nothing was explicitly discussed.
Setting:	• Nothing was explicitly discussed.
Provider Staffing Qualifications:	• Participants suggested this service could be offered by housing providers offering other services such as 1115 housing navigation or PSH/1915i benefit and should be linked to the plan of care.

Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants discussed the importance of developing approaches to reduce duplication of services, ensuring resources are distributed efficiently. This could be accomplished through prior authorization or pairing with other services such as 1115 HRSN or PSH/1915i HSS. • The group considered the need to provide essential household necessities, including food, for individuals transitioning into new housing. • Participants suggested that nutrition and medical needs be incorporated into the initial housing transition process, remediation efforts, or other medically necessary services to support overall well-being. • Participants discussed bundling services for initial move-in and home setup to include both food and household needs. A stacking approach, such as integrating SNAP into a combined application process, was suggested to streamline access and reduce administrative burdens. • Participants considered adjusting eligibility criteria to better prioritize individuals with complex care needs and identify service gaps. This approach was discussed as a way to address social risk factors and improve access to critical services.

G. Medically necessary home remediation services

Service Description:	• Participants discussed service agencies that provide goods to families supporting children with asthma. It was suggested that these services be considered under the medically necessary program, with comparisons made to requirements used by Children's National. • Participants discussed challenges related to individuals receiving poorly managed housing units, noting that HEPA vacuums have been provided in response to long-standing housing issues. It was observed that service utilization decreases when individuals receive coordinated, ongoing support. • Mold inspections were identified as an important intervention, with services being transferred to the Housing Administration for further action. Some participants raised concerns about requiring landlord notifications, noting that such requirements may not always be beneficial and should be limited to activities that require permission, such as those that could violate lease because of construction (wheelchair ramps for example). • A comparison was made to North Carolina's housing services, which focus on ensuring home safety and providing reimbursement for necessary modifications.
Beneficiary Eligibility Criteria:	• Participants noted that individuals transitioning into new housing or requiring safety interventions could benefit from additional support to help maintain stable housing for at least six months.
Frequency:	• Many participants supported the approach of allowing home remediation services at any point at which they meet minimum service eligibility criteria and have not reached the cap on expenses for this service.
Duration:	• Nothing was explicitly discussed.

Setting:	• Participants agreed with the North Carolina approach that states home remediation services occur in the enrollee's current place of residence or potential residence.
Provider Staffing Qualifications:	• Participants suggested this service could be offered by housing providers offering other services such as 1115 housing navigation or PSH/1915i benefit and should be linked to the plan of care. • Participants noted that some individuals may need significant support to coordinate home modifications.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants highlighted the importance of aligning housing services with medical needs, recommending that clinical personnel be involved in service planning. • The 1115 waiver was discussed as a potential way to expand services for individuals who may not qualify under the 1915i program. • The group suggested structuring services to automatically connect individuals to related support, reducing inefficiencies and improving coordination. • Participants raised concerns about service duplication and funding challenges, recommending strategies to enhance resource efficiency. • The group discussed flexible funding approaches to allow programs to address additional beneficiary needs based on individual assessments.

H. Home/environment accessibility modification services

Service Description:	• Participants discussed the importance of clinician observation before a housing transition, with assessments guiding care progression based on individual needs. • It was noted that nurse visits and home care coordination should be included to provide additional support. • Participants emphasized that COC dollars should be tied to Medicaid for housing support, ensuring beneficiaries receive services not covered by DBH vouchers. Some of these services were noted as being included in the HUD budget.
Beneficiary Eligibility Criteria:	• Participants suggested that all beneficiaries in need should be covered, with some services already included in the HUD budget.
Frequency:	• Participants suggested that services should be provided for as long as necessary, based on an individual assessment.
Duration:	• Nothing was explicitly discussed.
Setting:	• Nothing was explicitly discussed.
Provider Staffing Qualifications:	• Nothing was explicitly discussed.

Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants noted that home navigation and supportive care through care management could be reimbursable to assist with accessing one-time services. • Some participants discussed the benefits of a bundled approach to service oversight, ensuring continued support beyond initial transitions. It was noted that a one-time transition may not provide sufficient long-term stability, highlighting the need for coordinated care.

Section 2. Nutrition

A. Meal program (home delivered) services

Service Description:	• Participants discussed the differences between medically tailored meals (MTM), medically supportive meals, and nutritionally complete meals based on clinical diagnoses, health-related social needs (HRSNs), and USDA Dietary Guidelines.
	  ○ Medically Tailored Meals (MTM) must be fully prepared, meet Food is Medicine Coalition (FIMC) accreditation standards, be approved by a Registered Dietitian Nutritionist (RDN), and delivered directly to beneficiaries' homes.
	  ○ Medically Supportive Meals may be aligned with general nutritional needs but not targeted to a specific diagnosis.
	  ○ Nutritionally Complete Meals should meet the U.S. Department of Health and Human Services (HHS) definition of providing all essential nutrients.
	• Participants suggested that programs should be designed with flexibility, allowing beneficiaries to pre-select meals when feasible, while also maintaining quality, caloric, and macronutrient standards.
	• Participants suggested collaborating with food banks, grocery delivery services, Diabetes Prevention Programs (DPP), and leveraging 1115 waiver programs.

Beneficiary Eligibility Criteria:	• Participants discussed the potential value of launching a pilot program, with an initial focus on targeted Medicaid populations. Specific groups mentioned included individuals with Type 2 diabetes, homebound individuals, hospice and cancer patients, those with maternal and child health needs, and dual-eligible members. ○ Some participants thought a pilot program would not be necessary. • Participants suggested eligibility should consider functional limitations, such as inability to prepare meals due to physical or mental health conditions. • Participants suggested eligibility determinations should be guided by screenings conducted by care coordinators, incorporating key Social Determinants of Health (SDOH) such as food insecurity, housing status, pregnancy, emergency department usage, and transitions of care. Participants also

	emphasized the importance of considering life stages and health transitions, such as individuals undergoing chemotherapy. In some cases, eligibility could extend to entire families, for example, if a child qualifies, services could be offered to the household.
Frequency:	• Participants recommended allowing "up to three meals per day, up to seven days a week" to allow customization based on individual need and provider capacity. • Participants suggested frequency should also reflect diagnosis-specific needs and living situations (e.g., homeless, supportive housing). • Participants suggested flexibility and clarity are essential to accommodate a range of scenarios.
Duration:	• Participants suggested a standard duration of up to six months, with renewals permitted based on reassessments of clinical and needs-based criteria. ○ Participants noted six months may be insufficient for some and emphasized the need for reassessment during each renewal period. • For pregnancy-related cases, participants suggested services should span the pregnancy term and extend 6–12 weeks postpartum, or until the last medical check-up.
Setting:	• Participants suggested that meals are primarily delivered to beneficiaries' private residences but consideration should also be given to individuals in supported housing or experiencing homelessness.
Provider Staffing Qualifications:	• Participants suggested that Registered Dietitian Nutritionists (RDNs) are essential for designing and approving meal plans, overseeing client eligibility, and providing tailored nutrition counseling. • Participants suggested staff should have prior experience in relevant fields or direct service delivery. • Participants suggested flexibility to incorporate contracted staff or trained volunteers. • Suggested training mentioned by participants included: nutrition and culinary education, health-related social needs (HRSN), and customer service and participant engagement. • Some participants encouraged local or nonprofit organizations to promote community-based delivery.
Staffing Ratio/Caseload:	• Participants noted that FIMC Accreditation recommends 1 full-time RDN per 1,000 clients but requested that responsibilities of RDNs be clarified, especially when educational duties are included. • Some participants suggested that technology partners may help enhance delivery efficiency and support staff workflows.
Other Considerations:	• Participants emphasized a strong program framing and alignment with existing initiatives, collaboration with Managed Care Organizations (MCOs) to reduce access barriers, investment in infrastructure, such as storage, delivery, and data tracking systems, use of metrics and quality improvement strategies to define and measure program success, and cross-sector engagement to strengthen policy support and implementation sustainability.

B. Food package (delivered or for pick-up) services

Service Description:	• Participants discussed the importance of distinguishing between medically tailored and nutritionally appropriate food boxes, suggesting clear labels such as "Medically Tailored" and "Healthy Choice." • Participants suggested medically tailored food boxes should be prioritized for high-risk individuals, while nutritionally appropriate boxes can serve broader populations. • Some participants noted that dietary needs vary by condition (e.g., diabetes, heart failure, cancer), and flexibility is important to meet individual needs. • Participants discussed that standardized meals may improve cost-effectiveness but suggested allowing customization, especially for perinatal women and infants. • Participants suggested that meal accessibility factors (e.g., refrigeration and cooking capacity) should be considered when designing meal offerings. • Participants emphasized the need for clear guidelines to balance nutritional adequacy with flexibility.
Beneficiary Eligibility Criteria:	• Participants suggested that eligibility should expand beyond nutrition-related diagnoses to include lead exposure, asthma, preeclampsia, hypertension, obesity, substance use disorder, and behavioral health conditions. • Participants suggested that tailored meals and nutrition education should align with specific conditions, overseen by registered dietitians. • Participants noted that screening tools (e.g., Hunger Vital Sign) may not fully capture the severity of food insecurity and suggested a more detailed assessment or SMS-based technology could improve screening. • Participants noted that MCOs and referral entities are critical to eligibility determination and suggested that eligibility should not be solely determined by clinical providers, non-clinical providers can also identify individuals in need. • Participants emphasized that food insecurity alone should not determine eligibility. Participants noted that nutrition support can help reduce hospitalizations, ER visits, and long-term healthcare costs.
Frequency:	• Nothing was explicitly discussed.
Duration:	• Nothing was explicitly discussed.
Setting:	• Participants noted that programs like Food and Friends are delivered to various settings, including dialysis centers, not just home addresses. • Participants suggested that offering both delivery and pick-up options was recommended to increase accessibility. Food pick-up could also help reduce costs while still serving participants' needs.
Provider Staffing Qualifications:	• Participants suggested that both professional and lived experience should be valued when selecting providers. • Participants had some concerns that overly specific qualifications could create barriers for smaller organizations. • Participants suggested credentialed professionals, particularly registered dietitians, should guide dietary recommendations and allergy assessments. • Participants suggested that pre-approved food lists can be useful but should complement, not replace, expert evaluations. • Some participants encouraged local or nonprofit organizations to promote community-based delivery.

Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Some concerns were raised about meal package theft and strategies for secure delivery and expanded pick-up options were suggested.

C. Grocery benefit services

Service Description:	• A Produce Prescription (PRx) Program is a medical treatment or preventative service for eligible patients due to diet-related health risks or conditions, food insecurity, or other documented challenges in access to nutritious foods, and are referred by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy produce with no added fats, sugars, or salt, at low or no cost to the patient.
Beneficiary Eligibility Criteria:	• Participants suggested that physical ability and home environment should be part of eligibility screening including: Can the individual cook? Do they have access to a refrigerator? Are they homebound? Can they use fresh produce? Do they have sufficient dexterity to prepare meals? • Participants suggested that eligibility should prioritize individuals with diet-related chronic conditions such as diabetes, prediabetes, and hypertension. ○ Participants did want clarity on how diet-related disease eligibility would be confirmed: through a formal medical diagnosis, self-reporting, or a mix of both?
Frequency:	• Nothing was explicitly discussed.
Duration:	• Nothing was explicitly discussed.
Setting:	• Participants discussed the option of grocery benefits being provided via card or voucher for in-person use, or through delivery, particularly for individuals who may not have transportation or are homebound.
Provider Staffing Qualifications:	• Some participants encouraged local or nonprofit organizations to promote community-based delivery.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants discussed the logistical need for delivery models to support individuals who may not be able to access grocery stores, accommodating those with inconsistent housing situations, limited mobility, or communication challenges, and clarifying geographic limitations on eligibility and service delivery (e.g., whether support is restricted to DC addresses).

D. Nutrition counseling and education services

Service Description:	• Participants discussed incorporating flexible delivery methods to enhance access and engagement, including SMS-based or other digital platforms. • Telehealth combined with meal delivery was suggested as an effective model for reaching beneficiaries needing nutritional counseling. • There were differing views on bundling nutrition counseling with food provision. Some participants supported offering these services separately to prevent unnecessary barriers, while others noted that integration efforts in other states have had mixed results, with some states finding success in keeping the services distinct to allow for more tailored support. • A participant suggested maintaining a broad, flexible definition of nutrition education and counseling services but to make the eligibility criteria and coding clear. The participant cited the 1915(a) ADD waiver for home and community-based services as an example where approved services include cycle menus, recipe development, meal planning, grocery lists, and staff training but are all reimbursed under a single billing code for nutrition counseling. • A participant suggested allowing for many types of nutrition education as long as they support nutrition and health. One specific program that was suggested was the Diabetes Prevention Program (DPP). • Participants suggested looking at examples from other states such as North Carolina where they listed examples of nutrition education curriculum that included DPP and *A Taste of African Heritage and Cooking Matters.*
Beneficiary Eligibility Criteria:	• Participants discussed incorporating prevention strategies into the program. • Participants emphasized the importance of addressing risk factors early, particularly in children at risk for diet-related conditions. Another participant recommended prioritizing conditions where nutritional support can have the greatest measurable impact to guide program focus and maximize effectiveness. • Participants emphasized that diet-related conditions be central to beneficiary eligibility criteria for 1115 nutrition services.
Frequency:	• See comments below regarding Duration.
Duration:	• A participant noted that nutrition education classes are typically six weeks. • A participant noted that DC's 1915(b) IDD Waiver allows for up to 26 hours per year for 1:1 nutrition counseling.
Setting:	• A participant suggested defining allowable settings broadly to include FQHCs, Head Start centers, YMCAs, schools, community centers, etc. The participant also suggested that telehealth be an allowable setting.
Provider Staffing Qualifications:	• A participant suggested allowing RDNs to become independent Medicaid providers that do not have to be affiliated with a physician group and/or hospital as DC's Medicaid provider eligibility is currently structured. Several participants noted that there has been some discussion about making RDNs licensed providers within DC Medicaid for years. • A participant voiced concerns about having enough RDNs in the District to provide nutrition education only from RDNs. The participant suggested that nutrition counseling and 1:1 sessions should only be with an RDN but that other trained individuals should be allowed to provide group-based education that is based on an evidence-based curriculum.

Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Nothing was explicitly discussed.

Section 3. Reentry

A. Reentry case management services

Service Description:	• Critical to highlight person-centered service delivery. • Some disagreement on individuals who should provide services (outlined further in provider staffing qualifications section below) led to conversation around the need to clearly establish the relationship between medical and other behavioral health services and reentry case management services, especially the assessment and reassessment and differentiating the case management assessment from medical and other behavioral health service assessments. • A participant noted that case management should be tailored to the complexity of everyone's situation, particularly for those experiencing homelessness, who often prioritize immediate needs over long-term services. • Participants highlighted the importance of simplifying service delivery. It was recommended to differentiate between low- and high-need levels in targeted case management, especially during the critical first two weeks before release. • The group discussed the importance of warm handoffs during the transition of care. The CAA requires that any client transfer from one caregiver to another must occur through a handoff meeting, ensuring a smooth transition rather than a cold referral. Participants raised concerns about how new providers, who are mandated to follow this process, will implement it effectively. • Participants noted that some services have existed in other forms without billing Medicaid. Providers can continue offering services post-release, but these may not be Medicaid billable. Core Service Agencies (CSAs) have, in some cases, been reimbursed for engaging with incarcerated clients. Although few took advantage of this, those who did made a significant impact on their clients.
Beneficiary Eligibility Criteria:	• A participant suggested using Louisiana's program manual as a reference, noting that it provides clear eligibility criteria that could support a streamlined approach. It was also noted to review manuals and criteria from other states that are operating reentry waivers. • Participants discussed the need to establish clear eligibility criteria for services to design an effective framework of care. This framework would help ensure that services are provided to those who need them most, with careful consideration of everyone's unique circumstances.

	• Participants discussed the various reasons why providers face limitations on the services they can offer due to eligibility criteria. They agreed that resolving these issues is crucial to supporting effective reentry into the community. By addressing these eligibility challenges, providers will be better equipped to offer comprehensive services that meet the needs of reentering populations
Frequency:	• There was broad support among participants on flexibility in frequency to meet individual needs. • Participants suggested including a minimum frequency, but focus on tailored services to meet individualized care plan goals based on assessment of needs and clear guidelines to support stratification. • Participants suggested that it is important to keep administrative processes simple while still allowing changes in frequency. • The group discussed the need for some frequency adjustments based on individual circumstances but stressed the importance of keeping the process simple. They suggested limiting it to no more than two service levels, with a presumptive high-need designation to account for family and caregiver interactions.
Duration:	• Participants suggested that services should take advantage of the full 90-day pre-release period. • Participants suggested a baseline duration of 90 days both pre- and post-release, with flexibility to extend for an additional 90 days if needed. Participants broadly acknowledged that extensions would be crucial for addressing the diverse reintegration challenges faced by returning citizens, particularly those with more complex situations. For individuals with high levels of need, they recommended a minimum of six months of post-release support.
Setting:	• Participants suggested it is critical to deliver services in person in carceral setting where possible. Telehealth can be a helpful supplement but currently not available in carceral setting for case management services. • One participant strongly advocated against telehealth for youth during reentry, especially in facilities where proper handoffs are often missed. In-person services were recommended during the last 90 days before release to ensure strong community connections. • Broad support that telehealth could be a valuable tool to address patient preferences and reduce administrative barriers for providers and within facilities when used appropriately, but concerns were shared that telehealth was not likely always appropriate. • Suggestions for addressing telehealth include setting service-based limits (e.g. half of services within a given period can be delivered via telehealth). Participants noted that limits may look different for youth and adult populations. • Participants emphasized the importance of patient self-determination and patient autonomy.
Provider Staffing Qualifications:	• There was broad agreement among participants on leveraging individuals with lived experience and specific expertise in the carceral system to provide direct services given their ability to develop trust and expertise in navigating the system. • Some participants indicated the need to consider having licensed clinical staff conduct assessment and reassessment and develop care plans and then lean on lived experience workforce to deliver further services but there was significant disagreement in the group with many individuals highlighting that non-licensed staff should be able to do all facets of reentry case management services. • Some participants raised concerns about the requirement for licensed provider supervision and the burden this may place on CBOs.

Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants emphasized the need for robust interagency agreements (MOAs and MOUs) to close service gaps, particularly for individuals being released without stable housing. These agreements should outline detailed processes to ensure smooth transitions. • Participants advocated for a housing-first model, especially for those not ready for abstinence-only programs, as a way to provide stability and reduce recidivism. • It was noted that funding is available to provide phones with unlimited minutes upon release, which improves connectivity for returning citizens. Participants suggested it is important to connect these services to support case management communication and case management goals. • A participant emphasized the need for clear guidelines to establish a baseline for targeted case management, noting that understanding the population before release helps in stratifying needs. • A participant recommended developing a fact sheet/informational sheet at a 4th-grade reading level to improve accessibility of information for returning citizens. • Participants discussed differences in needs and requirements for juvenile vs. adult population. • Participants discussed concerns about quality and thoroughness of services in carceral setting versus community; people may not share concerns completely to carceral staff. • Participants noted that information sharing from carceral to community settings and vice versa to support continuity of care, while ensuring privacy and security considerations (both at the individual and policy level). • Participants suggested considering lessons learned from MCP experience contracting with CBOs and with returning citizen work. • Eligibility and enrollment-related concerns: One participant suggested that simplifying the Medicaid application process may reduce barriers, particularly since lengthy or complex documents can deter individuals from completing enrollment. One suggestion included establishing a 10–15 day pre-release window to share benefits information.

B. Medication Assisted Treatment (MAT) for substance use disorder (SUD)

Service Description:	• A participant highlighted ongoing confusion in the District about what is included under MAT coverage. While methadone is clearly recognized as a covered treatment, questions remain about whether other FDA-approved medications are permitted within MAT settings. It will be important for the waiver to clearly define which medications are eligible for coverage under MAT services. • A participant noted that she will follow up with DHCF and share information about Mary's Center, a primary MAT provider that could offer valuable insight for future discussions, as they support MAT for individuals transitioning from FBOP.

Beneficiary Eligibility Criteria:	• Eligible juveniles: It was discussed that MAT is not generally warranted for juveniles; its use in this population remains limited and based on clinical judgment. • The group noted that the waiver requires all participating facilities to offer all forms of MAT appropriate to the patient population. This provision prompted further discussion, as there continues to be concerns from the outpatient perspective regarding its applicability to youth. • A participant shared that they could help connect the group with a clinical lead from a local children's hospital who oversees SUD services for youth and may serve as a resource for future conversations to help ensure policy implementation is aligned to the clinical needs of youth, and they are not inadvertently excluded from appropriate and quality MAT service provision.
Frequency:	• It was discussed that the Bureau of Prisons has MAT social workers who actively support enrollment efforts prior to an individual's release. Participants noted that these efforts have been largely successful, with individuals often enrolled in services before reentering the community. Participants did not indicate roadblocks related to capacity, and the program supports a few individuals each month. • The group emphasized that having established referral relationships is critical to ensuring a smooth process and facilitating a warm handoff during the transition.
Duration:	• A participant noted that utilizing screening and assessments to identify individuals eligible for MAT services is essential.
Setting:	• It was discussed that there are important privacy considerations when offering MAT in jails and prisons, particularly in determining whether federal confidentiality protections apply. • A resource was shared that outlines key guidance on this issue: Privacy Considerations for MAT in Jails and Prisons (COE-PHI). • The group noted that this resource may help clarify the applicability of 42 CFR Part 2 and outline the protections that should be in place. Ensuring individuals understand their rights and the use of consent forms was highlighted as a critical component.
Provider Staffing Qualifications:	• It was discussed that clear definitions are needed for the behavioral health components of MAT services, particularly regarding staffing and supervision. • Participants raised questions around who is qualified to supervise behavioral health professionals providing MAT-related services. Specifically: 1) Must the supervisor be a medically trained practitioner? 2) Can a licensed behavioral health professional—such as a social worker or counselor—fill this role? • The group emphasized the importance of defining behavioral components, such as support groups associated with MAT, noting that medical staff typically do not engage in the psychosocial aspects of care. Clarifying these roles will be essential for program implementation.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants noted that a lack of a data sharing agreement creates barriers to service access. Even if a client meets eligibility criteria, the absence of an agreement may render them ineligible due to limitations in data exchange between agencies.

	• Participants suggested the use of formal data sharing agreements between carceral settings, providers, and payers to support coordinated service delivery. • A technical assistance partner who has completed similar work in California mentioned that for CA: many detention centers focused on expanding MAT that is allowable in local detention centers to include all FDA approved medications and expanded withdrawal management with MAT; one key challenge raised was direct pharmacy billing; and the funding will be able to expand things like long acting injectables which historically have been expensive to provide.

C. 30-day supply of prescription medications upon release

Service Description:	• Participants discussed the importance of reducing barriers for individuals on medications that require prior authorization, ensuring they have medication in hand at release and for refills. • Participants suggested that providing technical assistance for prescribers could help, though participants emphasized the need for strong communication to support individuals reentering the community and reduce barriers to care. • Participants noted that medical providers should ensure individuals have medication in hand prior to release. • Participants highlighted that delays in connecting with pharmacies remain a barrier, and accessing benefits immediately upon release is critical to preventing disruptions in care.
Beneficiary Eligibility Criteria:	• Nothing was explicitly discussed.
Frequency:	• Nothing was explicitly discussed.
Duration:	• Nothing was explicitly discussed.
Setting:	• Nothing was explicitly discussed.
Provider Staffing Qualifications:	• Nothing was explicitly discussed.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• A participant noted the importance of distinguishing between having Medicaid coverage and having timely access to prescribed medications. It was shared that ensuring a supply of medications upon release could increase engagement in treatment and reduce disruptions in care. • It was discussed that even with active Medicaid coverage, logistical barriers—such as lack of transportation or not having a Medicaid ID card—can delay medication access.

	• Ensuring a reliable medication supply upon release was identified as a key strategy to promote continuity of care, reduce avoidable health complications, and support successful reentry.

D. Behavioral health counseling and therapy services

Service Description:	• Participants suggested:
	  ○ Completing assessments before individuals transition from incarceration, with pre-release engagement to establish relationships, clarify meeting details, and support a smoother transition. If pre-release engagement is not possible, these activities should occur immediately after release.
	  ○ Minimizing or eliminating waiting periods for psychiatric services upon release, with service needs identified and arranged prior to release.
	  ○ Utilizing the waiver's allowance for behavioral health services to address identified needs, including diagnostic assessments to confirm behavioral health diagnoses. Therapy services, both in-person and via telehealth, were proposed to enhance engagement and readiness for reentry.
	  ○ The importance of a full scope of services, such as substance use screenings and behavioral health support, as critical to reentry success.

Beneficiary Eligibility Criteria:	• Participants suggested that when planning for a young person's discharge, it is ideal for the individual to have had an initial assessment, potentially one or two reassessments, and a tailored plan in place. By the time of discharge, there should be a clear plan outlining the ongoing services the youth will need. Emphasis was placed on the importance of placing youth in services specifically tailored to their individual needs. • Participants further suggested to use a measurement-based approach for screening, allowing results to inform decisions about who requires specific services (e.g., behavioral health, substance use disorder, trauma support). Specific interventions tailored to address the disproportionate percentage of individuals with trauma or untreated trauma were identified as particularly useful. Participants suggested that group therapy may require different eligibility criteria, such as individual's ability to participate appropriately in a group setting.
Frequency:	• One participant shared that, in their experience, therapy is often recommended multiple times per week for youth returning from DYRS; however, the actual frequency should be tailored to individual needs. • Participants suggested billing structures should allow for flexibility, enabling adjustments based on specific case requirements. • Participants suggested that the frequency of services align with assessments and individual risk levels, with current practices ranging from weekly to biweekly sessions.
Duration:	• Participants noted that therapy services are currently time-based rather than level-of-care-based. Participants suggested utilizing assessments to better determine care levels and linking service reimbursement to care needs. • Participants proposed exploring behavioral health service tiers in future discussions.

Setting:	• Participants emphasized ensuring confidentiality for both in-person and virtual services. • Some participants suggested a hybrid model involving internal and external providers with telehealth accommodations. Facility-based services should integrate with electronic health records to ensure continuity post-release. • Some participants suggested that understanding the mix of in-person versus telehealth services was vital for implementation. Differential rates for in-person and telehealth services were also proposed.
Provider Staffing Qualifications:	• Participants suggested that providers should meet the licensing requirements of their respective boards (e.g., licensed therapists, psychologists, psychiatrists, social workers, counselors). • Participants suggested that efforts should be made to reduce barriers, such as providing supervision for individuals who are not independently licensed. However, many participants expressed caution about lowering standards and emphasized the importance of maintaining high staff qualifications to ensure the quality of care provided. • Many participants noted that understanding best practices and standards of care is critical to ensuring successful transitions. It was observed that individuals often face more complex issues upon release due to receiving substandard care while incarcerated.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Participants suggested educating individuals and providers on enrollment processes to improve care transitions and coordination. • Participants suggested reviewing examples of substandard care to identify opportunities for improvement. This could help inform plans to strengthen care standards and better support individuals transitioning back into the community.

E. Peer support services

Service Description:	• Participants suggested a broader definition of peers that include certified peer support specialists who are trained by the Department of Behavioral Health (DBH) to support individuals with substance use disorders and mental health conditions, and other support from trained individuals with lived experience (e.g. peer navigators). • Participants described peer support services as playing key roles in both mental health and substance use disorder recovery, with peer navigators specifically focused on facilitating the provision of services during transitions. • Participants suggested there may be opportunities to review and enhance DYRS's existing "credible messengers" peer support program to expand services and create additional opportunities for support.
Beneficiary Eligibility Criteria:	• Several participants suggested that the eligibility approach could remain broad, noting that the trauma associated with experiences before, during, and after incarceration supports making services accessible to all who request them. • In the context of behavioral health, participants suggested that tying services to assessments and identified needs could enhance their effectiveness.

	• Participants shared that connecting individuals with someone who has shared similar experiences might provide meaningful support and help align services with individual needs.
Frequency:	• Participants suggested that frequency should be linked to assessment and risk level (youth side) and it was noted that youth transitioning back into the community may not always have opportunities to practice essential skills.
Duration:	• Participants suggested that duration should be tied to the goals of an individual's care plan
Setting:	• Participants highlighted the value of in-person delivery of services to support individuals transitioning to the community and facilitate a smoother handoff process • Though participants recognized the value of telehealth services, privacy concerns related to video conferencing were acknowledged, highlighting the need for clear privacy standards.
Provider Staffing Qualifications:	• Participants suggested that provider staffing qualifications include roles such as community support workers and encompass a range of existing programs. • Participants emphasized that lived experience is a key qualification for providers, as it can enhance support and relatability for those receiving services. • For youth-focused roles, the group discussed whether the same lived experience qualifications should apply, noting that background check requirements may differ. • There were differences of opinion and differences in current program requirements for time individuals would need to have post-release to serve in a peer support role. For example, one participant noted that credible messengers could have been released as recently as one year while other programs required 6 years post-release. • Participants recommended that peer support staff undergo structured training and follow a facilitation guide, with appropriate monitoring in place. • Participants suggested background checks remain a requirement but there was recognition that peer support providers would have prior justice involvement and this should be considered in the hiring process. • Participants suggested ongoing support and wellness resources to help prevent burnout and manage potential triggers for staff members. • One participant recommended clinical oversight to ensure a well-rounded perspective and mitigate potential biases, including religious influences, while adhering to best practices. • Participants noted that documentation and note submission should be incorporated into the supervision process to ensure accountability. • Leads and directors within each organization were identified as key figures for providing oversight and guidance to peer support providers • The discussion emphasized the importance of an inclusive staffing approach, incorporating individuals with diverse educational and professional backgrounds, supported by structured training and onboarding processes.
Staffing Ratio/Caseload:	• Participants suggested that caseload distribution be based on the level of need to ensure a balanced workload. It was noted that assigning one person exclusively to high-acuity cases could lead to burnout and should be avoided.

	• A 1:25 staffing ratio was shared as an example for community support workers to help maintain manageable caseloads and ensure effective support.
Other Considerations:	• There were significant gaps in understanding around current provisions for onsite visitation, particularly in DOC settings. Participants identified the need for provider training and communication to clarify the basic elements of the process.

F. Behavioral and physical health screening services

Service Description:	• Participants suggested alignment on standardized screening tools to ensure consistency in evaluations and appropriate program placement. These could include standardized tools already in use in the District. • Participants suggested that nutrition screenings be incorporated, with an emphasis on pre-enrollment in SNAP to improve access to food resources. • Participants suggested obtaining information from the DC Collaborative for Mental Health and Pediatric Primary Care on currently recommended child and youth mental health screenings to ensure a holistic approach to behavioral health screenings. • Participants noted that current screening processes may not capture all individuals in need or may not capture individuals at a time when they are comfortable fully engaging in the screening process, emphasizing the importance of comprehensive screenings to prevent gaps in support. • Participants suggested that tobacco screenings be included, as they align well with telehealth services. DC Quitline services (DCquitnow) are available through tele-counseling, and initial screenings can be conducted via telehealth. • Participants noted that assessment tools should encompass a broad range of needs, including behavioral health, medical conditions, housing, and nutrition, given their importance to reentry planning. Participants suggested expanding the scope of assessment tools to better capture these domains.
Beneficiary Eligibility Criteria:	• Participants suggested that eligibility criteria remain broad to promote inclusive access to services. • Participants suggested removing restrictions on screenings to maximize identification of individuals who may benefit from services.
Frequency:	• Participants suggested that screenings take place within 24-48 hours of intake to support the timely identification of needs. • Participants suggested that screenings be conducted at multiple points to allow for ongoing assessment and continued support.
Duration:	• Nothing was explicitly discussed.
Setting:	• Participants noted that due to the high volume of screenings needed, telehealth will need to play a role in behavioral health assessments. • Participants emphasized that availability of technology and digital literacy must be considered. Given the appropriate infrastructure, telehealth can serve as an effective tool for screenings. • Participants noted that technology barriers within agencies may impact the effectiveness of telehealth services. • Participants highlighted that confidentiality concerns, technology access, and digital support may serve as challenges to successful telehealth implementation.

	• Face-to-face interactions were recommended as an additional support option, rather than relying solely on telehealth, to better assist youth in accessing services.
Provider Staffing Qualifications:	• Nothing was explicitly discussed.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• Nothing was explicitly discussed.

G. Intensive family-based services for youth

Service Description:	• A participant noted that while the District maintains a list of evidence-based practice (EBP) models, there are ongoing challenges in implementation. Additional information would be helpful to better understand: what services are currently being provided; the availability of those services, and; how these models can be defined and operationalized more broadly across systems. • The group emphasized that this population will be assessed for behavioral health treatment needs and must have access to services that are aligned with the best possible outcomes. • It was discussed that while evidence-based models exist, they are not always accessible or available to all beneficiaries at the time they are needed. • It was discussed that the behavioral health models referenced are distinct from the screening and diagnostic services previously discussed, and are focused specifically on intensive behavioral health interventions. • Participants acknowledged the existence of treatment modalities that are outcome-driven, but expressed concern that community capacity to deliver these interventions—such as Multisystemic Therapy (MST)—is currently limited. • It was noted that routine medication management alone is unlikely to lead to the desired reentry outcomes.
Beneficiary Eligibility Criteria:	• Certain specialized services have specific eligibility requirements or operational constraints that create barriers to access. These capacity limitations prevent timely and equitable service delivery for youth in need. <u>Service or Billing Exclusions:</u> • Participants noted that service or billing restrictions for youth are often similar to those seen on the adult side; however, there was consensus that youth services should not be limited by adult service models. • When a young person requires an intensive level of care that is unavailable in their current program, transitioning them elsewhere can be particularly disruptive and difficult.

	• The importance of trusting relationships with providers was emphasized, especially in the context of service continuity and behavioral health treatment engagement. • Participants highlighted that provider-level policies and administrative requirements can interfere with continuity of care, underscoring the need to minimize disruption during transitions. <u>Restrictions on Billing and Oversight:</u> • It was noted that on the adult side, there is limited authority to manage where individuals are enrolled or to monitor if they are receiving services across multiple settings. • Participants expressed concern that without a central authority or data infrastructure, there is no clear oversight mechanism to track who is providing which services and to whom. • Participants noted that returning citizens who reenter with more structured service plans often face greater difficulty navigating system restrictions—this becomes a major focus during the transition period. • A participant recommended considering fewer service restrictions for returning citizens during the first few months post-release to support a smoother transition.
Frequency:	• Nothing was explicitly discussed.
Duration:	• Nothing was explicitly discussed.
Setting:	• Building and prioritizing service capacity in the community was highlighted as a critical need.
Provider Staffing Qualifications:	• A participant emphasized that a trusted bridge, such as a community-based provider, is essential to ensure successful connections to behavioral health or mental health services after reentry. Their experience with adults in transition suggests that individuals are more likely to adhere to treatment plans when strong provider relationships are in place. • It was further noted that pre-release engagement work is critical to ensuring care is effective post-release.
Staffing Ratio/Caseload:	• Nothing was explicitly discussed.
Other Considerations:	• A participant suggested increasing access to specialized family therapy services that have demonstrated strong outcomes. In particular, it was suggested that secure custody populations be reviewed to understand how many individuals had access to MST and did not respond well, which may indicate a need for more targeted psychiatric care, including trauma-informed and neurodevelopmental approaches. • Participants suggested the formation of a multi-stakeholder group to further explore gaps and opportunities. This group could help identify priorities that extend beyond the waiver and inform broader system-level improvements.