ATTACHMENT D
Section 1115 SUD Demonstration Implementation Plan

CMS' Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I – Milestone Completion

Milestones

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

Specifications:

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Current State:

The District's Department of Health Care Finance (DHCF) currently covers a wide array of OUD and SUD treatment services for Medicaid beneficiaries, including the range of services specified in Milestone 1. District SUD treatment services include assessment and diagnostic services; clinical care coordination; crisis intervention; individual, group, and family counseling; withdrawal management (WM) services; medication management; and medication-assisted treatment (MAT). Each of these services, with the exception of WM delivered in IMD settings, are covered by the Medicaid State Plan.

Residential treatment (ASAM levels 3.1, 3.3, and 3.5), as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD, are currently provided with local-only funding through the District's Department of Behavioral Health (DBH).

SUD treatment providers in the District provide services in accordance with the District of Columbia's Municipal Regulations (DCMR) and the individual needs of the client. The Medicaid State Plan governs the qualified practitioners for Medicaid covered services. For services that are not covered by Medicaid but are provided with local-only funding, qualified practitioner types are governed by DCMR Title 22, Chapter 63. See Appendix I for additional description of SUD treatment services and qualified practitioners. See Appendix II for additional requirements indicated by the ASAM level of care at which a provider is certified by DBH.

Future State:

The District is requesting waiver authority to allow for Medicaid reimbursement of residential treatment (ASAM levels 3.1, 3.3, and 3.5) as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD.

Below is a table that describes: 1) current SUD treatment services covered by the District at each level of care; 2) plans to improve access to SUD treatment services for Medicaid beneficiaries; and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	The Medicaid State Plan provides coverage for a wide array of outpatient services, including:[1] • Assessment and diagnostic • Clinical care coordination • Crisis intervention • Counseling • Medication management • MAT See Appendix II for additional requirements indicated by ASAM level 1.0.	Already provided.	No action needed.

| Coverage of intensive outpatient services | The Medicaid State Plan provides coverage for a wide array of intensive outpatient services, including:[2]

• Assessment and diagnostic
• Clinical care coordination
• Crisis intervention
• Counseling
• Medication management
• MAT

See Appendix II for additional requirements indicated by ASAM levels 2.1 and 2.5. | Already provided. | Conduct stakeholder engagement to identify potential modifications to current provider guidance and/or other DHCF and DBH policy to improve access to intensive outpatient services. (Timeline: 18-24 months) |

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[1] See State Plan Attachment 3.1A: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5-6), Supplement 6 to Attachment 3.1A (p. 1-18), Attachment 3.1B: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5), and Supplement 3 to Attachment 3.1B (p. 1-18).
[2] Ibid.

Coverage of medication assisted treatment (medications as well as counseling and other services)	The Medicaid State Plan provides coverage for all FDA-approved medications for use in MAT, as well as counseling and other services.[1]	Already provided.[2]	No action needed.
Coverage of intensive levels of care in residential and inpatient settings	The Medicaid State Plan provides coverage for inpatient hospitalizations in non-IMD settings.[3] Intensive residential care at ASAM levels 3.1, 3.3, and 3.5 is provided with local-only funding through DBH.[4] See Appendix II for additional requirements indicated by ASAM levels 3.1, 3.3, and 3.5.	Medicaid waiver and expenditure authority for intensive care delivered in an IMD setting is requested under this demonstration.	Medicaid waiver and expenditure authority requested.
Coverage of medically supervised withdrawal management	The Medicaid State Plan provides coverage for medically supervised WM in non-IMD settings.[5] WM services delivered in IMD settings are provided with local-only funding. See Appendix II for additional requirements indicated by ASAM level 3.7-WM.	Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this waiver.	Medicaid waiver and expenditure authority requested.

[1] See State Plan Attachment 3.1A: Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses (p. 5), Supplement 1 to Attachment 3.1A (p. 20), Attachment 3.1B: Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses (p. 4-5), and Supplement 1 to Attachment 3.1B (p. 19).

[2] Waiver authority is requested under this demonstration to exempt medications for MAT from the $1 co-payment otherwise associated with outpatient prescription medications.

[3] See state plan Attachment 3.1A: Inpatient Hospital Services (p. 1), Supplement 1 to Attachment 3.1A (p. 1-3), Attachment 3.1B: Inpatient Hospital Services (p. 2), and Supplement 1 to Attachment 3.1B (p. 1-3).

[4] See DCMR Title 22, Chapter 63.

[5] See State Plan Attachment 3.1A: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5-6), Supplement 6 to Attachment 3.1A (p. 1-18), Attachment 3.1B: Other Diagnostic, Screening, Preventive, and Rehabilitative Services (p. 5), and Supplement 3 to Attachment 3.1B (p. 1-18).

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

Specifications:

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and

- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current State:

Managed care organizations (MCOs) contracted with DHCF are required to provide behavioral health services, including SUD services, as defined in the State Plan, including physician and mid-level visits, inpatient hospitalization and emergency department services, Psychiatric Residential Treatment Facility (PRTF) services for enrollees less than 22 years old, and inpatient detoxification. MCOs are also required to provide inpatient treatment for enrollees aged 21 to 64 years old in an IMD, so long as the facility is a hospital providing SUD inpatient care or a sub-acute facility providing SUD residential services, and length of stay is of no more than 15 days. MCOs are required to develop and maintain a Utilization Management Program and conduct concurrent reviews and post-service reviews in accordance with their written Utilization Management policies and procedures. MCO Utilization Management policies and procedures are required to promote timely access to preventive treatment and rehabilitation services in accordance with evidence-based standards of health care, like InterQual Behavioral Health Criteria and Milliman Care Guidelines, and conform to managed health care industry standards. In addition, MCOs are responsible for referrals to DBH for outpatient SUD treatment.

For those services, as well as other DBH-funded services, the District's Assessment and Referral Center (ARC), managed by DBH, provides same day assessment and referral for individuals seeking treatment for SUD. There is also one mobile ARC, which visits communities throughout the District to conduct assessment and referral, as well as providing other services. DBH recently certified four additional intake and assessment sites where clients can be assessed and referred for SUD services.

To refer individuals seeking treatment to the appropriate program, qualified clinicians at the ARC, intake and assessment sites, and the mobile ARC conduct comprehensive assessments that includes the nature of the addiction, use history, any mental health care needs, and overall health status. The ARC, the intake and assessment sites, and the mobile ARC use an assessment tool called the Treatment Assignment Protocol (TAP), which incorporates both the Addiction Severity Index and ASAM criteria to ensure referral to an appropriate level of care and services.

After the appropriate level of care is determined, individuals can choose from a list of certified providers.

In addition to the intake and assessment providers, all SUD providers can perform ongoing and comprehensive assessments in the event of a change in an individual's status or to determine whether a different level of care or services is necessary. Authorizations for additional services or changes to placement or level of care are handled through DBH's Access Helpline (AHL). Providers submit the necessary documentation, including results from the TAP, urinalysis testing, and other clinical notes to AHL to request changes to or additional authorizations. Behavioral health professionals at AHL review the documentation and assessment results from providers to ensure interventions are appropriate for the diagnosis and level of care.

DBH's Program Integrity (PI) division conducts claims audits, false claiming investigations, and independent reviews to ensure all service delivery and documentation standards for SUD services are met.

Future State:

Concurrent with the demonstration, DBH is planning to further decentralize ARC services. In addition to the four newly certified intake and assessment providers, this will allow more certified community-based SUD providers to provide intake, assessment, and referrals, thereby creating multiple points of entry into the District's system of care for individuals in need of SUD services. DBH will ensure assessments continue to be based on tools like the TAP that are SUD-specific and reflect evidence-based clinical treatment guidelines.

DBH will continue PI activities and coordinate with DHCF's PI division, which will continue to ensure all standards are met for all services billed to Medicaid.

Below is a table that describes: 1) current use of evidence-based, SUD-specific patient placement criteria and utilization management approach in the District; 2) plans to increase the use of evidence-based, SUD-specific placement criteria and enhance utilization management; and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	The ARC, intake and assessment sites, and the mobile ARC use the TAP, which incorporates both the Addiction Severity Index and ASAM criteria, to determine appropriate level of care and services.	Decentralized intake, assessment, and referral system, where all SUD providers can provide intake and assessment services, to create multiple points of entry into the District's system of care.	DBH will ensure assessments continue to be based on tools like the TAP and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary. (Timeline: 12-18 months)

Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	AHL ensures beneficiaries have access to SUD services at the appropriate level of care. MCOs develop and maintain Utilization Management Programs to ensure beneficiaries have access to services, including SUD services, at the appropriate level of care.	Already implemented.	No action needed.
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	AHL ensures interventions are appropriate for the diagnosis and level of care. MCOs develop and maintain Utilization Management Programs to ensure interventions are appropriate for the diagnosis and level of care.	Already implemented.	No action needed.

Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings	DBH PI division ensures all service delivery and documentation standards for SUD services are met. The ARC, the intake and assessment sites, and the mobile ARC use the TAP to ensure all placements in residential treatment settings are appropriate. AHL ensures any changes to placement or level of care, including in residential treatment settings, are appropriate. AHL also authorizes any requests for additional services and provides oversight of lengths of stay in residential treatment settings. MCOs develop and maintain Utilization Management Programs that include reviewing placements in residential treatment settings.	Already implemented.	No action needed.

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

Specifications:

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;

- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Current State:

SUD treatment and recovery providers in the District, including all residential treatment providers, are regulated by DBH. DCMR Title 22, Chapter 63 specifies the certification standards for SUD treatment providers. The treatment framework of DCMR Title 22, Chapter 63 "is based on levels of care established by the American Society of Addiction Medicine (ASAM)"[1] and the certification process for each level of care aligns with the criteria set out by ASAM for all levels of care. Appendix II details the types of services, hours of clinical care, and staffing requirements at each ASAM level of care. SUD treatment providers must be certified by DBH in order to participate as District Medicaid providers.

Upon receipt of a complete application, DBH determines whether the applicant's facility services and activities meet the certification standards. To do so, DBH schedules and conducts an on-site survey. DBH is allowed access to all records necessary to verify compliance with certification standards and may conduct interviews with staff, others in the community, and clients (with client consent). DBH may deny certification if the applicant fails to comply with any certification standard. For approved providers, DBH issues one certificate valid only for the programs, premises, and levels of care as specified on the application.

Full certification as a SUD treatment provider is for one (1) calendar year for new applicants and two (2) calendar years for existing providers seeking renewal. Certification starts from the date of issuance of certification by DBH and is subject to the provider's continuous compliance with certification standards. A provider seeking renewal of certification is required to submit their certification application at least ninety (90) days prior to the termination of its current certification.

SUD providers are visited at least annually by DBH staff. DBH staff may conduct an on-site survey at the time of certification application, renewal, or at any other time during the period of certification. Upon presentation of proper identification, DBH staff have the authority to enter the premises of a SUD treatment or recovery program during operating hours for the purpose of conducting announced or unannounced inspections and investigations.

Decertification is the revocation of DBH certification and is issued by the Director of DBH. A decertified SUD provider may not provide any SUD treatment and shall not be reimbursed for any services as a SUD provider. Grounds for revocation include: failure to comply with certification requirements; breach of the contract with DBH for use of local funds, also known as a Human Care Agreement; violations of Federal or District law; or any other action that constitutes a threat to the health or safety of clients.

DCMR Title 22, Chapter 63 states that any certified provider may not deny admission for services to an otherwise qualified client because that person is receiving MAT services, even if the MAT services are provided by a different provider.[2]Additionally, under DBH Policy 311.3

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[1] See DCMR Title 22, Chapter 63, Section 6300.4.
[2] See DCMR Title 22, Chapter 63, Section 6300.8.

(dated August 19, 2015), access to methadone shall be made available to all clients including those in residential treatment, as clinically appropriate. SUD residential treatment providers who are not certified to provide MAT services are required to provide transportation for clients to obtain medications at the MAT clinic and participate in the coordination of client care with MAT providers.[1]

Future State:

DHCF and DBH will work with stakeholders to establish policies to ensure that appropriate facilitation between residential providers and clients occurs for all FDA-approved types of medications used in MAT.

Below is a table that describes: 1) current provider qualifications for residential treatment facilities; 2) plans to enhance provider qualifications for residential treatment; and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	DCMR Title 22, Chapter 63 lays out the certification standards for SUD treatment providers and aligns with the ASAM Criteria. Appendix II details the types of services, hours of clinical care, and staffing requirements at each ASAM level of care.	Already implemented.	No action needed.

[1] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/311.3%20TL-287.PDF

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	All SUD treatment providers in the District must apply for DBH certification. Upon receipt of a complete application, DBH determines whether the applicant's facility services and activities meet the certification standards as detailed in DCMR Title 22, Chapter 63. Full certification as a SUD treatment provider is for one (1) calendar year for new applicants and two (2) calendar years for existing providers seeking renewal. DBH staff may conduct an on-site survey at the time of certification application, renewal, or at any other time during the period of certification. SUD providers are visited at least annually by DBH staff.	Already implemented.	No action needed.

Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	DCMR Title 22, Chapter 63 states that any certified provider may not deny admission for services to an otherwise qualified client because that person is receiving MAT services, even if the MAT services are provided by a different provider. Under DBH Policy 311.3, access to methadone shall be facilitated for all clients including those in residential treatment, as clinically appropriate.	Ensure residential treatment facilities offer MAT for all FDA-approved types of medication on-site or facilitate access off-site.	DHCF and DBH will conduct stakeholder engagement and issue updated rulemaking, policies, bulletins, and/or care agreements as necessary to ensure residential treatment facilities offer or facilitate access to all FDA-approved medications for use in MAT. (Timeline: 12-18 months)

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Specifications:

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current State:

The District is entirely urban and there are certified SUD providers in each of the eight wards across the city. Appendix III lists all certified SUD providers in the District by level of care that are enrolled in Medicaid. There are no providers certified at ASAM level 3.7 (Short-Term Medically Monitored Intensive Withdrawal Management) in the District. Currently, all withdrawal management treatment in the District is provided in an inpatient hospital setting.

SUD providers work with DBH's Network Development team to continually maintain an up-to-date list of providers who are accepting referrals for new patients, are not accepting new patients, or who have temporarily suspended accepting new patients. This information is shared with the ARC and the AHL to ensure that they have current information when offering provider options to clients.

Additionally, the District is currently conducting a comprehensive assessment of the availability of SUD treatment services and beds using funding from the District of Columbia Opioid Response (DCOR) grant. The assessment will analyze SUD service adequacy with respect to demographics such as age, gender, and payer, and will assess the efficiency and effectiveness of the District's SUD treatment referral system.

Finally, DHCF contracts detail MCO provider network composition and access requirements. MCOs are required to develop and maintain a provider network which is sufficient to provide timely access to the full range of covered services to enrollees, including behavioral health services.

Future State:

The District is requesting waiver authority to allow for Medicaid reimbursement of residential treatment (ASAM levels 3.1, 3.3, and 3.5) as well as short-term, medically monitored WM services (level 3.7-WM) delivered in an IMD.

Concurrent with this demonstration, the District will work to certify additional providers to allow for treatment of individuals with SUD (ASAM level 3.7-WM), thereby increasing capacity to treat individuals with SUD for short-term, intensive stays in the community.

After the DCOR service assessment is complete, DBH and DHCF will consider strategies to address any gaps identified.

DHCF will also modify existing contracts, as necessary, to ensure sufficient provider capacity at critical levels of care is maintained for MCO enrollees.

Below is a table that describes: 1) current capacity to provide SUD treatment at each level of care; 2) plans to enhance provide capacity infrastructure; and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed

Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	There are certified SUD providers in each of the eight wards across the District. The District has 23 providers at 26 locations providing outpatient services. The District has 19 providers at 20 locations providing intensive outpatient services. The District has 3 opioid treatment programs (OTPs). In addition, in fiscal year 2018, 148 unique Medicaid providers prescribed buprenorphine and/or naltrexone. So far in fiscal year 2019, 167 unique Medicaid providers have prescribed buprenorphine and/or naltrexone.[2] The District has 8 providers in 9 locations providing intensive care in residential settings. Intensive care in residential settings is provided with local-only funding through DBH.	Medicaid waiver and expenditure authority is requested under this demonstration to exempt medications for MAT from the $1 co-payment otherwise associated with outpatient prescription medications. Medicaid waiver and expenditure authority for intensive care in an IMD setting is requested under this demonstration. Medicaid waiver and expenditure authority for WM services delivered in an IMD setting is requested under this demonstration. Expanded services to include WM.	Medicaid waiver and expenditure authorities requested. The District will also work to improve future assessments of SUD provider capacity, especially the availability of MAT and 3.7-WM services. (Timeline: 18-24 months)

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[2] Source: DC MMIS data accessed July 26, 2019, up to date as of July 19, 2019. These numbers only capture prescribed, non-injectable MAT medications.

	One private psychiatric hospital in the District provides WM services. The District's 7 acute care hospitals also all provide WM services. The Network Development team at DBH maintains an up-to-date list of SUD providers accepting new patients. As of July 2019, all providers are accepting referrals.		

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

Specifications:

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current State:

The District has implemented opioid prescribing guidelines. In 2018, DHCF updated its clinical prior authorization requirements on opioid prescriptions to include a program that limits the quantity and days of supply covered under the District's fee-for-service (FFS) Medicaid pharmacy benefit, on the basis of opioid-morphine milligram equivalents (MME). The program is designed to reduce the availability and utilization of high MME prescriptions and lessen the risk of SUD and diversion among Medicaid beneficiaries.[1] Between October 1, 2018 and July 1, 2019, there were 4,082 FFS Medicaid beneficiaries whose submitted opioid prescription claims exceeded the MME quantity and/or days of supply limits and triggered a review. Of those 4,082 FFS Medicaid beneficiaries, 1,057 received an authorization to exceed the MME quantity and/or days of supply limits based on medical need. The other 3,025 FFS Medicaid beneficiaries did not receive an authorization to exceed the MME and/or days of supply limits, thus lessening the potential risk of opioid misuse, addiction, and overdose.

DHCF covers naloxone for overdose reversal. Naloxone can be prescribed to Medicaid beneficiaries without prior authorization or any other restrictions. Other District agencies are also expanding access to naloxone for overdose reversal. For example, DC Health conducts a narcan/naloxone training every other month that is open to the public. The District Metropolitan Police Department (MPD) has also implemented a policy to require trained officers in specified units to carry naloxone while on duty. Naloxone-equipped members are to provide immediate assistance to overdose victims in accordance with MPD training.[2]

DC Health directs the District's Prescription Drug Monitoring Program (PDMP) with support from the vendor, Appriss, and has ongoing activities to increase utilization and improve functionality. As of July 2019, DC Health has implemented 22 direct PDMP integrations for District providers. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. As a result of these efforts, the District has seen a 24 percent increase in average number of PDMP queries per month between 2017 and 2018 and has experienced a 37 percent increase in total number of PDMP approved registrations in 2019 alone. The District also currently participates in interstate data sharing via the National

[1] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2018-25.pdf
[2] https://go.mpdconline.com/GO/GO_307_02.pdf

Association of Boards of Pharmacy (NABP) Prescription Monitoring Program InterConnect (PMPI) data sharing system. Additional information about the DC PDMP is included in Attachment A.

In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP, which is also anticipated to substantially increase PDMP registration and query.[1] Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine and naltrexone for Medicaid beneficiaries to check the DC PDMP and record findings in the patient's medical record.[2]

Concurrent with this demonstration, in July 2019, DBH launched its Community Response Team (CRT), a multi-site, 24/7 model of care consisting of a multidisciplinary team of licensed clinicians, community behavioral health specialists, and individuals with lived experience. The CRT provides critical incidents response, targeted community outreach, supportive behavioral health services, and community education.

In addition to the activities described above, District agencies have taken a number of other steps to address the opioid epidemic, including:

- **Opioid Task Force:** The multi-agency task force, jointly led by DBH and DC Health, monitors trends and identifies opportunities for policy interventions to reduce the frequency and severity of opioid-related overdoses. The task force meets monthly to review public health data and identify cross-agency strategies.

- **Medicaid Opioid Data Dashboard:** In 2018, DHCF was selected to participate in an IAP technical assistance program to create a Medicaid Opioid Data Dashboard. The dashboard presents metrics on OUD diagnoses, utilization of services, emergency room utilizations, and MAT utilization that can be shared with other District agencies to improve and better target service delivery.

- **Opioid Strategic Plan:** The District's opioid strategic plan, LIVE.LONG.DC.,[3] which can be located at https://dbh.dc.gov/publication/live-long-dc, was published in December 2018 and updated in March 2019. The plan identifies seven goals and related strategies to reduce opioid use, misuse, and related deaths through 2020.

  Work to implement the opioid strategic plan is already underway. In 2018, the District launched an anti-stigma social marketing campaign to increase awareness about opioid use, treatment, and recovery. The campaign provided community members with training on effective communication related to SUD and educated and promoted Good Samaritan laws for community members and law enforcement. The District also conducted provider

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[1] http://lims.dccouncil.us/Download/38775/B22-0459-SignedAct.pdf
[2] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf
[3] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf

continuing education on evidence-based guidelines for opioid prescribing and extended emergency legislation to make drug testing kits legal.

- **Removing Prior Authorization for MAT:** Consistent with the goals outlined in the opioid strategic plan, in April 2019 DHCF eliminated prior authorization requirements for buprenorphine and naltrexone for extended-release injectable suspension when used as part of MAT.[1]

- **DBH SOR Grant:** DBH received a two-year, $53 million State Opioid Response (SOR) grant from SAMHSA. The grant, known locally as the District of Columbia Opioid Response (DCOR) grant, will fund opioid-related prevention, treatment, and recovery support activities.

- **Buprenorphine-Waivered Provider Training:** The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) at DC Health has established a partnership via grant agreement with Howard University Hospital to provide DATA 2000 waiver training. The program conducts capacity building activities and provides technical support to clinicians–including physicians, NPs, PAs, and clinical pharmacists–eligible to apply for or already waived to prescribe buprenorphine-based treatment. The program aims to increase and expand the availability of providers willing to address OUD through appropriate prescribing and linkage to recovery services.

  HAHSTA also supports naloxone training and distribution, safe medication disposal, needle exchange programs, and other harm reduction initiatives.

In addition to the targeted responses to the opioid epidemic described above, the Prevention and Early Intervention Division at DBH broadly develops and delivers prevention and early intervention services, education, support, and outreach activities to help inform and identify children, youth, and their families who may be at risk or affected by some level of mental health and/or SUD. The division applies a public health and community-based approach to delivering evidence-based substance abuse prevention and mental health promotion programs.

The division administers grants and contracts that support four DC Prevention Centers located throughout the city. Each Prevention Center serves two designated wards. The Prevention Centers are dynamic hubs designed to strengthen the community's capacity to prevent and curtail the use of drugs at the local level. Each Prevention Center focuses on building collaborations and partnership within the wards and promoting healthy drug-free living. The staff at each Prevention Center works with communities and neighborhoods to provide substance abuse education, engage community leaders, youth, and families in taking action to reduce the risks and use of alcohol, tobacco, and other drugs, and address local conditions and elements that lead to substance abuse.

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[1] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf

Future State:

DHCF has already implemented opioid prescribing guidelines and covers naloxone for overdose reversal. Through SOR grant funding, DBH will enhance naloxone kit distribution by increasing the number of providers and sites distributing naloxone and providing additional training and naloxone kits for MPD.

The District will implement legislative changes mandating that all controlled substance prescribers in the District register for the DC PDMP. DC Health's outreach efforts to encourage PDMP registration, utilization, and integration are ongoing.

While the cornerstone of this demonstration is to expand the continuum of care by providing Medicaid reimbursement for individuals with SUD (or SMI) in residential and inpatient IMD settings, the District also plans to complement new residential and inpatient IMD services by bolstering the availability of community-based interventions, including:

- Crisis stabilization and mobile crisis outreach services in the community;
- Adding Recovery Support Services for individuals with SUD, including services delivered by certified peer specialists;
- Piloting Supported Employment Services for individuals with SUD, connecting individuals with training and skills to promote and maintain employment;
- Behavioral health services provided by independent and hospital-affiliated psychologists and other licensed behavioral health providers;
- Eliminating $1 co-payment cost-sharing requirement for prescriptions associated with MAT; and
- Transition planning services to permit certain behavioral health providers to participate in the discharge treatment planning process for individuals being discharged from an inpatient residential or other institutional setting.

Opioid-related prevention, treatment, and recovery support activities funded through the SOR grant are also ongoing. Through SOR, the District will initiate more than 70 activities, including:

- Implementation of a comprehensive, coordinated, and accessible system of OUD treatment and recovery care with multiple access points;
- Deployment of SBIRT, motivational interviewing, and peer support specialists across the continuum of care to identify and engage individuals in care;
- Training, technical assistance, and ECHO consultation for health care professionals to enhance their ability to treat clients with complex needs;
- Hospital emergency room MAT induction pilot to screen emergency room patients for potential SUD risk using SBIRT and connect interested patients who are identified as at-risk to a peer recovery coach to discuss recovery strategies and options, including initiating MAT; and
- Harm reduction efforts, such as using peers to engage individuals with SUD in harm reduction services, as well as developing a stakeholder workgroup to consider safe injection sites.

The District will evaluate the effectiveness of SOR grant activities to determine additional Medicaid changes through demonstration amendments or other means.

Overall, the demonstration will complement ongoing District efforts under the Medicaid State Plan and administration operations to enhance Adult Substance Abuse Rehabilitative Services (ASARS) and Mental Health Rehabilitation Services (MHRS) and identify opportunities for system improvements. The District's goal is to build a system of care that provides a greater continuum of behavioral health services; reduces substance use, misuse, and overdose fatalities; and moves Medicaid toward a more holistic, integrated approach to health care treatment.

Below is a table that describes: 1) current treatment and prevention strategies to reduce opioid abuse; 2) plans to implement additional prevention strategies and 3) a summary of action items that need to be completed to meet the milestone requirements.

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

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	DHCF has implemented MME limits, including a tapering period for "Current Users" of high doses of opioids, references to non-opioid pain management substitution strategies, and referral to SUD treatment. DHCF requires all prescribers to check the PDMP before providing prescriptions of buprenorphine.	Already implemented.	No action needed.

Expanded coverage of, and access to, naloxone for overdose reversal	Naloxone is covered by Medicaid and can be prescribed without prior authorization or any other restrictions. The District MPD requires trained officers in specified units to carry naloxone while on duty.	Through SOR, the District will distribute additional naloxone kits and conduct additional training.	Activities funded through the SOR grant are ongoing.

	DC Health conducts naloxone training every other month.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	DC Health directs the DC PDMP with support from the vendor, Appriss. As of July 2019, DC Health has implemented 22 direct PDMP integrations for District providers. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP. Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine or naltrexone for Medicaid beneficiaries to check the PDMP and record findings in the patient's medical record. Additional information about the DC PDMP is included in Attachment A.	The District will implement legislative changes mandating that all controlled substance prescribers in the District register for the DC PDMP. Additional information about the DC PDMP is included in Attachment A.	DC Health will update and clarify relevant rulemaking, as necessary. DC Health's outreach efforts to encourage PDMP registration, utilization, and integration are ongoing. Additional information about the DC PDMP is included in Attachment A.
Other	Various opioid-related prevention, treatment, and recovery support activities through SOR grant.	Under this demonstration, the District proposes to expand the service	Medicaid waiver and expenditure authority requested.

	DBH CRT responds to individual and community crises, conducts targeted community engagement and outreach, provides supportive behavioral health services, and community education.	continuum for SUD treatment, including: • Crisis stabilization and mobile crisis outreach services • Recovery Support Services • Supported Employment Services pilot • Behavioral health services provided by independent and hospital-affiliated psychologists and other licensed behavioral health providers • Eliminate $1 co-payment cost-sharing requirement for prescriptions associated with MAT • Transition planning services Opioid-related prevention, treatment, and recovery support activities funded through the SOR grant will continue.	DHCF and DBH will issue rulemaking, policies, bulletins, and/or care agreements as necessary for waiver services. (Timeline: 12-18 months) The District will evaluate the effectiveness of SOR grant activities to determine additional Medicaid changes through demonstration amendments or other means. (Timeline: 18-24 months) District efforts under the Medicaid State Plan and administration operations to enhance ASARS and MHRS services and identify opportunities for system improvements are ongoing.

6. Improved Care Coordination and Transitions between Levels of Care

Specifications:

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

Current State:

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

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

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

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

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

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[1] See DCMR Title 22, Chapter 63, Section 6302.
[2] See DCMR Title 22, Chapter 63, Section 6326.
[3] See DCMR Title 22, Chapter 63, Section 6334.

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

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

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

Future State:

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

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

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

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

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

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

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

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

Section II – Implementation Administration

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

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Section III – Relevant Documents

Not Applicable.

<u>**Attachment A – SUD Health Information Technology (IT) Plan**</u>

Section I.

Specifications:

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:
- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

Current State:

DC Health implemented the District's PDMP in 2016 and directs the DC PDMP with support from the vendor, Appriss. Dispensers in the District are required to report prescription data on dispensation of Schedule II, III, IV and V drugs, as well as products that contain butalbital and cyclobenzaprine.

As of July 2019, there are more than 8,000 health care professionals registered with the program who have conducted more than 150,000 PDMP queries, including patient lookups and self-checks. Data from 2018 show that the number of reported opioids dispensed in the District decreased by 8.5 percent compared to 2017 during a period in which the DC PDMP substantially increased the number of registered prescribers.

The District currently participates in interstate data sharing via the National Association of Boards of Pharmacy (NABP) Prescription Monitoring Program InterConnect (PMPI) data sharing system. The District currently shares data with 21 states. Through the District's PDMP vendor, Appriss, the District also has access to multi-state data via NarxCare. NarxCare is also a decision support platform that allows providers to coordinate care and actively manage a patient's risk or need for referral. NarxCare can also automatically deliver risk scores when a patient presents for care.

Multiple grants through the CDC and SAMHSA enabled DC Health to enhance the functionality of the DC PDMP, including implementation of quarterly prescriber reports, Appriss Analytics Package, and NarxCare. Beginning in April 2018, quarterly prescriber reports are available through providers' DC PDMP account dashboards. These reports summarize providers prescribing of covered substances and their standing among peers, which may positively influence prescribing and treatment decisions.

The DC PDMP has Tableau analytic software that enables DC Health and participating prescribers to view, track, and analyze trends in long-term prescribing. Current PDMP data

indicate a decline in opioid prescribing in the District. Additionally, a clear majority of District providers' long-term trend in opioid prescribing shows patterns are generally in line with or below CDC opioid-morphine milligram equivalents (MME) guidelines.

Additional CDC funding is available to support PDMP integration with electronic health records (EHRs) in the District. As of July 2019, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration. DC Health is also conducting an extensive public awareness campaign regarding prescription-related opioid use. As a result of these efforts, the District has seen a 24 percent increase in average number of PDMP queries per month between 2017 and 2018 and has experienced a 37 percent increase in total number of PDMP approved registrations in 2019 alone.

The Medicaid program has additional treatment and prevention strategies to address SUD, including a Pharmacy Lock-in Program (PLP). The PLP restricts Medicaid beneficiaries to the use of one pharmacy when their medication history reflects safety concerns.[1] The PLP is designed to safeguard the appropriate use of mediations when a Medicaid beneficiary misuses drugs in excess of the customary dosage for the proper treatment of a given diagnosis or misuses multiple drugs in a manner that can be medically harmful.

In 2018, DHCF imposed new limits on opioid-MME in Medicaid prescriptions.[2] The limits are designed as a preventive method to reduce the risk of opioid-naïve and opioid-experienced beneficiaries from unintentionally becoming addicted to or overdosing on prescription opioids. The limits are based on national best practices, including the CDC Guideline for Prescribing Opioids for Chronic Pain.

In 2019, the DC Council passed legislation requiring all controlled substance prescribers to register for the DC PDMP, which is also anticipated to substantially increase PDMP registration and query.[3] Consistent with the legislation, DHCF requires all prescribers of MAT-related buprenorphine and naltrexone for Medicaid beneficiaries to check the District's Prescription Drug Monitoring Program (PDMP) and record findings in the patient's medical record.[4]

Future State:

DC Health's work to improve participation in the PDMP is ongoing. In July 2019, all licensed prescribers and dispensers of controlled substances will be required to register with the DC PDMP. DC Health will work closely with all District health care professional licensing boards and stakeholder organizations to ensure prescribers and pharmacists are aware of the new mandate and are able to register in a timely manner to ensure compliance.

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[1] https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N0020609
[2] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal%2018-25.pdf
[3] http://lims.dccouncil.us/Download/38775/B22-0459-SignedAct.pdf
[4] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Policy%20%2319-001%20Removal%20of%20Prior%20Auth.%20Req.%20for%20Medication-Assis_0.pdf

In addition, DC Health will continue supporting further integration with EHRs and pharmacy management systems. Integration with regional health information exchange, via CRISP DC and other District HIEs, is also planned. The ultimate goal is to ensure that prescribers and dispensers have single sign-on access to the DC PDMP in order to facilitate PDMP query for all prescriptions of mandated covered substances, while minimizing disruptions to clinical workflow.

DC Health will also continue engaging partners from other jurisdictions to expand data sharing agreements to access PDMP data. In addition, the CDC will require participation in the federal database, RxCheck, which may provide further opportunities for interstate data sharing.

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

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	DC Health and the DC PDMP participate in the NABP PMP InterConnect data sharing system. The District currently shares data with 21 states. Through the District's PDMP vendor, Appriss, the District also has access to multi-state data via NarxCare. Utilizing multi-state data, NarxCare can automatically deliver risk scores when a patient presents for care.	Already implemented.	DC Health will explore integration with RxCheck. (Timeline: 18-24 months)
Enhanced "ease of use" for prescribers and other state and federal stakeholders	The DC PDMP includes the Appriss Analytics Package which enables the system to generate prescriber reports	Expanded DC PDMP-EHR integrations with clinical organizations.	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP.

	summarizing prescribing patterns and comparing prescribing practices to peers. Through CDC funding, DC Health has supported the initial cost of PDMP integration with EHRs so that providers can view information from the DC PDMP without having to open a separate window or system. To date, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration.		
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	District providers who have participation agreements with CRISP DC, one District HIE, have access to data available via NABP's PMPI.	DC PDMP integrated with CRISP DC to track prescribing and facilitate query.	DC Health will integrate District HIEs with the DC PDMP via Appriss. (Timeline: 18-24 months)
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[1] (see also	The DC PDMP has Tableau analytic software that enables DC Health and participating prescribers to view, track, and analyze	Expanded use of Tableau analytics software to conduct additional compliance reviews and analysis of trends.	DC Health's work to enhance the analytic capabilities within the DC PDMP is ongoing.

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[1] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

"Use of PDMP" #2 below)	trends in long-term prescribing. DC Health's outreach and clinical coordinators provide academic detailing to ensure District providers have updated information on CDC guidelines on opioid prescribing. DHCF has a Pharmacy Lock-in Program (PLP) to restrict Medicaid beneficiaries to the use of one pharmacy when their medication history reflects safety concerns. DHCF has limits on opioid-MME in Medicaid prescriptions.	The District's Drug Utilization Review (DUR) Board will offer provider education seminars on safely prescribing opioids for chronic pain.	DC Health's academic detailing activities are ongoing. DHCF's PLP will remain in place. DHCF's opioid-MME limits will remain in place. The District's DUR Board will create and offer provider education seminars on safely prescribing opioids for chronic pain. (Timeline: 12-18months)
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The District's PDMP vendor, Appriss, maintains a proprietary patient matching algorithm to match patients receiving opioid prescriptions. With respect to the District's MPI for health information exchange, the MPI for CRISP DC has	As the DC PDMP is integrated with HIE, a workflow similar to other national patient matching approaches will be implemented in order to leverage the strength of existing patient matching algorithms.[2]	District stakeholders will continue collaborating to ensure the District's approach to patient matching increasingly meets the criteria for Level 4 of the Sequoia Project's patient matching maturity model, indicating *"innovation, on-going optimization,*

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[2] The integration of MPIs is anticipated to function using the following workflow: 1) Patient is searched in HIE using the HIE's matching algorithm; 2) User selects patient; 3) The patient's demographics are sent to the DC PDMP; and 4) The DC PDMP matches to the nearest likely patient and presents the data.

	arguably achieved Level 3 maturity using the Sequoia Project's model, which indicates "*advanced use of existing technologies with associated management controls and senior management awareness, use of quality metrics*."[1]		*and senior management active involvement."*
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/ business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	The DC PDMP is available to all providers in the District. Through CDC funding, DC Health has supported the initial cost of PDMP integration with EHRs so that providers can view information from the DC PDMP in the prescribing workflow, without having to open a separate window or system. To date, the DC PDMP program has implemented 22 connections with health entities, such as pharmacy dispensing systems, HIEs, and EHRs, through the Statewide Gateway integration.	Expanded DC PDMP-EHR integrations and DC PDMP-HIE integrations will support workflow and business process improvements.	In summer and fall 2019, DC Health will use CDC funding to integrate additional EHRs with the DC PDMP. Training and technical assistance for organizations utilizing HIE services is ongoing.

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[1] See: https://sequoiaproject.org/resources/patient-matching/

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

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

Section II. Implementation Administration

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Section III. Relevant Documents

Not Applicable.

Appendix I – SUD Treatment Services and Qualified Practitioners

Medicaid SUD Treatment Services and Qualified Practitioners[1]

Service Description	Qualified Practitioners
Assessment/Diagnostic and Treatment Planning Services: Assessment/diagnostic services include the evaluation and ongoing collection of relevant information about a client to determine or confirm a SUD diagnosis and the appropriate level of care. The assessment serves as the basis for the plan of care, which establishes medical necessity, and is designed to help the client achieve and sustain recovery.	Physician, psychologist, licensed independent clinical social worker (LICSW), licensed graduate social worker (LGSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), advance practice registered nurse (APRN), certified addiction counselor (CAC) I and II, and registered nurse (RN)
Clinical Care Coordination (CCC): The initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a client's care needs. CCC services focus on linking clients as they transition through the levels of care and ensuring that the plan of care is formulated with the overarching goal of recovery, regardless of the client's current status.	Physician, psychologist, LICSW, LGSW, APRN, RN, licensed independent social worker (LISW), LPC, and LMFT
Crisis Intervention: Immediate short-term treatment intervention, which assists a client to resolve an acute personal crisis that significantly jeopardizes the client's treatment, recovery progress, health, or safety.	Physician, psychologist, LICSW, LGSW, APRN, RN, LISW, LPC, LMFT, and CAC I and II
SUD Counseling/Therapy, including individual/group/family/group psychoeducation: Individual SUD counseling/therapy is a face-to-face service for symptom and behavior management; development, restoration, or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills to facilitate long-term recovery. Group therapy includes cognitive behavioral groups, support groups, and interpersonal process groups. Family counseling/therapy is a planned, goal-oriented therapeutic interaction between the practitioner and the client's family, with or without the client present.	Physician, psychologist, LICSW, LGSW, APRN, RN, LISW, LPC, LMFT, and CAC I and II

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[1] The Medicaid State Plan governs the qualified practitioners for Medicaid covered services.

Psychoeducational groups are designed to educate clients about substance abuse and related behaviors and consequences.	
Medication Management: Includes the coordination and evaluation of medications consumed by clients, monitoring potential side effects, drug interactions, compliance with doses, and efficacy of medications. Also includes the evaluation of a client's need for MAT, the provision of prescriptions, and ongoing medical monitoring/evaluation related to the use of psychoactive drugs.	Physician, APRN, RN, licensed practical nurse (LPN), PA, LICSW, LISW, LGSW, LPC, and CAC I and II within scope of respective licenses
Medication Assisted Treatment (MAT): The use of pharmacotherapy treatment for opioid or other forms of dependence. A client who receives MAT must also receive SUD counseling/therapy. Use of this service should be in accordance with ASAM service guidelines.	Physician, APRN, PA (supervised by physician), RN, and LPN (supervised by MD, RN, or APRN)

Non-Medicaid SUD Treatment Services and Qualified Practitioners[1]

Service Description	Qualified Practitioner
Case Management: Implementation of the plan of care and administrative facilitation of the client's service needs, including, but not limited to, scheduling of appointments, assisting in completing applications, facilitating transportation, tracking appointments, and collecting information about the client's progress. Also encompasses the coordination of linkages such as vocational/educational services, housing services, legal monitoring entities, child care, public assistance, and social services. Also includes training in the development of life skills necessary to achieve and maintain recovery.	Clinical staff authorized to provide treatment and other services based on their license; individual with at least a bachelor's degree from an accredited college or university in social work, counseling, psychology, or closely related field; individual with at least a GED or high school diploma, four (4) years of relevant, qualifying full-time-equivalent experience in human service delivery; certified recovery coaches; or certified peer specialists.
Drug Screening: Toxicology sample collection and breathalyzer and urine testing to determine and detect the use of alcohol and other drugs.	There is no specific qualified practitioner type but providers must comply with all District regulations on drug screening, including chain of custody requirements and proper training to collect samples.

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[1] For services that are not covered by Medicaid, qualified practitioner types are governed by DCMR Title 22, Chapter 63.

Appendix II – Additional Provider Requirements by ASAM Level of Care[1]

ASAM Level of Care	Provider Requirements
Level 1.0: Opioid Treatment Program (OTP)	OTPs deliver medication assisted treatment (MAT) in accordance with District and Federal regulations, as well as with ASAM practice guidelines. Under DBH policy, the provision of MAT must be accompanied by a clinically appropriate array of SUD treatment services including counseling. Under DHCF policy, the expectation is that providers will provide linkages to these services if not offer them directly and encourage beneficiaries to seek continued support.[2]
Level 1.0: Outpatient	Providers shall have the capacity to provide up to eight (8) hours of SUD treatment services per week, per client.
Level 2.1: Intensive Outpatient Program (IOP)	Providers shall have the capacity to provide a minimum of nine (9) hours of a mixture of SUD treatment services per week for adults and at least six (6) hours of SUD treatment services per week for youth under the age of twenty-one (21).
Level 2.5: Day Treatment	Providers shall have the capacity to provide a minimum of twenty (20) hours of a mixture of SUD treatment services per week, per client.
Level 3.1: Clinically Managed Low-Intensity Residential	Providers shall have the capacity to provide a minimum of five (5) hours of a mixture of SUD treatment services per week, per client.
Level 3.3: Clinically Managed Population-Specific High-Intensity Residential	Providers shall have the capacity to provide a minimum of twenty (20) hours of mixture of SUD treatment services per week, per client. Case management alone does not satisfy the minimum service hour requirements.
Level 3.5: Clinically Managed High-Intensity Residential	Providers shall have the capacity to provide a minimum of twenty-five (25) hours of a mixture of SUD treatment services per week, per client. Case management alone does not satisfy the minimum service hour requirements.
Level 3.7: Short-Term Medically Monitored Intensive Withdrawal Management	Twenty-four (24) hour medically directed evaluation and withdrawal management services shall be provided. Additionally, providers must have a physician on staff that is able to respond within one (1) hour of notification. Providers shall have medical staff (MD, PA, APRN, or RN) on duty twenty-four (24) hours per day, seven (7) days per week. Medical staff shall have a client-to-staff ratio of 12-to-1 during daytime operating hours, a 17-to-1 ratio during

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[1] DCMR Title 22, Chapter 63.
[2]https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Final%20Policy%20Access%20to%20Buprenorphine.pdf

|	evening hours, and a 25-to-1 ratio during the night shift. Providers shall have psychiatric services available on-site, through consultation or referral as medically necessary.

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

ASAM Level of Care	Certified Providers Enrolled in Medicaid
Level: Opioid Treatment Program (OTP)	• Partners in Drug Abuse Rehabilitation and Counseling (PIDARC) • Good Hope Institute • United Planning Organization
Level 1.0: Outpatient	• Calvary's Healthcare • Clean and Sober Streets • Community Connections • Family and Medical Counseling Services Inc. • Federal City Recovery Services • Good Hope Institute • Hillcrest Children and Family Center (2 locations) • Holy Comforter Community Action Group Outpatient Program • Inner City Family Services • LaClinica Del Pueblo • Latin American Youth Center • Life Stride, Inc. • MBI Health Services, LLC (2 locations) • PIDARC • Regional Addiction Prevention (RAP) Inc. • Salvation Army Harbor Light Center • So Others Might Eat (SOME) (2 locations) • United Planning Organization • Volunteers of America • Washington Hospital Center Outpatient Behavioral Health Services • Whitman Walker Clinic (2 locations)
Level 2.1: Intensive Outpatient Program (IOP)	• Calvary's Healthcare • Clean and Sober Streets • Community Connections • Family and Medical Counseling Services Inc. • Federal City Recovery Services • Goshen Health Care and Management Services • Hillcrest Children and Family Center (2 locations) • Holy Comforter Community Action Group Outpatient Program • LaClinica Del Pueblo • Life Stride, Inc. • MBI Health Services, LLC (2 locations)

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[1] Data current as of July 2019.

	• Regional Addiction Prevention (RAP) Inc. • Salvation Army Harbor Light Center • So Others Might Eat (SOME) (2 locations) • Washington Hospital Center Outpatient Behavioral Health Services
Level 2.5: Day Treatment	• Holy Healthcare Behavioral Services • MBI Health Services, LLC • Regional Addiction Prevention (RAP) Inc.
Level 3.1: Clinically Managed Low-Intensity Residential	• Clean and Sober Streets • Federal City Recovery Services (2 locations) • Salvation Army Harbor Light Center • Samaritan Inns Inc. (2 locations)
Level 3.3: Clinically Managed Population-Specific High-Intensity Residential	• Regional Addiction Prevention (RAP) Inc. • Samaritan Inns Inc. (2 locations)
Level 3.5: Clinically Managed High-Intensity Residential	• Clean and Sober Streets • Federal City Recovery Services • Regional Addiction Prevention (RAP) Inc. • Safe Haven Outreach Ministry, Inc. – Sibley Plaza • Salvation Army Harbor Light Center • Samaritan Inns Inc.

Appendix IV – SUD Provider Locations in the District, by ASAM Level of Care[1]
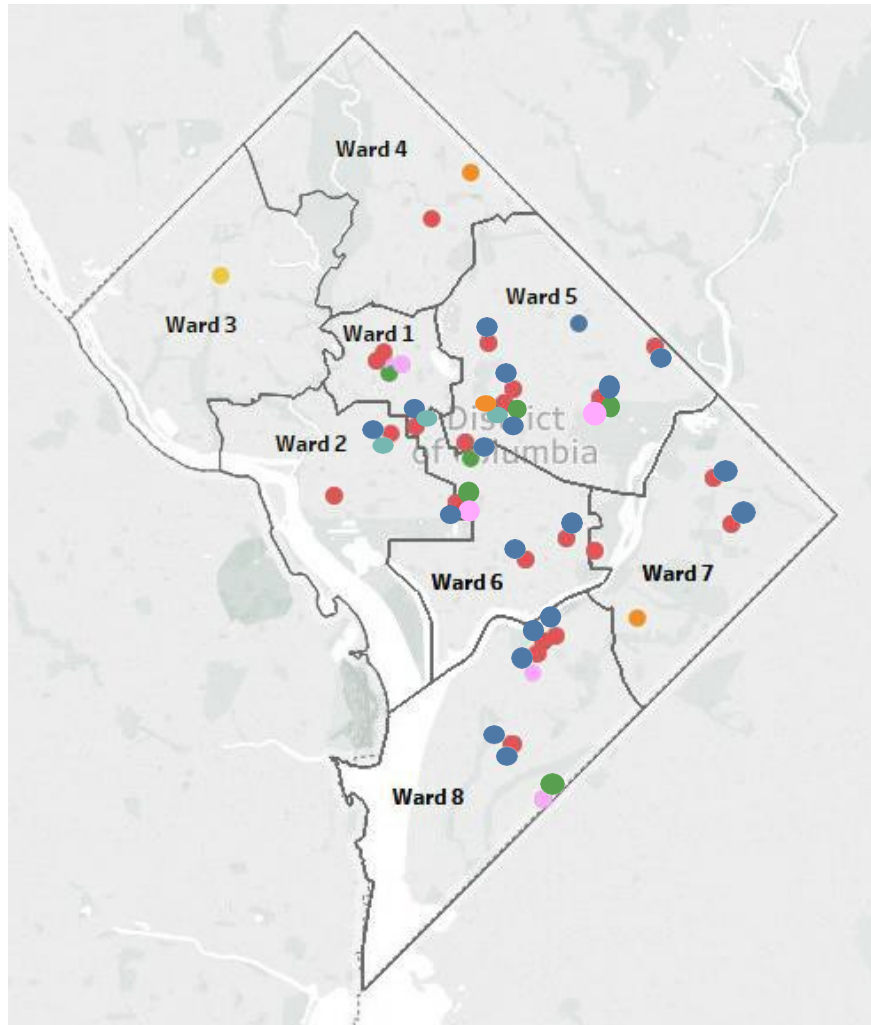
ASAM Level of Care	
🔴	Level 1.0: OTP or Outpatient
🔵	Level 2.1: Intensive Outpatient Program
🟠	Level 2.5: Day Treatment
🟣	Level 3.1: Clinically Managed Low-Intensity Residential
🌊	Level 3.3: Clinically Managed Population-Specific High-Intensity Residential
🟢	Level 3.5: Clinically Managed High-Intensity Residential
🟡	Level 3.7: Short-Term Medically Monitored Intensive Withdrawal Management

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[1] Data current as of July 2019.