District of Columbia Section 1115 Medicaid Demonstration Renewal Request

Draft Application for Public Comment

April 1, 2024

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I. Introduction

a. Purpose

The Department of Health Care Finance (DHCF) is requesting a five-year renewal of the District of Columbia's Behavioral Health Transformation Section 1115 Demonstration, which ends on December 31, 2024. DHCF is requesting an extension of two (2) components from the original demonstration while also requesting additional authorities.

The purpose of this renewal is to continue to address ongoing structural challenges and gaps to provide a more seamless experience of care, improve treatment rates and outcomes, and promote healthier lives for District residents. The aims of this renewal align with the overarching mission of DHCF to provide comprehensive, cost-effective, and quality healthcare services for all District residents, addressing not only behavioral health but also physical and social needs. Focusing on improving health outcomes ensures that all people have an equal opportunity to achieve their optimal health. In line with this, DHCF is transitioning towards a holistic approach to health care that integrates social needs, aiming to create a health system that delivers 'whole-person' care.

Medicaid beneficiaries are more likely than the general population to experience health-related social needs such as high-stress environments, housing instability, food insecurity, and poverty. The term health-related social need (HRSN) refers to health-harming conditions such as housing instability and food insecurity. Similarly, social determinants of health (SDOH) are the factors that impact health outcomes, including economic stability, education, health care access, and the built environment or neighborhood. With this renewal, DHCF's initiatives to incorporate addressing social needs into care delivery and improve care coordination for beneficiaries will include: adding additional services and supports to Medicaid that address HRSN; integrating physical and behavioral health care delivery with HRSN; and infrastructure investments to support care coordination, screening, and delivery of services and supports to address HRSN.

A subset of District Medicaid beneficiaries eligible for 1915(c) and 1915(i) waivers, can receive housing and nutrition services and supports. Managed care plans (MCPs), with review and approval by DHCF, can also provide their own unique value-added benefits to support HRSN. However, these services are not available to all Medicaid beneficiaries. There are also gaps in care for individuals during transitions periods, like justice-involved individuals returning to the community. Addressing SDOH is vital for achieving equitable health outcomes. Therefore, addressing Medicaid beneficiary HRSNs is key to reducing persistent health disparities experienced by beneficiaries across the program. Further, DHCF's vision for whole-person, beneficiary-centered care relies on addressing needs holistically, and inclusive of HRSN.

The District believes that Medicaid reimbursement for the targeted HRSN services requested in this demonstration will help eligible beneficiaries residing in the District to stay connected to Medicaid coverage and access needed health care. The District intends to test whether expanding eligibility for these services to populations beyond those receiving section 1915(c) and 1915(i) home and community-based services (HCBS) waivers or providing additional services will

improve the health outcomes of certain Medicaid beneficiaries and improve their utilization of appropriate care. Access to targeted HRSN services may also help to reduce health disparities.[1]

This application builds on the existing demonstration goal of maximizing access to quality behavioral health services while including new goals to guide whole-person centered initiatives. The new goals address root causes of health disparities by also focusing on SDOH by incorporating HRSN services to address structural disparities including housing security and food insecurity in tangible ways that will improve health outcomes. Specifically, the new goals are aimed around improving health outcomes during transitions.

b. Rename from Behavioral Health Transformation Demonstration

DHCF proposes to implement an updated program design that broadens the focus of the Behavioral Health Transformation Section 1115 Demonstration to address several SDOH. This includes implementing HRSN benefits and supporting transition populations to reduce health care disparities in the District. Accordingly, the proposed new name for this demonstration program extension is Whole-Person Care Transformation.

c. Overview of DC Medicaid Program

In Fiscal Year (FY) 2023, there were approximately 308,000 District residents enrolled in Medicaid.[2] Those enrolled in Medicaid generally receive services through fee-for-service (FFS) or Medicaid managed care plans (MCPs).

Nearly nine (9) in ten (10) Medicaid beneficiaries receive access to health care through MCPs. Specifically, in FY 2023, 86% of beneficiaries received services through MCPs, while 14% received access through FFS.[3] Fee-for-service beneficiaries go directly to providers who accept Medicaid, and the District is responsible for the clinical, administrative, and claims functions of the FFS population. FFS beneficiaries include Medicaid-covered groups not in managed care, members who are awaiting managed care assignment, and services excluded from MCP contracts.

In managed care, beneficiaries are enrolled in one (1) of five (5) MCPs contracted with the District.[4] Managed care covers acute, primary, specialty, and certain behavioral health services. The District contracts with MCPs at capitated rates to provide access to services for the DC Healthy Families Program (DCHFP), the Child and Adolescent Supplemental Security Income Program (CASSIP), and dual-eligible individuals.

Populations not included in the DCHFP managed care include beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE), the Intellectual and Developmental

[1] Oregon Health Plan Demonstration Approval. https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf
[2] Data extracted from the Medicaid Management Information System (MMIS) in February 2024.
[3] Data extracted from the Medicaid Management Information System (MMIS) in February 2024.
[4] Two of the District's MCPs serve populations with special needs through the District Duals Choice Dual-Eligible Special Needs Plan (D-SNP) and Health Services for Children with Special Needs (HSCSN). The remaining three MCPs serve the DC Healthy Families Program.

Disabilities (IDD) Waiver Program, the Individual and Family Support (IFS) Waiver Program, and the Elderly and Persons with Physical Disabilities (EPD) Waiver Program. Beneficiaries placed on spend-down, incarcerated, in the foster care system, or admitted to a psychiatric residential treatment facility (PRTF) for more than 30 days are also, generally, not enrolled in MCPs.

To ensure that care is appropriately connected and data driven, DHCF serves as the State Health Information Technology Coordinator and leads health information technology (HIT) and health information exchange (HIE) policy. HIT and HIE systems allow providers to support outreach, referral, care coordination, care transitions and step-down, and client treatment and recovery efforts and further allow the District to support person-centered care and improve health outcomes.

II. Program Overview, Description and Objectives

On November 6, 2019, the Centers for Medicare and Medicaid Services (CMS) approved the District's section 1115(a) demonstration, the "Behavioral Health Transformation" (Project No. 11-W-00331/3) which allowed the District to begin receiving federal financial participation effective January 1, 2020 through December 31, 2024, to provide services to address gaps in the behavioral health delivery system for serious mental illness (SMI)/serious emotional disturbances (SED) and substance use disorder (SUD).

The overall goals of the Behavioral Health Transformation demonstration were to maintain and enhance access to mental health services, opioid use disorder, and other SUD services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with SMI/SED or SUD. Additionally, there were five (5) specific outcome goals for SMI/SED and six (6) specific outcome goals for SUD outlined in the approved demonstration. CMS requires an independent evaluation to assess the District's progress in the achievement of these specific outcome goals. The District selected the American Institutes for Research (AIR) to conduct the independent evaluation. The findings from AIR's interim evaluation report, which includes data from the first 2.5 years of the demonstration, are summarized below. As highlighted in the interim evaluation report, the COVID-19 public health emergency (PHE) occurred within two months of the demonstration's start and continued through the entire period of the report's analysis. Although AIR used control variables to account for the COVID-19 PHE and the influence of other concurrent District programs targeting similar populations and outcomes, the impact of the demonstration on the SMI/SED and SUD goals may not have been completely isolated. The District's progress in achieving the SMI/SED and SUD goals is presented, to the extent possible, below. An electronic copy of AIR's complete draft interim evaluation report may be obtained on the DHCF website at http://dhcf.dc.gov/1115-waiver-initiative and will be included as an appendix upon final submission of this demonstration renewal request to CMS.

a. Status of SMI/SED Goals

1. Reduce utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

The District made progress in meeting this goal during the demonstration period. While utilization of the hospital ED among Medicaid beneficiaries with SMI/SED has decreased, there has been no significant change in the length of stay associated with hospital ED visits. It is unclear whether the lack of progress in length of stay is associated with changes in policies on care delivery during the COVID-19 pandemic.

2. Reduce preventable readmissions to acute care and specialty hospitals and residential settings.

The District has not yet achieved this goal. A statistically significant increase in unplanned 30-day readmissions to acute care and specialty hospitals and residential settings was observed. However, data specific to preventable readmissions was not available to totally assess progress on meeting this goal.

3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the District.

The District has met this goal during the demonstration period. The availability of crisis stabilization services and mobile crisis units has increased during the demonstration period. Additionally, the number of beneficiaries utilizing crisis stabilization services increased.

4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.

The District has met this goal during the demonstration period. The number of beneficiaries with SMI/SED who used any mental health services increased. The number of episodes of care where institution for mental diseases (IMD) providers billed the District Medicaid program for assessments or treatment of physical conditions also increased during the demonstration period.

5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Results related to this goal during the demonstration period are mixed. The percentage of beneficiaries with SMI/SED who received mental health follow-up within seven (7) to thirty (30) days after receiving care for a mental health illness/episode at a hospital or emergency department, remained the same and decreased, respectively.

b. Status of SUD Goals

1. Increase rates of identification, initiation, and engagement in treatment of SUD.

Results related to this goal during the demonstration period are mixed. While there was no statistically significant increase in the identification, initiation, and engagement of SUD treatment, the District also did not observe a statistically significant decrease in these rates either. The District continues to observe rates of identification, initiation, and engagement in a post-COVID-19 environment.

2. Increase adherence to and retention in treatment.

The District has not yet achieved this goal. The District experienced no change in the percentage of beneficiaries adherent to and retained in treatment.

3. Reduce overdose deaths, particularly those due to opioids.

Data is not yet available to assess the District's progress on reducing overdose deaths, particularly those due to opioids.

4. Reduce utilization of hospital emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

Results related to this goal during the demonstration period are mixed. There was no reduction in the utilization of hospital emergency departments and inpatient hospital settings for preventable or medically inappropriate incidents. Data specific to incidents that were preventable or medically inappropriate were not quantified.

5. Decrease admissions to the same or higher level of care where the readmission is preventable or medically inappropriate.

The District has not yet achieved this goal. The District experienced no change in this metric during the demonstration period.

6. Improve access to care for physical health conditions among beneficiaries with SUD.

The District has not yet achieved this goal. During the demonstration period, there was a decrease in the percentage of Medicaid beneficiaries with SUD who received care for a physical condition.

c. Changes in Service Authority since the Approval of the Behavioral Health Transformation Demonstration

Special terms and conditions of the Behavioral Health Transformation demonstration allowed for temporary waiver authority for certain services through December 31, 2021. Several services were moved from the STCs twenty (20) to thirty-five (35) to the District's Medicaid State Plan, as detailed below:

- DC-21-0009, approved by CMS on September 24, 2021, with an effective date of January 1, 2022, transitioned STC 27 of the demonstration to the Medicaid State Plan, and permits the District to enroll additional licensed providers (psychologists, licensed

independent clinical social workers, licensed professional counselors, and licensed marriage and family therapists) to serve the behavioral health population.

- DC-21-0010, approved by CMS on April 26, 2022, with an effective date of January 1, 2022, transitions mental health rehabilitative services (MHRS) and adult substance use rehabilitative services (ASURS), which include STCs 20 through 26 and STC 28, to the Medicaid State Plan. These services include STC 21, Comprehensive Psychiatric Emergency Program (CPEP); STC 22, mobile crisis intervention and outreach services; STC 23, psychiatric residential crisis stabilization services; STC 24, recovery support services; STC 25, psychosocial rehabilitative services; STC 26, trauma informed services; and STC 28, transition planning services.
- DC-21-0011, approved by CMS on May 23, 2022, with an effective date of July 1, 2022, transitions STCs 29 and 30, supported employment services, from the demonstration to the Medicaid State Plan.

Implementation of these services under the Medicaid State Plan has assisted in closing the gap in behavioral health services in the District. During the initial demonstration period, services designed to address SED were moved from the demonstration to the Medicaid State Plan. As sufficient services are available under the Medicaid State Plan to address SED needs, this demonstration renewal identifies new areas of need in the District's delivery system.

d. Objectives of the Whole-Person Care Transformation Demonstration

As the District moves toward a whole-person care delivery system, it strives to achieve a comprehensive health delivery system that addresses SDOH. The District intends to use targeted HRSN services requested in this demonstration to help eligible beneficiaries residing in the District to stay connected to Medicaid coverage and access needed health care.[5] Through this demonstration, the District will address ongoing structural challenges with the delivery of services for SMI and SUD, and target HRSN related to housing, nutrition, and justice-involvement that have systemic impacts on individual and community health. As the District continues to close the gap in and achieve a comprehensive health system, it has three overarching demonstration goals: continue to maximize access to quality behavioral health services; improve health outcomes during transitions to reduce health disparities and drive sustainable transformation through reentry and HRSN services; and develop and maintain infrastructure to support the delivery of reentry and HRSN services.

III. Demonstration Renewal Request

To build on the successes of the District's Behavioral Health Transformation demonstration, DHCF requests to extend existing demonstration programs, implement new reentry and HRSN services, and to develop infrastructure for these services under Whole-Person Care

[5] Oregon Health Plan Demonstration Approval. https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf

Transformation demonstration. An overview of the continuing and new programs and how they are mapped to the overarching goals of the demonstration is included in Table 1. Each demonstration goal and associated policies and programs are discussed in more detail below.

Table 1: Overview of Programs Included in Demonstration Renewal Request		
Primary goal	**Policy/program name**	**Status within this renewal request**
Goal 1: Continue to maximize access to quality behavioral health services and improve coverage of a broader continuum of treatment for individuals with SMI/SUD.	1.a Behavioral health services for SUD and SMI delivered in an IMD	Continuing
	1.b Remove cost-sharing requirement for prescriptions associated with medication-assisted treatment (MAT)	Continuing
Goal 2: Improve health outcomes during transitions (e.g. justice-involved individuals returning to the community or individuals experiencing or at risk of homelessness) to reduce health disparities and drive sustainable transformation through reentry and health-related social needs (HRSN) services.	2.a Services for justice-involved individuals up to 90 days pre-release	New
	2.b Housing supports tailored to beneficiaries experiencing high-risk care transitions	New
	2.c Nutritional supports tailored to health risk, nutrition-sensitive health conditions, and/or for children or pregnant or postpartum beneficiaries and their households	New
	2.d HRSN case management, outreach, and education supports	New
Goal 3: Develop and maintain effective District infrastructure and system capacity to deliver Medicaid-reimbursed reentry and HRSN services.	3.a Funding for transitional, non-service expenditures to support the reentry demonstration	New
	3.b Funding for HRSN administrative costs and infrastructure	New

Goal 1: Continue to maximize access to quality behavioral health services and improve coverage of a broader continuum of treatment for individuals with SMI/SUD.

During the Behavioral Health Transformation demonstration period, the District expanded Medicaid's service array to improve treatment coverage for individuals with SMI/SED or SUD. Various crisis stabilization, recovery support, trauma informed, supported employment, and psychologist and other licensed behavioral health provider services that were initially included in

the demonstration to support these populations, were transitioned to permanent State Plan authority, effective January 1, 2022.[6]

Although the State Plan now provides a comprehensive array of community-based behavioral health services, there is additional need for residential and inpatient behavioral health services for Medicaid beneficiaries with an SMI or SUD. Under current federal policy, there are very limited instances when Medicaid programs may cover treatment in settings that qualify as IMDs.

a. Behavioral health services for individuals with SMI and/or SUD delivered in an IMD

Request

The District requests to extend the authority to reimburse for short-term, clinically appropriate care delivered in residential and inpatient treatment settings that qualify as IMDs for individuals with an SMI or SUD. The request is consistent with the authority provided in CMS approval of the Behavioral Health Transformation demonstration (Project No. 11-W-00331/3).

Policy and Program Description

Benefits

Covered services include those associated with clinically appropriate, short-term stays for acute care delivered in residential and inpatient treatment settings that qualify as IMDs to District Medicaid beneficiaries with SMI or SUD. Reimbursement for long-term inpatient IMD stays is not being requested under this demonstration.

SMI and SUD inpatient and residential treatment under this demonstration is proposed for clinically appropriate care based on placements using nationally recognized level of care and utilization criteria.

SUD residential inpatient treatment under this demonstration program would be included for clinically appropriate care associated with American Society of Addiction Medicine (ASAM) Levels 3.1, 3.3, 3.5, 3.7, and 4.0. Eligible inpatient and residential providers will continue to be certified with District requirements for SUD treatment. These providers will deliver care in accordance with ASAM criteria.

For treatment of SMI, these providers will be accredited by a national organization (or otherwise meet Medicare conditions of participation). Treatment staff will be certified or licensed in accordance with District requirements.

Eligibility

Medicaid beneficiaries between the ages of twenty-one (21) and sixty-four (64) years of age are eligible for services provided within an IMD under the demonstration program, if such services are determined to be medically necessary to resolve or ameliorate the symptoms associated with the acute phase of a behavioral health crisis or symptoms associated with an SMI or SUD.

[6] See DC 21-0009, DC 21-0010, and DC 21-0011 for more information.

Medical necessity shall be determined by a qualified practitioner practicing in accordance with licensure requirements as set forth in District regulations.

Demonstration Objective and Rationale

This renewal request provides the opportunity to continue residential and inpatient treatment services for individuals with SMI or SUD. These services fill an important gap in the continuum of behavioral health services in the District, that would not be Medicaid-reimbursable if not for 1115 demonstration waiver and expenditure authorities.[7] In FY 2023, one-quarter of Medicaid beneficiaries had a behavioral health diagnosis. Among those with a behavioral health diagnosis, 82% had only a mental health diagnosis, 13% had a mental health and SUD diagnosis, and 5% had only an SUD diagnosis.[8]

Many individuals with SMI and/or SUD diagnoses in the District can receive appropriate levels of care through State Plan-covered community-based services. However, higher levels of care offered in inpatient or residential settings are necessary for others to address behavioral health needs. In 2022, 1,063 beneficiaries had an IMD stay[9] related to SMI, and 1,219 beneficiaries had an IMD stay related to SUD.[10] Maintaining the existing demonstration authority to provide coverage of residential and inpatient treatment services in IMDs will ensure that Medicaid beneficiaries have continued access to the level of care most clinically appropriate for their care needs.

Implementation Plan

Because the District is requesting an extension of an existing flexibility allowed under the current demonstration program, the IMD service portion of the program will continue to be in effect at the beginning of the new demonstration period on January 1, 2025, or on the date determined by CMS in their Demonstration approval, whichever is later.

b. Remove cost-sharing requirement for prescriptions associated with MAT

Request

The District requests the authority to continue to waive cost-sharing requirements for prescriptions associated with MAT. The $1 copayment that is in effect under the State Plan would be waived for beneficiaries receiving services under the demonstration. The continuation of this policy will ensure there are minimal barriers to access MAT prescriptions. The request is

[7] Outside of the "in lieu of services" policy regarding IMDs, outlined at 42 CFR 438.6(e).
[8] Data extracted from the Medicaid Management Information System (MMIS) in January 2024. Behavioral health diagnoses include SUD and mental health conditions. SUD diagnoses include alcohol, opioid and other drug use and dependence. Mental health diagnoses include SMI, such as schizophrenia and bipolar disorder, and non-SMIs, such as anxiety.
[9] For purposes of this data, "IMD stay" is defined as a stay longer than 15 days. IMD stays covered under the Behavioral Health Transformation demonstration averaged 60 days or less.
[10] Data extracted from the District's DY4 Q1 Quarterly Monitoring Report for the Demonstration (Project No. 11-W-00331/3).

consistent with the authority provided in CMS approval of the Behavioral Health Transformation demonstration (Project No. 11-W-00331/3).

This policy would continue to be in effect at the beginning of the new demonstration period on January 1, 2025, or on the date determined by CMS in their Demonstration approval, whichever is later.

Goal 2: Improve health outcomes during transitions to reduce health disparities and drive sustainable transformation through reentry and HRSN services.

a. Services for Justice-Involved Individuals up to 90 Days Pre-Release

The justice-involved population has many health-related social needs and experiences adverse health outcomes, including high rates of hospitalization and death, upon their return to the community.[11] Historically, carceral systems are responsible for providing comprehensive health care while individuals are in their custody, and many individuals transition to Medicaid coverage upon release. This transition leads to barriers in accessing timely care, which can contribute to the poor health outcomes experienced by this population. Providing select Medicaid-covered pre-release services to the justice-involved population through 1115 demonstration authority[12] will facilitate the improved coordination of treatment and services that address HRSN and health needs during their return to the community.

Request

The District requests expenditure authority to provide select services to justice-involved Medicaid beneficiaries during the ninety (90) day period prior to their return from carceral settings into the community. The services include the following:

- Medication Assisted Treatment;
- Case Management/Care Coordination;
- Necessary 30-day supply of medications after release;
- Comprehensive behavioral and physical health screenings;
- Counseling/Therapy;
- Peer Support Services; and,
- Intensive, family-based services for youth.

These services would be provided in-person, or via telehealth, as appropriate. Authority to cover these services is requested for all Medicaid-eligible individuals in the following carceral settings:

- Department of Corrections (DOC) Secure Facilities:

[11] Incarceration and Health: A Family Medicine Perspective (Position Paper). https://www.aafp.org/about/policies/all/incarceration.html

[12] SMD #23-003 outlines the new opportunity for states to waive the long-standing "inmate exclusion" policy (see §1905(a)(30)(B) of the Social Security Act.), which prevents states from providing Medicaid coverage while an individual, who would be otherwise eligible for Medicaid if not for their incarceration status, is incarcerated.

    - Central Detention Facility (CDF, also known as the DC Jail); and,
    - Correctional Treatment Facility (CTF).
- Department of Youth Rehabilitation Services (DYRS) Secure Facilities:
    - New Beginnings Youth Development Center (New Beginnings); and,
    - Youth Services Center (YSC).

Additionally, the District requests the authority to enroll eligible individuals in DC Medicaid coverage and engage them in case management services before they are released from Federal Bureau of Prison (BOP) custody to the extent possible. DHCF believes there is no overlap between the requested authorities and the care that BOP is statutorily required to provide to incarcerated individuals. Unlike other states, the District of Columbia does not operate a state prison system.[13] Any DC code offender sentenced on a felony charge with more than eighteen (18) months remaining to serve is sent out of District to a BOP facility. In other states, this level of offense would be committed to the State's prison system, which would be eligible for participation in 1115 demonstrations. In December 2023, 2,532 DC Code offenders were in BOP custody.[14] Allowing DHCF to ensure individuals are enrolled in Medicaid and in contact with a case manager before being released from custody to a DC address would improve care transitions for this population and ease their return to the community. The District is not requesting the authority to provide the full suite of pre-release services to beneficiaries in BOP custody, as those are the responsibility of BOP.

Policy and Program Description

Overview of Current Systems

The District corrections system includes four different secure detention facilities, two operated by the Department of Corrections (CDF and the CTF), and two operated by the Department of Youth Rehabilitation Services (New Beginnings and YSC). These facilities house adults and juveniles,[15] respectively.

Unlike other states, whose corrections systems also include state prisons, the District of Columbia does not operate a state prison. Therefore, many offenses that would result in state prison confinement in any other state, result in DC Code offenders entering BOP custody. While there are options for inmates leaving BOP custody to help facilitate their return to the District,[16] DHCF believes that providing Medicaid covered case management services before the individuals leave BOP custody will better prepare them for reentry.

Since 2014, the District has had policies in place regarding Medicaid enrollment and Medicaid eligibility suspension for justice-involved individuals. For individuals in DOC or DYRS custody

[13] The National Capital Revitalization and Self-Government Improvement Act of 1997 (The Revitalization Act) led to major changes to the District's criminal justice system, including the closure of the District-operated prison.
[14] DC Code Offenders and DC Residents in BOP Custody. https://www.dcjsat.net/Agency%20Dash%20-%20FBOP.html
[15] Juveniles are defined as youth up to age 18 in the District corrections system.
[16] BOP inmates may either go to a halfway house in Baltimore County or be transferred to DC Jail at the end of their sentence.

who are preparing to return to the community and are not already enrolled in Medicaid, a Medicaid application may be completed as part of the pre-release planning process. If eligibility requirements are met, the individual is enrolled in Medicaid. However, eligibility determinations are not always completed before the individual returns to the community.

The District suspends Medicaid beneficiaries' coverage for full-scope benefits by adding an incarceration code within the eligibility system when a beneficiary enters the justice system. While incarcerated, DHCF coverage is limited to acute care in inpatient settings for individuals with suspended Medicaid coverage.[17] Although this policy is preferential to termination of Medicaid coverage, beneficiaries still experience delays in care upon release into the community under the current system. Further, beneficiaries are not enrolled in an MCP immediately upon eligibility determination for Medicaid. They are initially enrolled in the District's FFS program, and enrolled in an MCP after the beneficiary completes the selection process or when the 30-day selection period expires. This prevents beneficiaries from benefiting from case management provided by MCPs immediately upon release. Additionally, beneficiaries are not necessarily enrolled in the same MCP prior to incarceration, which is not optimal but at times unavoidable. This demonstration can be used as an opportunity to improve eligibility and enrollment processes, including exploring the operational feasibility of more timely selection of an MCP, prior to returning to the community.

Benefits

Consistent with SMD #23-003, *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated*, case management services will be a key component in the District's justice reentry demonstration. Case management will aim to improve connections with community-based providers that will be able to address an individual's physical health, behavioral health, and HRSNs upon release. Case management services will include an initial assessment of the individual's needs, the development of a care plan, connections and referrals to community-based providers, and monitoring and follow-up activities to ensure the care plan is implemented and the individual is able to access other medically necessary pre-release services.[18] The District aims to ensure the smooth transition from the pre-release case manager to completing the assessment and enrollment process in case management services and supports provided by the MCPs.

Providing individuals with MAT while in carceral settings is a best practice that can improve their return to the community and prevent relapse for SUD by establishing treatment before release.[19] DOC has an existing, comprehensive MAT program for SUD, including opioid use disorder (OUD) and alcohol use disorder. DYRS has not historically provided MAT services as part of SUD treatment. However, the District plans to include MAT coverage in carceral settings as part of the demonstration to sustain the DOC MAT program, and enhance the existing SUD treatment program in DYRS settings to include MAT services. Any funds freed up by the new

[17] See §1905(a)(30)(B) of the Social Security Act.
[18] See 42 CFR 440.169
[19] Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States. https://store.samhsa.gov/sites/default/files/pep19-matbriefcjs_0.pdf

federal match will be used in a reinvestment plan, that will be developed after CMS approval of the demonstration.

To further support reentry into the community, the demonstration will include the coverage of a thirty (30) day supply of all necessary prescriptions for individuals upon release, as clinically appropriate. Having medications in-hand upon release addresses a barrier to meeting medical needs and promotes adherence to any treatment regimens established while in corrections facilities.

Additionally, to build on existing, locally-funded programs, the District plans to provide comprehensive behavioral and physical health screenings, counseling/therapy from existing carceral providers and in-reach counseling/therapy from community-based providers either in-person or via telehealth, peer support services from individuals with lived experience returning to the community after incarceration, and intensive, family-based services for youth transitioning home after incarceration. The District expects these services will help identify and address physical and behavioral health issues that are prevalent in the justice-involved population and provide additional support during their return to the community to mitigate negative health outcomes often experienced by this population.

Providing pre-release services for ninety (90) days, rather than thirty (30) days, will allow providers, case managers, and peer specialists to develop trust and establish care with individuals before they return to the community. The ninety (90) day pre-release period will allow appropriate time to initiate case management services, connect individuals with community-based providers and services, including community-based services that will address the justice-involved populations' health-related social needs, such as housing, upon reentry. Additionally, the District will attempt to use the ninety (90) day timeframe to aid the justice-involved population in selecting an MCP in which they will be enrolled after release. While each MCP covers a standard set of services, DHCF expects that the advanced knowledge of which MCP will provide benefits will help smooth the individual's transition to receiving further care in the community and assist the MCP in better supporting the beneficiary's transition needs and managing physical and behavioral risks during the transition period.

Providers

This demonstration will rely on both carceral providers as well as community-based behavioral health and case management providers that will provide in-reach services to the population. All providers participating in the justice reentry demonstration will be required to comply with the Medicaid provider participation policies established by DHCF.

Demonstration Objective and Rationale

The pre-release services provided to justice-involved populations will support the District's goal of improving care for people during transitions, reduce health disparities in the District, and promote the objectives of Medicaid by providing case management and targeted supporting services in order to improve care transitions.

Similar to nationwide trends, there are significant racial disparities among the District's justice-involved population. In 2023, eighty-seven percent (87%) of DOC inmates were Black, compared to forty-five percent (45%) of the general population in the District.[20] Formerly incarcerated populations experience worse health outcomes and higher rates of poverty than the general population. Studies have shown that the justice-involved population experiences higher rates of hospitalizations and death in the weeks immediately following release from incarceration. [21] Throughout calendar year 2023, 4,350 people were released from DOC custody, with the majority of men (sixty-seven percent (67%)) and women (eighty percent (80%)) returning to the community upon release.[22] Ensuring eligibility and enrollment processes have been completed and investing in services that can improve health during incarceration and connection to continued care and services that address HRSN upon release can help reduce health disparities in the District.

Additionally, the justice-involved population in the District experiences higher rates of mental health issues and substance use disorders than the general population. On average, in 2023, eighty-seven percent (87%) of youth placed at a DYRS secure facility have at least one mental health diagnosis.[23] Historically, approximately sixty percent (60%) of men and seventy-five percent (75%) of women entering the DOC system had a mental illness diagnosis upon intake and forty percent (40%) of those men and sixty percent (60%) of those women were diagnosed with SMI,[24] compared to twenty-three percent (26%) of adults in DC's general population with a mental illness, twenty-five percent (24%) of whom met the definition of SMI in 2022.[25] Similarly, in 2023, an average of seventy percent (70%) of youth placed at a DYRS secure facility,[26] and nineteen percent (19%) of adults entering the DOC system had at least one substance use disorder,[27] compared to the twenty-three percent (23%) of youth and twenty-four percent (24%) of adults in DC's general population who had a substance use disorder in the last year.[28] People with SUD who leave the justice system and reenter into the community are at high risk of relapse and death compared to those without SUD.

In addition to the provision of MAT and associated counseling, allowing community-based providers to provide in-reach mental health and SUD counseling or therapy will promote the development of trust with the behavioral health system prior to reentry into the community. This

[20] DC Department of Corrections – Facts and Figures – October 2023. https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20October%202023.pdf
[21] Incarceration and Health: A Family Medicine Perspective (Position Paper). https://www.aafp.org/about/policies/all/incarceration.html
[22] DC Department of Corrections – Facts and Figures – October 2023. https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20October%202023.pdf
[23] Data provided by DYRS.
[24] Data provided by DC DOC for FY19-FY23.
[25] SAMHSA National Survey on Drug Use and Health: Model-Based Estimated Prevalence for States. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates
[26] Data provided by DYRS.
[27] Data provided by DC DOC
[28] SAMHSA National Survey on Drug Use and Health: Model-Based Estimated Prevalence for States. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates

will allow the advanced development of a care plan and promote continuity of treatment, which, if adhered to, should lead to improved care transitions, better health outcomes, and fewer ED visits and inpatient hospitalizations among the justice-involved population.

By improving eligibility and enrollment processes for justice-involved populations and providing the targeted reentry services described above to individuals in the ninety (90) days leading up to their return to the community, the reentry program aims to achieve the following goals:

- Improve physical and behavioral health outcomes of DHCF beneficiaries following reentry by providing targeted pre-release services and promoting continuity of care upon release;
- Reduce the number of ED visits and inpatient hospitalizations among the reentry population by connecting them to ongoing community-based providers prior to release;
- Promote the continuity of medication treatment after release;
- Reduce SUD relapse and increase access to and adherence for SMI treatment;
- Reduce recidivism; and,
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers by improving existing infrastructure.

Better supporting the reentry of justice-involved populations into the community aligns with Federal priorities. In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Patients and Communities Act,[29] which included various Medicaid provisions to address the opioid crisis. Section 5302 required CMS to develop best practices for states to help inmates released from public institutions to return to the community and issue a letter to states outlining opportunities for Medicaid demonstrations based on the identified best practices. DHCF included a request for the authority to support the justice-involved population in 2019, in its application for the District's Behavioral Health Transformation demonstration, but the request was not approved by CMS at the time. DHCF believes the reentry program for justice-involved individuals is consistent with CMS guidance and aims to test innovative approaches to coverage and quality services to improve care transitions, starting pre-release, to individuals who are incarcerated. This program aims to facilitate continuity of care upon release and improve access to quality services upon reentry to the community.

Implementation Plan

The District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on improving the infrastructure necessary to support the services and populations impacted by this demonstration. The transitional, non-service infrastructure expenditures to support the reentry demonstration are outlined in Goal 3.a. Beginning in demonstration renewal year two (i.e. calendar year 2026), the District will begin the phase-in of services across all service sites

[29] See Pub L. No. 115-271

participating in the program. The District looks forward to working with CMS to develop an implementation plan to provide reentry services to justice-involved populations.

b. Housing Supports

Supporting continuity of care for populations experiencing transitions can combat adverse health outcomes tied to housing instability.[30] The District recognizes that the most impactful housing policies are implemented alongside other services an individual might need. For example, an individual experiencing homelessness who has a chronic health condition or behavioral health need will require a safe, stable living situation in addition to care coordination to access needed health care. Deploying additional Medicaid funding for housing services and supports could improve health outcomes and reduce health disparities.[31]

Request

The District requests expenditure authority to provide housing services and supports to individuals eligible under the demonstration.

Policy and Program Description

Current Landscape

Since 2015, the District has made significant investments to make homelessness rare, brief, and nonrecurring through coordinated efforts under the Interagency Council on Homelessness (ICH) and two iterations of the District's Strategic Plan, Homeward DC.[32, 33] Guided by this strategic plan, the District has seen substantial reductions in homelessness, driven primarily by reductions in family homelessness.

Even so, Homeward DC 2.0 notes that rent continues to rise at a rate beyond increases in income.[34] In 2022, the average one-bedroom apartment in the District cost about $2,400 per month and that year at least 44,000 households in the District (the majority of which had annual incomes below $50,000) spent more than half of their income on rent.[35] Severely cost-burdened households (those that spend more than half of their income on rent) are more likely than other renters to sacrifice necessities (e.g. health care) to pay rent and experience unstable housing situations (e.g. evictions).[36] Many individuals covered by Medicaid are impacted by high housing costs and are at increased risk of losing housing due to adverse life events, potentially

[30] Housing as a Determinant of Health Equity: A Conceptual Model. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7146083/
[31] Oregon Health Plan Demonstration Approval. https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf
[32] Homeward DC: 2015-2020. https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.11%20web.pdf
[33] Homeward DC 2.0 https://dhs.dc.gov/sites/default/files/dc/sites/dhs/publication/attachments/Homeward-DC-2.0-%20Report_FY2021-2025%5B1%5D.pdf
[34] Ibid.
[35] Growing share of DC renters spend at least half of their income on rent. https://www.npr.org/local/305/2023/09/19/1200323237/growing-share-of-d-c-renters-spend-at-least-half-of-their-income-on-rent
[36] Housing Needs by State: District of Columbia. https://nlihc.org/housing-needs-by-state/district-columbia

exacerbating health conditions and increasing utilization of emergency, acute, and long-term care.

Homeward DC 2.0 also identified improving access to health care, especially for individuals with complex health needs, an essential component to achieve the District's vision to make homelessness rare, brief, and nonrecurring.[37] Data from the Annual Homelessness Point-in-Time (PIT) Count further reinforces that focus. According to the 2023 PIT Count, the population of individuals experiencing chronic homelessness in the District is older and have high rates of concurrent behavioral health and physical health comorbidities.[38] The median age for individuals surveyed was forty-seven (47), with thirty-five percent (35%) over the age of fifty-five (55). Many individuals reported behavioral health needs, including histories of mental illness (29%), substance use (nineteen percent (19%)), and dual diagnosis (twelve percent (12%)). Homelessness may increase risk of behavioral health acuity and admission, with rates of homelessness in individuals with District IMD stays averaging over sixty percent (60%). Beyond behavioral health, PIT Count individuals also reported health conditions including: chronic health problems (sixteen percent (16%)); physical disability (fourteen percent (14%)); and developmental disability (six percent (6%)).

Currently, District housing-related services and supports are delivered through a range of funding strategies, including local and federal grant dollars, Managed Care value-add services, and 1915(i) authority and other waivers. In 2022, the District implemented housing navigation and stabilization services for its permanent supportive housing (PSH) program under the 1915(i) State Plan Amendment, as a result of years of partnership between DHCF, the state housing agency (Department of Human Services (DHS)), ICH, and District PSH providers.

DHCF intends to build on the partnerships with DHS and ICH, as well as other government agencies, like the Department of Behavioral Health (DBH), and other stakeholders, to expand Medicaid housing-related services and supports to assist additional beneficiaries. The 2021 DC SUD Community Need and Service Capacity Assessment, funded by the CMS SUPPORT 1003 Provider Capacity Grant, identified transitional supportive housing services and incorporation of housing assistance in care coordination models as two of the primary remaining gaps in the District's SUD service continuum, even after the implementation of the 1115 Behavioral Health Transformation demonstration. The assessment also noted that providers and SUD clients alike mentioned the need for supports to address environmental factors that influence health outcomes, such as safe and affordable housing and reduced impacts of institutional racism and underlying trauma.[39] This demonstration can implement such transitional supportive housing services for beneficiaries with SUD, as well as for other transition populations such as returning citizens.

[37] Homeward DC 2.0 https://dhs.dc.gov/sites/default/files/dc/sites/dhs/publication/attachments/Homeward-DC-2.0-%20Report_FY2021-2025%5B1%5D.pdf

[38] Homelessness in Metropolitan Washington: Results and Analysis from the Annual PIT Count. https://www.mwcog.org/file.aspx?D=cNIoGencJPm463aX0VC4iezyhJddJ%2b0CHWJv0gBajVw%3d&A=krOIQIAuqaJwMnUiVaD2nsIwN67PN6dmrf2qwXkiNWc%3d

[39] DC SUD Community Need and Service Capacity Assessment. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DC%20SUD%20NA%20-%20Final%20Report%20for%20Distribution%20Feb%202021.pdf

Similarly, the District intends to use this demonstration to bring innovative care models, such as medical respite, to Medicaid following the successful implementation of the District's Pandemic Emergency Program for Medically Vulnerable Individuals (PEP-V).

Benefits

Consistent with the November 2023 CMS framework of *Coverage of HRSN Services in Medicaid and CHIP*,[40] the District proposes to provide the following services as a part of this benefit:

- Rent/temporary housing for up to six (6) months and related utility assistance;
- Short-term pre-procedure and/or post-hospitalization housing for up to six (6) months;
- Transition, navigation, pre-tenancy, and tenancy-sustaining services;
- One-time transition and moving costs;
- Medically necessary home remediations; and,
- Home/environmental accessibility modifications.

Eligibility

Consistent with the November 2023 CMS framework, the District proposes to provide housing services and supports for beneficiaries transitioning out of or experiencing the following situations:

- Institutional care or congregate settings such as nursing facilities (NFs), IMDs, intermediate care facilities (ICFs), acute care hospitals, group homes, and correctional facilities
- Homelessness, risk of homelessness, or transitioning out of an Emergency Shelter as defined by 24 CFR 91.5
- Individuals transitioning out of the child welfare system including foster care

Individuals currently receiving housing services authorized under the District's approved Medicaid State Plan are not eligible for 1115 housing services.

Demonstration Objective and Rationale

Medicaid housing services and supports are a critical component of the District's housing first and health in all policies efforts. The District's renewed focus on Homeward DC 2.0's goal nine, "Improve Access to Care for Individuals with Complex Health Needs", responds to the need for additional efforts serving homeless individuals who are aging and have ongoing health needs.[41] Individuals who are aging or have health conditions may have greater difficulty navigating and accessing housing and health care and have unique needs that require targeted, person-centered

[40] Coverage of HRSN Services in Medicaid and CHIP: November 2023. https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf
[41] Homeward DC 2.0 https://dhs.dc.gov/sites/default/files/dc/sites/dhs/publication/attachments/Homeward-DC-2.0-%20Report_FY2021-2025%5B1%5D.pdf

care strategies.[42] The District believes that Medicaid reimbursement for targeted housing services and supports will help eligible beneficiaries stay connected to Medicaid coverage and access needed health care.

DHCF included a request for the authority to provide supportive housing services in 2019, in its application for the District's Behavioral Health Transformation demonstration, but the request was not approved by CMS at the time. DHCF believes the targeted housing services and supports requested in this demonstration are consistent with CMS guidance and aims to test whether expanding eligibility for these services to populations beyond those receiving HCBS waiver services or providing additional services will improve the health outcomes of certain Medicaid beneficiaries and improve their utilization of appropriate care. Access to targeted housing services and supports may also help to reduce health disparities.[43]

Implementation Plan

DHCF does not currently implement a comprehensive HRSN service framework outside of its HCBS waiver supports and needs to build a foundation for the housing services and supports described in this request. As outlined in Goal 3.b, the District proposes using HRSN infrastructure funding to develop processes for implementing new Medicaid housing services and supports, strategies for expanding the Medicaid provider network and enhancing their business and operational practices, and additional technology investments to support HRSN screening, service delivery, and care coordination. As such, the District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on building the provider capacity and infrastructure necessary to enable Medicaid reimbursement for housing services and supports. Beginning in demonstration renewal year two (i.e. calendar year 2026), the District will begin providing Medicaid reimbursement for housing services and supports delivered to eligible beneficiaries.

c. Nutrition Supports

Nearly one (1) in three (3) residents in the Greater DC area are experiencing food insecurity.[44] The USDA has found that diet-related chronic diseases affect food insecure communities at a higher rate and, in turn, almost ninety percent (90%) of health care spending is linked to diet-related chronic disease.[45] Deploying additional Medicaid funding for nutrition services and supports could improve health outcomes, reduce health disparities, and potentially be cost effective supplements to traditional Medicaid medical services.

[42] Homelessness in Metropolitan Washington: Results and Analysis from the Annual PIT Count. https://www.mwcog.org/file.aspx?D=cNIoGencJPm463aX0VC4iezyhJddJ%2b0CHWJv0gBajVw%3d&A=krOIQIAuqaJwMnUiVaD2nsIwN67PN6dmrf2qwXkiNWc%3d

[43] Oregon Health Plan Demonstration Approval. https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf

[44] Capital Area Food Bank: 2022 Hunger Report. https://hunger-report.capitalareafoodbank.org/report-2022/#report-intro

[45] USDA Actions on Nutrition Security. https://www.usda.gov/sites/default/files/documents/usda-actions-nutrition-security-infographic.pdf

Request

The District requests expenditure authority to provide nutrition services and supports to individuals eligible under the demonstration.

Policy and Program Description

Current Landscape

The District has prioritized access to healthy, quality food through numerous non-profit organizations, local grant investments, and government agencies. A subset of District Medicaid beneficiaries can receive nutrition services and supports through HCBS waivers and some District Medicaid managed care plans provide value-added nutrition benefits.

However, changes in food prices over the last four (4) years have increased beyond the rate of general inflation in the United States.[46] Due in part to these rapidly increasing prices, the Capital Area Food Bank found that more than one (1) million people in the Greater Washington DC area are food insecure.[47] In addition to increasing prices, more than 160,000 District residents with lower incomes in Wards 7 and 8 only have access to three (3) full-service grocery stores.[48] This grocery store gap limits access to healthy food options and may lead to negative health outcomes.

Benefits

Consistent with the November 2023 CMS framework of *Coverage of HRSN Services in Medicaid and CHIP*,[49] the District proposes to provide the following services as a part of this benefit:

- Nutrition counseling and education;
- Home delivered meals or pantry stocking, up to three (3) meals a day, for up to six (6) months;
- Fresh produce prescriptions, protein boxes, and/or grocery provisions, up to three (3) meals a day, for up to six (6) months; and,
- Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs.

[46] Inflation has fallen. Why are groceries still so expensive? https://www.washingtonpost.com/business/2024/02/02/grocery-price-inflation-biden/
[47] Capital Area Food Bank: 2022 Hunger Report. https://hunger-report.capitalareafoodbank.org/report-2022/#report-intro
[48] Still Minding the Grocery Gap in DC: A 2021 Update. https://www.dchunger.org/wp-content/uploads/2021/10/DCHS-Report_Still-Minding-the-Grocery-Gap_2021.pdf
[49] Coverage of HRSN Services in Medicaid and CHIP: November 2023. https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf

Eligibility

Consistent with the November 2023 CMS framework, the District proposes to extend nutrition services and supports to beneficiaries with certain health risks, nutrition-sensitive health conditions, and/or children or pregnant or postpartum beneficiaries and their households.

Demonstration Objective and Rationale

Similar to the objectives of the HRSN housing services and supports described above, the demonstration's nutrition services and supports will test whether expanding eligibility for nutrition services to populations beyond those receiving services through HCBS waivers or providing additional services will improve health outcomes of certain Medicaid beneficiaries and improve their utilization of appropriate care. Access to targeted nutrition services and supports may also help to reduce health disparities.[50]

Implementation Plan

DHCF does not currently implement a comprehensive HRSN service framework outside of its HCBS waiver supports and needs to build a foundation for the nutrition services and supports described in this request. As outlined in Goal 3.b, the District proposes using HRSN infrastructure funding to develop processes for implementing new Medicaid nutrition services and supports, strategies for expanding the Medicaid provider network and enhancing their business and operational practices, and additional technology investments to support HRSN screening, service delivery, and care coordination. As such, the District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on building the provider capacity and infrastructure necessary to enable Medicaid reimbursement for nutrition services and supports. Beginning in demonstration renewal year two (i.e. calendar year 2026), the District will begin providing Medicaid reimbursement for nutrition services and supports delivered to eligible beneficiaries.

d. HRSN Case Management, Outreach, and Education

Request

The District requests expenditure authority to provide case management, outreach, and education services to eligible individuals under this demonstration. HRSN case managers could facilitate linkages to other District and federal resources and benefit programs, provide benefit program application assistance, and would ensure HRSN waiver services are appropriately integrated into a beneficiary's overall care plan and coordinated with the rest of their treatment team.

HRSN case management services are intended specifically for beneficiaries that are receiving at least one of the housing or nutrition services authorized by the demonstration. DHCF will ensure HRSN case management services are not duplicative of other case management services authorized under the District's approved Medicaid State Plan.

[50] Oregon Health Plan Demonstration Approval. https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf

Demonstration Objective and Rationale

The goal of case management is to coordinate services a beneficiary needs to improve overall health and health care utilization. Lack of stable housing or inadequate nutrition may impede a beneficiary's ability to access needed health care. A stronger case management system will allow the District to more effectively connect eligible beneficiaries with the medically necessary services identified in their care plan.

Implementation Plan

DHCF does not currently implement a comprehensive HRSN service framework outside of it HCBS waiver supports and needs to build a foundation for the housing, nutrition, and HRSN case management services described in this request. As such, the District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on building the provider capacity and infrastructure necessary to enable Medicaid reimbursement for HRSN services. Beginning in demonstration renewal year two (i.e. calendar year 2026), the District will begin providing Medicaid reimbursement for HRSN services delivered to eligible beneficiaries.

Goal 3: Develop and maintain effective District infrastructure and system capacity to deliver Medicaid-reimbursed reentry and HRSN services.

The District recognizes the additional work necessary to successfully expand justice-involved reentry and HRSN services and supports to meet the needs of Medicaid beneficiaries. This will require scaling and refining existing infrastructure investment, working with partners on systems integration, and enabling data sharing necessary to support screening, service delivery, and care coordination. DHCF plans to continue existing infrastructure investments in addition to seeking additional infrastructure funding through this demonstration to support the delivery and integration of the new demonstration services and improve outcomes.

a. Funding for Transitional, Non-Service Expenditures to Support the Reentry Demonstration

Request

The District requests expenditure authority for time-limited, non-service expenditures to develop the infrastructure necessary to successfully implement the justice-involved reentry demonstration outlined in Goal 2.a.

Policy and Program Description

The District plans to use reentry infrastructure funding for the following:

- Provide IT support to ensure community-based "in-reach" providers are able to provide demonstration services in carceral facilities via telehealth;
- Provide IT support to support data sharing capabilities between carceral facilities, DHCF, and community-based providers;

- Hiring and training of staff to aid in eligibility determinations and enrollment, and support the delivery of services to justice-involved populations; and,
- Outreach, education, and stakeholder convening to advance collaboration between DHCF, DOC, DYRS, and community-based organizations.

Demonstration Objective and Rationale

DHCF plans to explore additional funding sources to support and build infrastructure necessary to provide reentry services. However, the waiver authority for specific, time-limited, non-service expenditures allows DHCF to provide additional infrastructure support that cannot be achieved through other avenues.

Implementation Plan

The District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on improving the infrastructure necessary to support the services and populations impacted by the reentry demonstration, before phasing-in new Medicaid reentry services beginning in demonstration renewal year two (i.e. calendar year 2026). The District plans to continue infrastructure investments through all five years of the demonstration renewal period to ensure high quality service delivery.

b. HRSN Administrative Costs and Infrastructure

Request

The District requests expenditure authority to develop the infrastructure necessary to successfully implement the HRSN services outlined in Goals 2.b, 2.c and 2.d.

Policy and Program Description

The District plans to use HRSN infrastructure for the following activities:

- Technology
- Development of business or operational practices
- Workforce development
- Outreach, education, and stakeholder convening

Demonstration Objective and Rationale

DHCF does not currently implement a comprehensive HRSN service framework outside of its HCBS waiver supports and needs to build a foundation for the HRSN services proposed in this demonstration request. Investments in HRSN infrastructure will be necessary to support the development of processes for implementing new Medicaid HRSN services, strategies for expanding the Medicaid provider network and enhancing their business and operational practices, and additional technology to support HRSN screening, service delivery, and care coordination.

Implementation Plan

The District plans to use the first demonstration renewal year (i.e. calendar year 2025) to focus on building the provider capacity and infrastructure necessary to enable Medicaid reimbursement for new HRSN services, before phasing-in the new HRSN services beginning in demonstration renewal year two (i.e. calendar year 2026). The District plans to continue infrastructure investments through all five years of the demonstration renewal period to ensure high quality service delivery.

IV. Demonstration Evaluation and Monitoring

a. Evaluation

The District of Columbia will conduct a thorough, independent evaluation of the demonstration by contracting with an independent evaluator. The design and methods of the evaluation will be developed with CMS and the evaluator. The evaluation design and evaluation reports will follow CMS guidelines.

In the table below, DHCF presents a preliminary evaluation plan. DHCF identified some of the most important goals of the demonstration to potentially explore in the evaluation. Each goal is linked to potential research questions and methods that would allow researchers to analyze whether the demonstration met its identified goals. All components of the preliminary plan (including goals, research questions, and methods) are subject to change as the program is implemented and an evaluator is identified.

Under goal 1, the demonstration will continue to test whether the expenditure authority granted under this demonstration results in increased access to health care services and improved health outcomes for individuals with SMI/SUD. The District's existing evaluation may offer research questions to draw on as those reports progress. The existing evaluators from the first five years of the demonstration found that the simultaneous start of the demonstration and the COVID-19 public health emergency (PHE) precluded the analysis from entirely removing the effects of the Demonstration from that of the PHE. In the second five years of the demonstration, the District expects that the end of the PHE will result in utilization and other trends that make it easier to evaluate the impact of ongoing demonstration policies.

Goals 2 and 3 will introduce new Medicaid reimbursed HRSN and reentry services. Under goal 2, the demonstration will test whether new HRSN and reentry services improve health outcomes and reduce health disparities. Under goal 3, the demonstration will analyze the effectiveness of infrastructure and system capacity to deliver HRSN and reentry services.

Data for goal 1 will continue to be from sources that were used in the first five years of the demonstration such as the Medicaid Management Information System (MMIS), the Department of Behavioral Health (DBH), and the Office of the Chief Medical Examiner (OCME). Data for goals 2 and 3 will require new data sharing from District agencies, such as the Department of Corrections (DOC), DC Health, and the Department of Human Services (DHS). HRSN and reentry goals will also require additional data from the District's eligibility system, called the DC Access System (DCAS). To the greatest extent possible, the District will use nationally

recognized, standard quality measures, such as CMS core set, Healthcare Effectiveness Data and Information Set (HEDIS), and others to evaluate the success of the demonstration.

Table 2: Potential Evaluation Research Questions and Methods			
New/Continuing	**Research questions**	**Potential evaluation method**	**Data sources**
Goal 1: Continue to maximize access to quality behavioral health services and to improve coverage of a broader continuum of treatment for individuals with SMI/SUD.			
New	What types of care do beneficiaries receive after they leave an IMD setting?	- Analyze utilization of behavioral health services and treatment by setting.	- MMIS
Continuing	Is there a reduction in ED use and preventable hospital readmissions among beneficiaries with SMI/SUD?	- Analyze ED use, hospitalization admissions and other high acuity health care.	- MMIS
Continuing	Is there an increase in rates of identification, initiation, and engagement in SUD treatment? Is there an increase in adherence to and retention in SUD treatment?	- Analyze utilization of SUD services and treatment.	- MMIS
Continuing	Is there a reduction in overdose deaths, particularity those due to opioids?	- Analyze data on overdose deaths.	- OCME - DBH
Goal 2: Improve health outcomes during life transitions to reduce health disparities and drive sustainable transformation through reentry and HRSN services.			
New	Does providing 90 days of pre-release services rather than 30 days better support the beneficiary's transition needs and manage physical and behavioral health risks during the transition period?	- Analyze utilization of medical health services and treatment. - Analyze number of beneficiaries who actively select a managed care plan versus default to auto assignment.	- MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies
New	How do increases in HRSN services impact health care utilization of primary and preventive health care?	- Analyze utilization of medical health services and treatment. - Stratify by populations, such as justice-involved populations, individuals experiencing or at risk of homelessness, and other populations identified through the evaluation.	- MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies
New	How do increases in HRSN services impact health care utilization of potentially avoidable, high acuity health care?	- Analyze ED use, hospitalization admissions and other high acuity health care. - Stratify by populations, such as justice-involved populations, individuals experiencing or at risk of homelessness, and other populations identified through the evaluation.	- MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies

New	How do increases in HRSN services impact health care utilization of behavioral health care?	- Analyze utilization of behavioral health services and treatment. - Stratify by populations, such as justice-involved populations, individuals experiencing or at risk of homelessness, and other populations identified through the evaluation.	- MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies
New	What is the impact of HRSN on reducing health disparities? Will HRSN contribute to a reduction in disparities in access, quality, or health outcomes?	- Evaluator will identify an approach to measure the impact on health disparities that will stratify by subpopulations.	- MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies
Goal 3: Develop and maintain effective District infrastructure and system capacity to deliver Medicaid-reimbursed reentry and HRSN services.			
New	What is the effectiveness of the infrastructure investments authorized through the demonstration to improve system capacity to deliver Medicaid-reimbursed reentry and HRSN services?	- Analyze infrastructure and system capacity through a mixed methods approach that may include quantitative data, surveys, and stakeholder interviews.	- Survey and stakeholder interviews - MMIS - DCAS - DOC, DC Health, DHS, and other DC agencies
New	How are local investments changing during the demonstration given the new Medicaid-reimbursed services?	- Analyze changes in local and federal expenditures during the demonstration.	- MMIS - DOC, DC Health, DHS, and other DC agencies

b. Monitoring

The District requests the opportunity to work with CMS to update its SMI and SUD monitoring protocols. In particular, the District requests to limit quarterly monitoring of claims-based metrics under goal 1 on behavioral health services to the services that are authorized under the demonstration: services for individuals with SMI and/or SUD delivered in an IMD and removal of cost-sharing requirements for FFS MAT prescriptions.

During the first five years of the demonstration, the District reported metrics quarterly on the entire behavioral health system, with the original demonstration scope including a broader set of behavioral health service changes that have largely transitioned to State Plan authority. During the demonstration renewal period, the District requests to focus the quarterly monitoring on select metrics that can be reasonably tied to the demonstration and limiting the subpopulations to those that are most relevant to the District's demonstration goals. The District also requests to collaborate with CMS on best practices for analyzing trends, given that annual updates in metric specifications can lead to a break in the comparability of data points over time.

The District looks forward to the opportunity to work with CMS to make improvements to its SMI and SUD monitoring protocols to more closely align reporting with the District's demonstration goals and authorized services.

V. Waiver and Expenditure Authorities

The District requests waiver of the following sections of the Social Security Act, to the extent necessary, to support implementation of the proposed demonstration:

- Comparability requirements described in section 1902(a)(17): This demonstration includes benefits and cost-sharing specific to eligibility criteria described in Section III of this application that may not be comparable to benefits and cost-sharing provided under the State Plan.
- Amount, Duration, and Scope requirements described in section 1902(a)(10)(B): To enable the District to offer a different benefit package to demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.
- Comparability; Provision of Medical Assistance and Reasonable Promptness: To allow the District to offer HRSN services only to an individual who meets the qualifying criteria for HRSN services and to allow the District to delay the application review process for HRSN services in the event the District does not have sufficient funding to support providing these services to eligible beneficiaries.

DHCF requests the following Expenditure Authorities:

- Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment or withdrawal management services for SUD or primarily receiving treatment for SMI, who are short-term residents/inpatients in facilities that meet the definition of an IMD.
- Expenditures for select covered services furnished to individuals otherwise eligible for Medicaid if not for their status as an inmate of a public institution.
- Expenditures for payments for allowable pre-release administrative costs, services, supports, transitional non-service expenditures, infrastructure, and interventions not otherwise eligible for Medicaid payment.
- Expenditures for health-related social needs services not otherwise covered that are furnished to eligible individuals, including housing and nutrition supports.
- Expenditures for payments for allowable HRSN administrative costs and infrastructure not otherwise eligible for Medicaid payment.

To the extent that CMS advises the District that different or additional authorities are necessary to implement the programmatic vision and operational details described above, the District requests such waiver or expenditure authority, as applicable.

VI. Impact on Program Expenditures and Enrollment

This demonstration would permit the District to continue to provide coverage of behavioral health services provided in IMDs; provide services to the justice-involved population who would otherwise be eligible for Medicaid if not for their incarceration status; provide services to address beneficiaries HRSN, such as housing and nutrition; and provide infrastructure funding to support system capacity in the delivery of these services. The projected impact of providing these demonstration services on the District's Medicaid program expenditures is summarized in Table 4 below.

In May 2023, prior to the restart of post-PHE eligibility redeterminations, there were approximately 311,000 individuals enrolled in the District's Medicaid program; it is expected that enrollment will have decreased by at least 10 percent by mid-2024 before stabilizing. While this demonstration does not make changes to Medicaid eligibility, enrollment is expected to increase because of the eligibility and enrollment efforts that will be implemented as part of the reentry demonstration.

VII. Impact on Delivery System and Payment Rates for Services

Delivery System

The District of Columbia currently utilizes both FFS and managed care systems as specified under its State Plan for delivering Medicaid benefits. Generally, there will be no differences in the delivery system used to provide benefits to demonstration participants than those provided under the State Plan. However, the District plans to include the full length of IMD stays outlined in Goal 1.a of this demonstration in MCP capitation rates.[51]

Payment Rates for Services

The District does not anticipate needing to raise provider rates for obstetric care, primary care, or behavioral health services since the current rates meet or exceed the 80% Medicare rate requirement for HRSN Section 1115 Demonstrations.[52] However, should the District's Medicaid to Medicare provider rate ratio fall below 80% in one of these care categories, the District will increase and sustain Medicaid FFS provider base payment rates and managed care payment rates. DHCF will work with CMS to implement this program change upon approval to the extent applicable.

VIII. Demonstration Financing and Budget Neutrality

Below are summary tables of the District's historical and projected demonstration expenditures.

[51] During the District's Behavioral Health Transformation Demonstration program, IMD stays up to 15 days were paid for directly by MCPs, consistent with 42 CFR 438.6(e); stays longer than fifteen (15) days were paid for through FFS. This created an administratively burdensome process for DHCF, MCPs, and IMD providers.
[52] CMS All State Call: December 6, 2022. https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf

Table 3: Historical Demonstration Expenditures					
SUD IMD Services MCO	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 4,045,735	$ 1,086,977	$ 1,838,017	$ 2,494,274	$ 9,465,003
Eligible Member Months	3,638	1,717	2,425	2,108	-
PMPM Cost	$ 1,112.08	$ 633.07	$ 757.95	$ 1,183.24	-
SUD IMD Services FFS	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 5,646,336	$ 380,060	$ 1,239,670	$ 712,442	$ 7,978,508
Eligible Member Months	2,049	898	667	337	-
PMPM Cost	$ 2,755.65	$ 423.23	$ 1,858.58	$ 2,114.07	-
SMI IMD Services MCO	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 284,193	$ 1,354,261	$ 3,323,593	$ 2,250,130	$ 7,212,177
Eligible Member Months	31	103	167	134	-
PMPM Cost	$ 9,167.52	$ 13,148.17	$ 19,901.75	$ 16,792.01	-
SMI IMD Services FFS	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 4,932,831	$ 1,057,229	$ 5,849,518	$ 3,592,805	$ 15,432,805
Eligible Member Months	583	293	579	424	-
PMPM Cost	$ 8,461.12	$ 3,608.29	$ 10,102.79	$ 8,473.60	-
Non-State Plan Services	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 0	$ 0	$ 0	$ 20,055	$ 20,055
Eligible Member Months	-	-	-	66	-
PMPM Cost	-	-	-	$ 303.86	-
Non-IMD Services	**DY1**	**DY2**	**DY3**	**DY4**	**Total**
Total Expenditures	$ 5,601,875	$ 1,573,130	$ 1,093,068	$ 1,412	$ 8,200,465
Eligible Member Months	12,989	3633	2598	24	-
PMPM Cost	$ 431.28	$ 433.01	$ 420.73	$ 58.83	-

Table 4: Projected Demonstration Expenditures								
SUD IMD Services MCO	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	2,108	-	2,135	2,149	2,163	2,177	2,191	-
PMPM Cost	$ 1,183.24	5%	$ 1,247	$ 1,310	$ 1,375	$ 1,444	$ 1,516	-
Total Expenditures	-	-	$ 2,663,682	$ 2,814,890	$ 2,974,685	$ 3,143,563	$ 3,322,031	$ 14,918,851
SUD IMD Services FFS	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	337	-	310	310	310	310	311	-
PMPM Cost	$ 2,114.07	5%	$ 2,431	$ 2,552	$ 2,680	$ 2,814	$ 2,955	-
Total Expenditures	-	-	$ 752,348	$ 790,616	$ 830,832	$ 873,092	$ 917,503	$ 4,164,391

SMI IMD Services MCO	Base Year (DY4)	Trend Rate	DY6	DY7	DY8	DY9	DY10	Total
Eligible Member Months	134	-	136	136	136	136	136	-
PMPM Cost	$ 16,792.01	5%	$ 17,703	$ 18,589	$ 19,518	$ 20,494	$ 21,519	-
Total Expenditures	-	-	$ 2,402,948	$ 2,525,172	$ 2,653,614	$ 2,788,588	$ 2,930,428	$ 13,300,750
SMI IMD Services FFS	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	424	-	403	403	403	404	404	-
PMPM Cost	$ 8,473.60	5%	$ 9,422	$ 9,894	$ 10,388	$ 10,908	$ 11,453	-
Total Expenditures	-	-	$ 3,794,052	$ 3,987,034	$ 4,189,833	$ 4,402,943	$ 4,626,899	$ 21,000,763
Justice-Involved Reentry Services -Adult	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	-	-	-	7,513	7,519	7,525	7,532	-
PMPM Cost	-	5%	-	$ 1,223	$ 1,284	$ 1,348	$ 1,415	-
Total Expenditures	-	-	$ 0	$ 9,185,394	$ 9,652,603	$ 10,143,604	$ 10,659,582	$ 39,641,183
Justice-Involved Reentry Services – Youth	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	-	-	-	186	186	186	186	-
PMPM Cost	-	5%	-	$ 5,542	$ 5,819	$ 6,110	$ 6,416	-
Total Expenditures	-	-	$ 0	$ 1,030,831	$ 1,083,264	$ 1,138,364	$ 1,196,266	$ 4,448,724
Justice-Involved Reentry Infrastructure	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	-	-	-	-	-	-	-	-
PMPM Cost	-	-	-	-	-	-	-	-
Total Expenditures	-	-	$ 150,000	$ 150,000	$ 200,000	$ 0	$ 0	$ 500,000
HRSN Services	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	-	-	-	-	-	-	-	-
PMPM Cost	-	-	-	-	-	-	-	-

Total Expenditures	-	-	$0	$85,000,000	$130,000,000	$130,000,000	$130,000,000	$455,000,000
HRSN Infrastructure	**Base Year (DY4)**	**Trend Rate**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total**
Eligible Member Months	-	-	-	-	-	-	-	-
PMPM Cost	-	-	-	-	-	-	-	-
Total Expenditures	-	-	$18,000,000	$18,000,000	$10,000,000	$10,000,000	$10,000,000	$66,000,000

IX. Public Notice

DHCF published a Notice of Public Comment in the *District of Columbia Register* on March 29, 2024. The publication in the *District of Columbia Register* can be found at: https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N135488

An electronic copy of the proposed demonstration renewal application may be obtained on the DHCF website at http://dhcf.dc.gov/1115-waiver-initiative, upon request from DHCF via email at dhcf.waiverinitiative@dc.gov, or from Joe Weissfeld, Director, Health Care Reform and Innovation Administration, Department of Health Care Finance, 441 4th Street NW, 9th Floor South, Washington, D.C. 20001. A printed copy of the proposed demonstration renewal application is available for viewing upon request at Department of Health Care Finance Main Entrance, 441 4th Street NW, 9th Floor South, Washington D.C. 20001.

The District's thirty (30) day public comment period will be open from April 1, 2024 through 6:00 PM on April 30, 2024. Interested parties may send written comments concerning the demonstration renewal application to Melisa Byrd, Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, 441 4th Street NW, Suite 900S, Washington, D.C. 20001, or via email at dhcf.waiverinitiative@dc.gov.

DHCF will hold three public hearings during the comment period, where written and oral comments on the proposed renewal application will be accepted. Scheduling information for the public hearings will be posted to the DHCF website at http://dhcf.dc.gov/1115-waiver-initiative and is detailed below:

The first public hearing will take place on Tuesday, April 9, 2024 from 3:00 to 4:30PM via web conference and teleconference only. Individuals can join the first public hearing by phone by dialing 1-206-420-0854 and using the access code 984 829 331, or by web conference by going to https://teams.microsoft.com/l/meetup-join/19%3ameeting_NThkNGIzMjItZDgwNy00NGZhLTg1NDYtNjBkNjVkOWMxOGZk%40thread.v2/0?context=%7b%22Tid%22%3a%228fe449f1-8b94-4fb7-9906-6f939da82d73%22%2c%22Oid%22%3a%22762ec901-c0d1-4e55-896b-92ac24f1c430%22%7d

The second public hearing will take place on Monday, April 22, 2024, from 10:00 to 11:30AM in Ora Glover Meeting Room at Anacostia Neighborhood Library, 1800 Marion Barry Avenue SE. There is no web or teleconference option for the second public hearing.

The third public hearing will take place during the Medical Care Advisory Committee (MCAC) meeting on Wednesday, April 24, 2024, from 5:30 to 7:30PM via web conference and teleconference only. Individuals can join the third public hearing by phone by dialing 1-202-860-2110 and using the access code 2314 418 4314, or by web conference by going to https://dcnet.webex.com/dcnet/j.php?MTID=mbf18619302169d72726a6555cceb3d59

X. Demonstration Contact

Joe Weissfeld, Director, Health Care Reform and Innovation Administration

DC Department of Health Care Finance

(202)-442-9090

joe.weissfeld@dc.gov or dhcf.waiverinitiative@dc.gov