ATTACHMENT C
Section 1115 SMI/SED Demonstration Implementation Plan

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

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

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

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

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

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

2. Required implementation information, by SMI/SED milestone

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

Prompts	Summary
	mental health treatment and accredited by a nationally recognized accreditation entity. If additional hospitals wish to participate in the demonstration, the District will ensure that they are licensed and meet Medicare conditions of participation.
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current State:* As part of the licensure issuance and renewal process for hospitals (including psychiatric hospitals), DC Health performs licensure surveys annually and complaint investigations upon occurrence. DC Health's licensure surveys include unannounced visits to assess the facility's compliance with the statutes and rules governing the facility. Federal validation surveys are performed upon request from CMS to assess the accrediting organization's ability to ensure a hospital's compliance with CMS' health and safety standards.
	Future State: If residential treatment providers or additional hospitals wish to participate in the demonstration, the District will ensure the facilities meet applicable District licensing, certification, and accreditation requirements.
	Summary of Actions Needed: No action needed at present. If residential treatment providers or additional hospitals wish to participate in the demonstration, the District will ensure the facilities meet applicable District licensing, certification, and accreditation requirements.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current State:* The Department of Health Care Finance (DHCF) contracts with a quality improvement organization (QIO) to conduct utilization review to monitor appropriateness and quality of care provided to Medicaid fee for service (FFS) beneficiaries. Hospitalizations at specialty hospitals, including psychiatric hospitals, must be authorized by DHCF's QIO. The QIO also provides oversight on lengths of stay by conducting concurrent utilization reviews during hospitalizations at specialty hospitals to determine the clinical appropriateness of current and proposed levels of care. DHCF's current QIO uses InterQual Behavioral Health Criteria, an established evidence-based guideline used by many insurers, to make initial authorization and concurrent utilization review decisions. Managed care organizations (MCOs) contracted with DHCF are required to develop and maintain a Utilization Management Program. Stays in psychiatric hospitals and residential treatment settings are allowable for MCO beneficiaries under the "in lieu of services" provision of federal Medicaid Managed Care rules. MCOs contracted with DHCF conduct independent utilization reviews of those hospitalizations and inpatient stays, based on standards such as InterQual Behavioral Health Criteria and Milliman Care Guidelines, for their enrollees.
	Future State: Stays for FFS beneficiaries in psychiatric hospital settings will be authorized by DHCF's QIO. The QIO will also provide oversight on lengths of stay by conducting concurrent utilization reviews. (Timeline: 12-24 months)

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

Prompts	Summary
1.g Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current State:* See responses to Sections 1.a, 1.b, 1.c, 1.d, 1.e, and 1.f.
	Future State: The requirements and policies described in Sections 1.a, 1.b, 1.c, 1.d, 1.e, and 1.f ensure good quality of care is provided in inpatient and residential treatment settings and the District will continue to provide oversight as necessary.
	Summary of Actions Needed: No action needed.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	*Current State:* For services delivered by providers certified by the District's Department of Behavioral Health (DBH) and/or DBH-funded services, DBH imposes several discharge planning and care coordination requirements on psychiatric hospitals and community-based providers, including timeframes in which certain activities must occur. For consumers receiving Mental Health Rehabilitation Services (MHRS) benefits, hospitals must notify the consumer's core service agency (CSA) or assertive community treatment (ACT) provider, if applicable, of the admission. The DBH Access Helpline (AHL) is able to provide information about an individual's CSA/ACT provider to the hospital, if needed. For MHRS-eligible consumers who do not have a pre-existing relationship with a CSA or ACT provider, the DBH AHL will link an individual to a CSA in accordance with DBH's consumer choice policy. When notified of an admission, CSA/ACT providers are expected to establish contact with the consumer and provide the hospital with relevant consumer information, such as psychosocial, treatment course, and medication history. The CSA/ACT provider is to maintain ongoing contact with the consumer and the hospital, which can include participation in the hospital's treatment team meetings and the discharge planning process. MCOs contracted with DHCF are responsible for coordinating services for MCO beneficiaries between settings of care, including appropriate discharge planning for stays in psychiatric hospitals and residential treatment settings. MCOs are required to assist in the development of an appropriate discharge plan prior to an MCO beneficiary's hospital discharge or change in treatment setting and when possible, participate in discharge planning meetings. As part of clinical management, MCOs are responsible for collaborating with staff in other District agencies, community service organizations, and other providers to meet beneficiaries' health care needs. MCOs are also responsible for care coordination and case management for beneficiaries receiving services through DBH. In addition, MCO Care Coordination and Case Management programs are required to be tiered models, with at least one tier designed for

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

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

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

Prompts	Summary
	of care measures. The bonus payments are based on outcomes largely derived from improved care coordination and transitional services.
	Future State: The additional services being proposed under this demonstration will complement the District's existing Health Home programs by providing a framework in which health home beneficiaries with significant health needs will be able to receive support with care navigation. The Health Home programs are anticipated to grow over time and are a critical part of DHCF's investment to integrate the full array of primary, acute, behavioral health, and long-term services for Medicaid beneficiaries.
	Summary of Actions Needed: No action needed.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health	*Current State:* As part of the demonstration application, the District conducted an assessment of the availability of mental health services to provide a baseline understanding of current rates of utilization, provider participation, and Medicaid enrollment against which to measure as the demonstration is implemented. The assessment includes information on the number of District providers of mental health services and a brief overview of the District's population with SMI/SED. DHCF was unable to compare DHCF's network to the total number of providers in the District for several categories of providers who treat mental illness, including psychiatrists or other practitioners who are authorized to prescribe, other types of practitioners authorized to treat mental illness, and intensive outpatient/partial hospitalization providers. The District's assessment of the availability of mental health providers is available in Attachment 2 of the demonstration application. Additional information on the District behavioral health system is available in the District of Columbia Uniform Application fiscal year 2018/2019 – State Behavioral Health Assessment and Plan Substance Abuse Prevention and

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

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

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

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

Prompts	Summary
	responsible for ensuring these services are provided by providers with appropriate expertise in mental health, including on-call access to a psychiatrist. See Section 5.a for additional information on the District's currently available non-hospital, non-residential crisis stabilization services. Additionally, no providers are currently certified by DBH to provide intensive day treatment services. District stakeholders have identified some regulatory requirements related to operations as the primary barrier to certification.
	Future State: MCOs contracted with DHCF will continue to be responsible for ensuring crisis stabilization services are available 24-hours, seven days a week. See Section 5 for additional information on the District's plan to increase non-hospital, non-residential crisis stabilization services. Under modified regulatory requirements, DBH successfully certifies providers to offer intensive day treatment services in the District.
	Summary of Actions Needed: See Section 5 for additional information on the District's plan to increase non-hospital, non-residential crisis stabilization services. DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care. (Timeline: 18-24 months)
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, including through supported employment and supported education programs	*Current State:* Clinically appropriate behavioral health services are available to all Medicaid beneficiaries through Free-standing mental health clinics (FSMHCs) and FQHCs. FSMHCs and FQHCs provide diagnostic assessment and treatment services on an outpatient basis and serve as easily accessible providers for those with behavioral health needs. As discussed in Section 3.d, as part of provider training for all their network providers, MCOs contracted with DHCF include training on the manifestations of mental illness, use of screening tools to identify such problems, and how to

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

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

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

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

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

Prompts	Summary
identification/engagement, integration, and specialized programs for young people	*Future State:* Due to the breadth of covered services and activities described in Sections 4.a, 4.b, and 4.c, strategies to increase earlier identification/engagement, integration, and specialized programs for young people have already been implemented and are ongoing.
	Summary of Actions Needed: No action needed.
SMI/SED. Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current State:* As discussed in Sections 4.a and 4.c, there are ongoing efforts in the District to assess community needs and increase the availability of non-hospital, non-residential crisis stabilization services. Examples of relevant initiatives include: • The Access Helpline (AHL), which is operational 24-hours, seven days a week and is staffed by behavioral health professionals. AHL can refer callers to immediate help, including by activating mobile crisis teams; • The Comprehensive Psychiatric Emergency Program (CPEP), which is a 24-hour, seven day a week facility that provides multi-disciplinary, emergency psychiatric services to assess and stabilize consumers, including through extended observation care. It serves individuals aged 18 and over who present either voluntarily or involuntarily; • DBH's Community Response Team (CRT), which recently merged DBH's Mobile Crisis, Homeless Outreach, and Pre-Arrest Diversion Pilot Programs into a single program. CRT is DBH's integrated, multidisciplinary approach to improve behavioral health outcomes in the District with a focus on expanded, proactive service offerings and tailored responses to behavioral health support needs. The CRT model includes teams of licensed clinicians, community behavioral health specialists, and individuals with lived experience and, unlike the previous programs, the CRT operates 24-hours, seven days a week; • The Crisis Intervention Officer (CIO) program, which is a partnership with MPD to train approximately 125 officers each year to support people with mental illness who come to the attention of law enforcement but do not meet the threshold for arrest; and • The Children and Adolescent Mobile Psychiatric Service (ChAMPS), in which a community-based provider provides on-site, immediate help to children facing a behavioral or mental health crisis whether in the home, school, or community.
	Future State: As part of this demonstration, the District seeks to create a new reimbursement methodology for CPEP and for CRT mobile crisis and outreach services to more appropriately account for and value the services provided. The

Prompts	Summary
	demonstration also proposes adding coverage for psychiatric crisis stabilization services as a treatment alternative to psychiatric inpatient hospitalizations.
	Summary of Actions Needed: DHCF and DBH will work with District stakeholders to assess a long-term sustainable plan to increase availability of non-hospital, non-residential crisis stabilization services for Medicaid beneficiaries throughout the District. These efforts will build upon information provided in the District's assessment of the current availability of mental health services included in our demonstration application and will incorporate an assessment of services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders. This assessment will also include a review of changes to reimbursement and financing policies that address gaps in access to community-based providers as identified in the District's assessment of current availability of mental health services. (Timeline: 18-24 months)
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current State:* District residents can access community-based mental health services through several types of providers. Core service agencies (CSAs) serve as the main entry point for accessing the Mental Health Rehabilitation Services (MHRS) benefits, which include diagnostic assessment, medication/somatic treatment, counseling, day/rehab services, and community support. Free-standing mental health clinics (FSMHCs) also provide diagnostic assessment, medication/somatic treatment, and counseling services. As of July 2019, there are 51 CSAs and as of June 2019 there are 29 FSMHCs, 15 of which are also certified as a CSA. There are additional providers certified by DBH which deliver specialty mental health services such as Assertive Community Treatment (ACT), Community Based Intervention (CBI) for youth and children, and trauma-informed services, like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy. However, no providers are currently certified by DBH to provide intensive day treatment services. District stakeholders have identified regulatory requirements related to operations as the primary barrier to certification. In addition to CSAs, DHCF beneficiaries have access to 360 Medicaid-enrolled psychiatrists and advanced practice registered nurses with a behavioral health focus, 175 of whom billed DHCF in the past year. As indicated in the mental health services assessment, the District acknowledges that there is less than one psychiatrist/prescriber enrolled in Medicaid per 100 Medicaid beneficiaries with SMI. DHCF beneficiaries also have access to community-based services through federally qualified health centers. In fiscal year 2018, 41 FQHC locations billed for behavioral health treatment provided to DHCF beneficiaries.

Prompts	Summary
	Future State: Under modified regulatory requirements, DBH is planning to certify providers to offer intensive day treatment services in the District. As part of this demonstration, the District proposes to fund services offered in a peer-partnered facility, "Clubhouse," targeting support services for adults with SMI to assist them with social networking, independent living, budgeting, self-care, and other skills to enable community living. The District also seeks to add vocational services to currently provided supported therapeutic employment services for individuals with SMI. These additional services will connect individuals with training and skills to promote and maintain employment. The demonstration proposes to reimburse for behavioral health services provided to individuals with SMI/SED or SUD by psychologists and other licensed behavioral health providers practicing independently, either in a separate practice or hospital setting. The demonstration also proposes to reclassify two trauma-informed services for children, adolescents, and adults—the Trauma Recovery and Empowerment Model (TREM) and Trauma Systems Therapy (TST)—and change the reimbursement methodology. Currently, these services are provided and billed under the MHRS Counseling service definition. Creating a separate service definition for TREM and TST will allow for better tracking of service utilization. Increasing the reimbursement rates to be on par with other trauma-informed services is intended to promote additional service availability.
	Summary of Actions Needed: DHCF and DBH will work with District stakeholders to assess a long-term sustainable plan to increase availability of on-going community-based services and services in integrated care settings for Medicaid beneficiaries throughout the District. This assessment will include a review of potential changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the District's assessment of current availability of mental health services, specifically to increase the number of psychiatrists/prescribers enrolled in Medicaid. (Timeline: 18-24 months) DBH will issue updated certification regulations for intensive day treatment services to address barriers identified by stakeholders and maintain high-quality care. (Timeline: 18-24 months) DBH and DHCF will develop and issue rulemaking and other policies as necessary regarding the proposed waiver services that increase access to community-based services. (Timeline: 12-18 months)

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

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

Prompts	Summary
	Based on a landscape assessment of EHRs in use across the District, DHCF identified at least 17 different EHR vendor-based systems in use within the District. DBH and DBH-certified providers use three separate EHR systems to document clinical care and to coordinate billing and reporting: • iCAMS: Supports mental health programs and the providers who administer those services. o iCAMS is an implementation of Credible's behavioral health EHR. • Avatar: Provides comprehensive management for inpatient hospitalizations at Saint Elizabeths Hospital. o Avatar is a product of Netsmart's behavioral health EHR. • DATA/WITS: Supports services for clients with SUD and the DBH-contracted providers who support them. o DATA/WITS is an EHR solution developed and currently maintained by FEi Systems. A subset of behavioral health providers also have stand-alone, certified EHRs. As a result of this diversity in technology and implementation, DHCF is investing heavily in HIE services to achieve interoperability needed to ensure District resident's health information is available whenever and wherever needed. All four of the Medicaid MCOs in the District are participating in HIE, as are all of the District's acute care hospitals, and approximately 40 percent of ambulatory providers submitting 100 or more claims per year. In fiscal year 2019, DHCF awarded a competitively-bid five-year grant to CRISP DC to implement five core HIE capabilities: clinical patient lookup; simple and secure digital messaging; population health management analytics; specialized registry submission; and electronic clinical quality measurement (eCQMs).
Statement 2: Please confirm that your state's SMI/SED Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes. The District's State Medicaid Health IT Plan (SMHP) was approved by CMS on January 23, 2019. The report addresses information needs of the behavioral health system in the District. In addition, DBH has identified strategies to align investments with the District's SMHP.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability	Yes, the District intends to assess the applicability of the Interoperability Standards Advisory and 45 CFR 170 Part B and incorporate the relevant standards where applicable.

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

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

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

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

	accomplished through a recently awarded grant to CRISP DC, a regional HIE serving the District, Maryland and West Virginia. Currently, more than 8,200 people from 85 organizations utilize CRISP DC to access health information from outside of their own organization EHR. 109 providers or practice organizations have active DIRECT accounts in the District, including most of the FQHCs. CRISP DC provides free DIRECT accounts to any District Medicaid provider through the recently awarded Core HIE Capabilities for Providers grant funded by DHCF (fiscal year 2019 to fiscal year 2023). DHCF's grant allows CRISP DC to support five core HIE capabilities for providers over the next five years, including patient lookup of encounters and clinical data, electronic clinical quality measures, panel analytics and secure messaging. The DHCF Core HIE Capabilities grant is also supporting CRISP DC's outreach efforts among behavioral health providers. These efforts will to implement changes to the DC Mental Health Information Act (DC Code § 7–1203), which requires that behavioral health providers offer notice to their patients that they participate in HIE to exchange mental health information. District policies also require providers to give patients the opportunity to opt out of HIE services, including Direct messaging and e-Referral, if they so choose. To inform providers about changes to the DC Mental Health Information Act, CRISP DC and the DC Behavioral Health Association are also in the process of forming a workgroup to advise CRISP DC on implementing HIE for behavioral health providers. In addition, DHCF has partnered with the DC Hospital Association and the DC Primary Care Association to form an "e-Referral collaborative" of hospitals, health systems, FQHCs and HIEs with the goal of implementing DIRECT-based referrals in 2019. DHCF is funding technical assistance for these organizations and supporting the cost of DIRECT accounts if necessary. This technical assistance is contracted through fiscal year 2021.
	Future State: In fiscal year 2019 DHCF is implementing a new three-year HIE Connectivity grant to provide technical assistance to connect nearly all Medicaid providers to HIE by 2022. As one component of the Connectivity grant, behavioral health providers have been assigned priority for technical assistance in order to support e-referrals and better care integration across physical and behavioral health services. In fiscal year 2020 the Connectivity grantee will continue to support provider adoption and use of EHR technology for e-referrals, emphasizing the role of Saint Elizabeths Hospital and the community-based mental health providers to facilitate transitions of care.
	Summary of Actions Needed: Support CRISP DC Direct implementation; sustain collaborations with DCPCA/DCHA and District HIEs via the e-referral collaborative. Ensure that acute care hospitals, IMDs, community-based behavioral

	health providers (e.g. MHRS providers, free-standing mental health clinics), and primary care providers are incorporated into these discussions and have access to relevant technologies. (Timeline: 18-24 months) DBH and DHCF will collaborate to assess opportunities to support DBH-certified providers' adoption and use of certified EHR technology, which enables direct messaging among physical and mental health providers. (Timeline: 18-24 months)
1.2 Closed loop referrals and e-referrals from institution/ hospital/clinic to physician/ mental health provider	*Current State:* In addition to the work described in Section 1.1, DHCF has funded the Association to improve discharge planning from a major hospital in the District using HIE and Direct. The focus of the Discharge Innovations grant is not behavioral health, but includes at least one CSA, McClendon Center, who will participate in developing best practices to facilitate follow-up by community providers after hospital discharge. The grantee is using CRISP DC to transmit structured discharge information to the next level of care, paving the way to standardize that process for all e-referrals and transitions in the District. This work is contracted through fiscal year 2019.
	Future State: The Core HIE Capabilities grantee (CRISP DC) is required to implement a secure messaging and referral system in fiscal year 2020. As this project matures, CRISP DC will measure and track improvement in e-referrals between institutions (hospital/clinical) to mental health providers.
	Summary of Actions Needed: Implement projects described in Section 1.1 and ongoing work with the DC Hospital Association. (Timeline: 18-24 months)
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community-based supports	*Current State:* The District offers a wide array of community-based supports and is working within and across agencies to build coordinated systems that facilitate e-referral from physician and mental health providers to community-based supports. Eligibility and enrollment processes for many of these services are in the process of being integrated into the DC Access System (DCAS). As of fiscal year 2019, DCAS manages eligibility and enrollment for MAGI Medicaid, SNAP, TANF, LIHEAP, and well as a number of state and local assistance programs. DHCF is measuring the adoption and use of HIE tools, including the use of Direct, over time. By harmonizing the performance and reporting requirements of grants and contracts, DHCF is receiving monthly updates on HIE measures, such as the number of providers with Direct accounts, the number of users who logged into CRISP DC in the last 30 days, and the number of organizations contributing clinical document architecture (CDAs) to CRISP DC.

	In fiscal year 2019 the District awarded a planning grant to screen, e-refer, and conduct follow-up for social needs and services, which was awarded to the DC Primary Care Association (DCPCA). This planning grant will inform the design and build of a technical screening and referral solution that will leverage the HIE network, called the DC Community Resource Information Exchange, or CoRIE. Funding for CoRIE was approved by CMS as part of the District's fall 2018 HITECH IAPD submission (approved on December 3, 2018) and is in active procurement. The CoRIE grant will be a competitively-bid and is a two to three-year grant that will be awarded in fall 2019.
	Future State: DCAS Release 3 will further integrate eligibility and enrollment for Non-MAGI Medicaid (Elderly and Disability Population), Alliance (Unknown Citizenship Status), Immigrant Children's Program, and Homeless Services. These programs will be incorporated into the DCAS system by spring 2020. Centralized data management will reduce data entry and improve data consistency and quality of care coordination information across programs. The CoRIE grant will conclude in 2021 and enable greater integration of services to facilitate transitions of care and e-referral from physician and mental health providers to community-based supports. DHCF is exploring strategies to achieve interoperability between DCAS and CoRIE to streamline screening and e-referrals for community-based supports.
	Summary of Actions Needed: Execute current workplans and timeline for DCAS deployment and CoRIE grant procurement. Continue efforts to facilitate interoperability between systems. (Timeline: 18-24 months)
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* DBH Policy 115.6 requires that MHRS and Adult Substance Abuse Rehabilitative Services (ASARS) providers maintain a behavioral health record and an electronic care plan.[9] Of the 62 MHRS, ASARS, and FSMHC providers that billed Medicaid in fiscal year 2018, 52 were known to have EHRs, though most were reliant on DBH-financed and supported systems which are not certified technology. Only 20 practices had a stand-alone EHR. As of summer 2019, nine of these behavioral health providers are participating with CRISP DC, the regional HIE. Among the nine acute care hospitals and six non-acute care hospitals in the District of Columbia, nearly all have an electronic health record. However, one of the two Institutes of Mental Disease, the Psychiatric Institute of Washington (PIW) documents care on paper. Saint Elizabeth's Hospital EHR must be upgraded to take full advantage of emerging HIE opportunities. Electronic care plans are developed as a requirement of the My DC Health Home program and the My Health GPS Health Home program.

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

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

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

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

[11] Ibid.

	information across programs. Based on these data, in the event of a medical or social need–or emergency–providers with whom a client or beneficiary has a relationship will receive an alert.
	Summary of Actions Needed: DHCF to implement workplan for the HIE Core Capabilities and Connectivity Grants to expand access to the ENS service among behavioral health providers. DHCF to implement workplans for DCAS and CoRIE and design for interoperability among systems to the extent feasible. DBH and DHCF will continue to review program requirements related to the Health Home programs to ensure these efforts are successfully supporting consistent use of electronic alerts and workflow that uses alerts in an efficient manner that improves transitions of care. (Timeline: 18-24 months)
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* All DBH clients for MHRS services complete and sign a standard consent form. This includes care coordination programs such as the My DC Health Home program. The District's HIE governance approach is based on an opt-out process implemented at the provider level. Individual level consent is not required for data exchange, provided the provisions of the Health Insurance Portability and Accountability Act (HIPAA) are met by providers and the HIE. The HIEs do not currently have a consent management system in place; individuals who submit an opt-out request are simply opted out of all HIE services. Until the past few years, the exchange of mental health data was not allowable in the District. As a result, all Medicaid claims that include one of an identified set of mental health ICD-9/10 codes are suppressed by CRISP DC (approximately 27 percent of all Medicaid claims) and are not exchanged. Pursuant to changes in the DC Mental Health Information Act in December 2016 providers may now use the HIE to exchange mental health encounter information, including care relationships, as long as notice has been provided to beneficiaries. CRISP DC has created a workgroup with the DC Behavioral Health Association to support mental health providers' participation in HIE. Counseling notes and 42 CFR part 2 information may not be exchanged without consent. DHCF is in the process of updating our Notice of Privacy Practices (NPP) and CRISP DC is contacting all of their participating providers to update their NPPs to allow for exchange of mental health encounter information. DBH has also expressed an intent to update provider NPPs to clarify provider policies and allow beneficiaries to opt out of HIE services. The DC HIE Policy Board subcommittee on Policy has a workgroup that is focusing on approaches to consent management.

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

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

[12] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid-Reimbursable-Telemedicine-Services-Notice-of-Fourth-Emergency-and-Proposed-Rulemaking.pdf
[13] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Telemedicine%20Provider%20Guidance_FINAL_5_5_17.pdf

	can also be used as an effective modality of care to provide MAT. DBH and DHCF will implement a TeleMAT pilot in fiscal year 2020 to explore further uses of telemedicine for individuals with co-occurring disorders.
	Summary of Actions Needed: Finalize DHCF telehealth rule for FFS. Implement MCO contract modifications to clarify telemedicine payment policy. Clarify policies and continue to share best practices implementing telemedicine for SMI/SED. (Timeline: 12-18 months)
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[14])	*Current State:* My Health GPS and FQHC providers have access to advanced analytic reports for population health management through HealthEC. This capability supports care coordination and panel management and is based on both claims and clinical data for the provider's panel of patients. In the base year of the Core HIE Capabilities grant with CRISP DC (fiscal year 2019), they will expand the number of providers who have access to these analytic tools and provide training at practice sites. *Patient Care Snapshot* is another CRISP DC tool that provides health information such as a patient's recent visits, procedures, and medications, in addition to a detailed list of organizations, providers, and care managers who have an existing relationship with the patient. CRISP DC also has an encounter notification service (ENS) which enables providers and care coordinators to receive real-time alerts when a patient has a hospital encounter. Organizations can customize ENS to receive the alerts that are most relevant to them, such as hospital admission, hospital discharge, or emergency room visits. To date, there are nearly 90 District practices enrolled in ENS and all Medicaid beneficiaries are on an active ENS panel with either their provider or MCO.
	Future State: CRISP DC and their partners will work together to create additional reports and an enhanced analytics capability to support care coordination and panel management, using claims and clinical data. Enhancements will allow staff and providers to address health issues in specific patient populations, thus delivering appropriate and targeted medical services when they are most needed. Later this year, CRISP DC will alert clinicians and discharge planners when a patient is enrolled in a care management program, such as a formal Health Home or an informal arrangement with an MCO case manager. In fiscal year 2020, integration of Fire and EMS data into the HIE will allow providers to be alerted via ENS of ambulance visits, even if these FEMS visits do not result in a transport or hospital encounter. Providing CRISP DC data

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

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

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

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

Section 3: Relevant documents

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