



District Of Columbia Health & Human Services System Market Profile



Health & Human Services System Market Profile Overview

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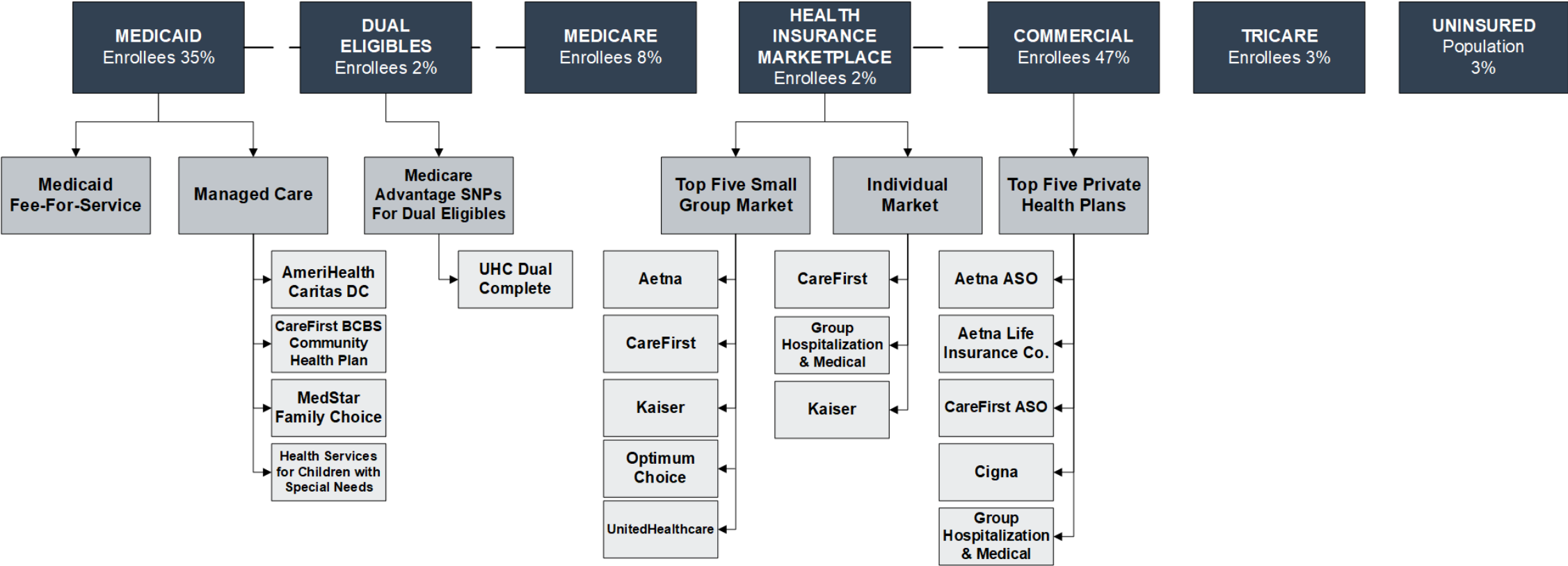
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A. Executive Summary

A.1. District Of Columbia Physical Health Care Coverage by Payer

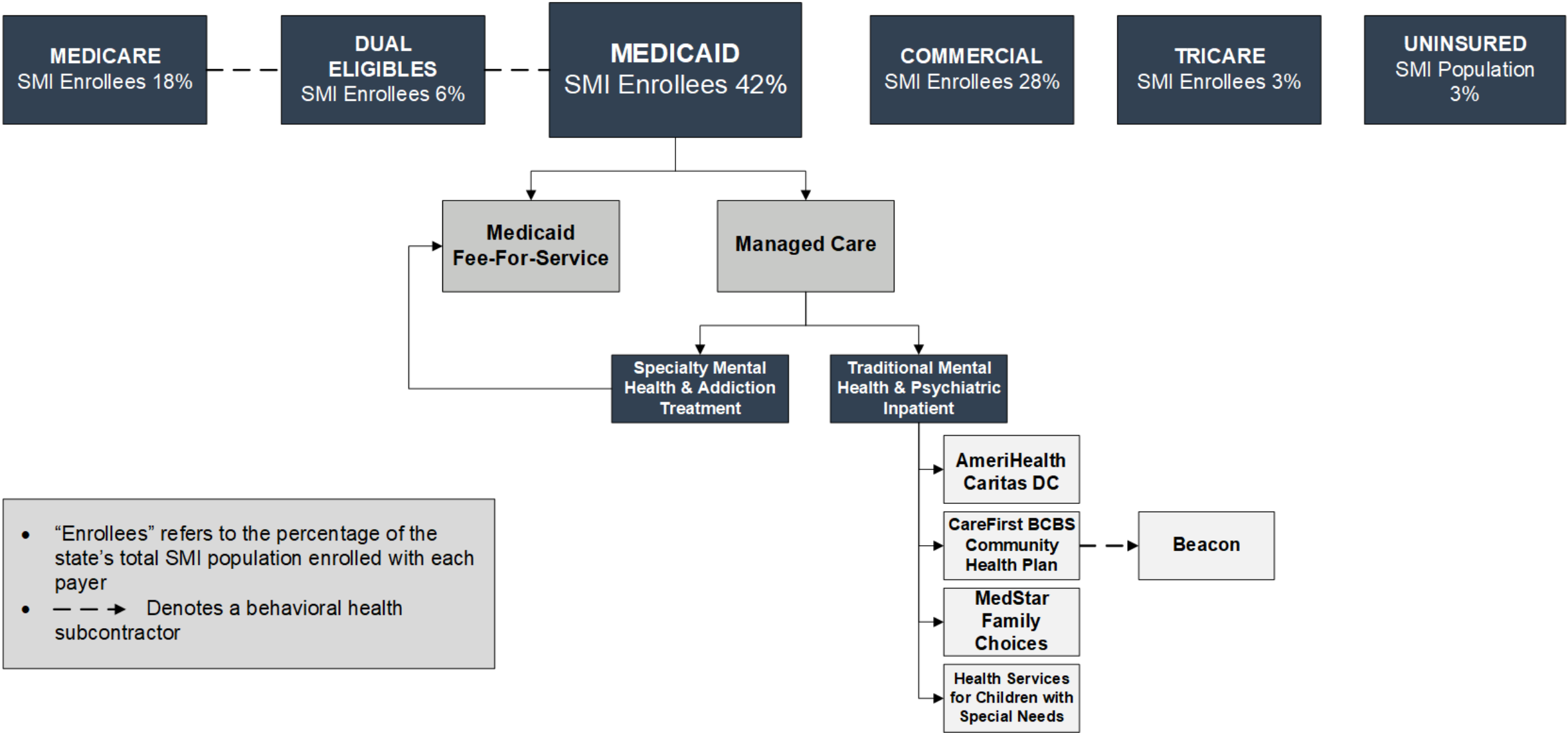
Total District Of Columbia Population- 670,050

Estimated SMI Population- 46,811



“Enrollees” refers to the percentage of the state’s total population enrolled with each payer.

A.1. District Of Columbia Behavioral Health Care Coverage by Payer



A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state has two health home programs—one for individuals with multiple chronic conditions, and one for individuals with SMI.
Patient-Centered Medical Home (PCMH)		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant		None

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The D.C. Health Care Alliance, operated by the Department of Health Care Finance, provides limited health benefits through a managed care delivery system for qualified uninsured citizens with income up to 200% of the FPL.
- For all others, the District of Columbia Department of Health provides funding for safety-net physical health services.

Mental Health Services

- The Department of Behavioral Health is responsible for mental health safety-net services for the uninsured population.

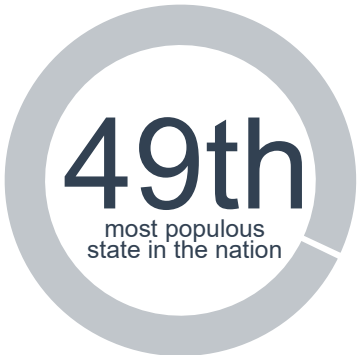
Addiction Treatment Services

- The Department of Behavioral Health is responsible for addiction treatment safety-net services for the uninsured population.

B. District Of Columbia Health Financing System Overview

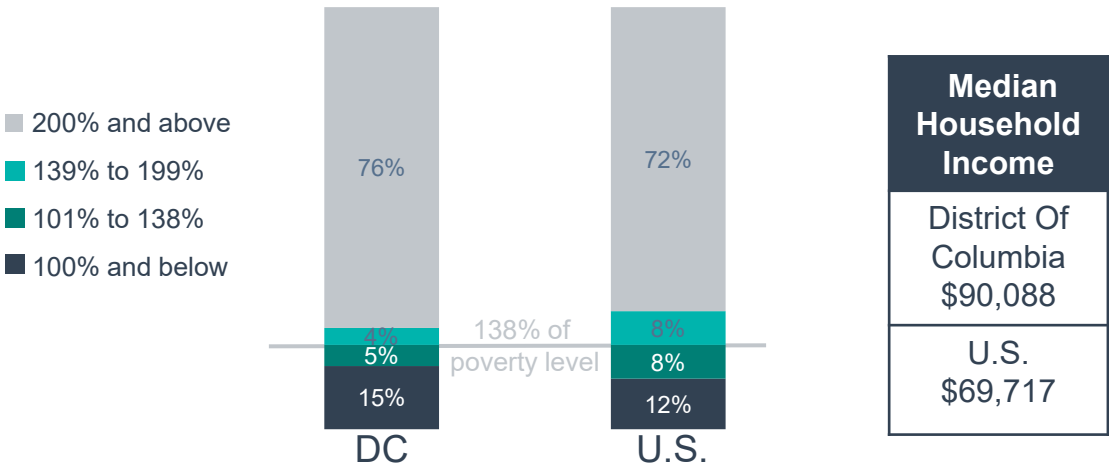
B.1. Population Demographics

Total District Of Columbia Population- 670,050
Estimated SMI Population- 46,811

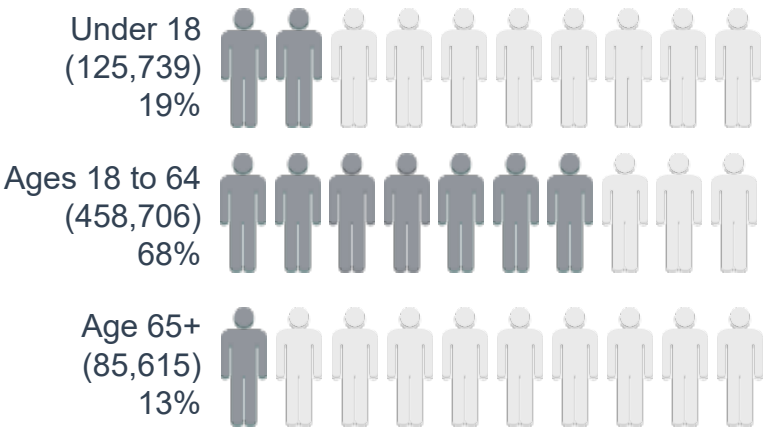


<1% of the
U.S. population

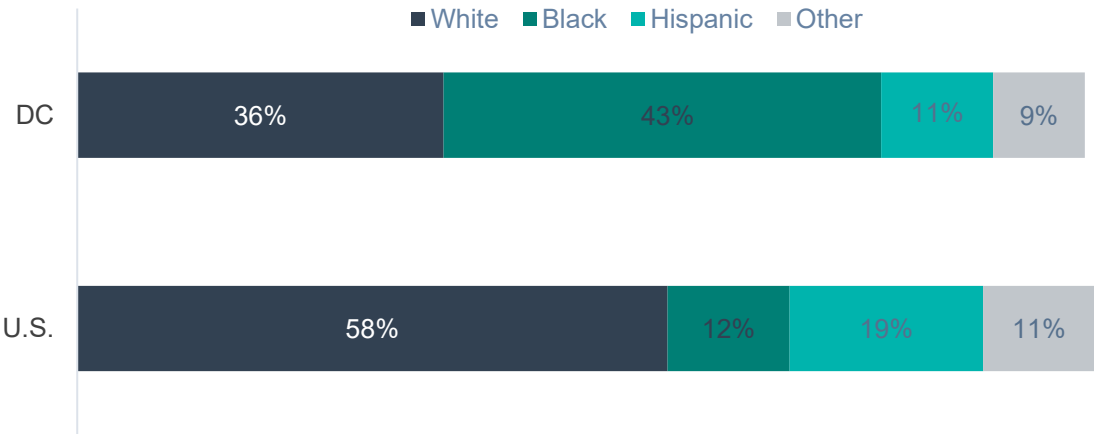
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



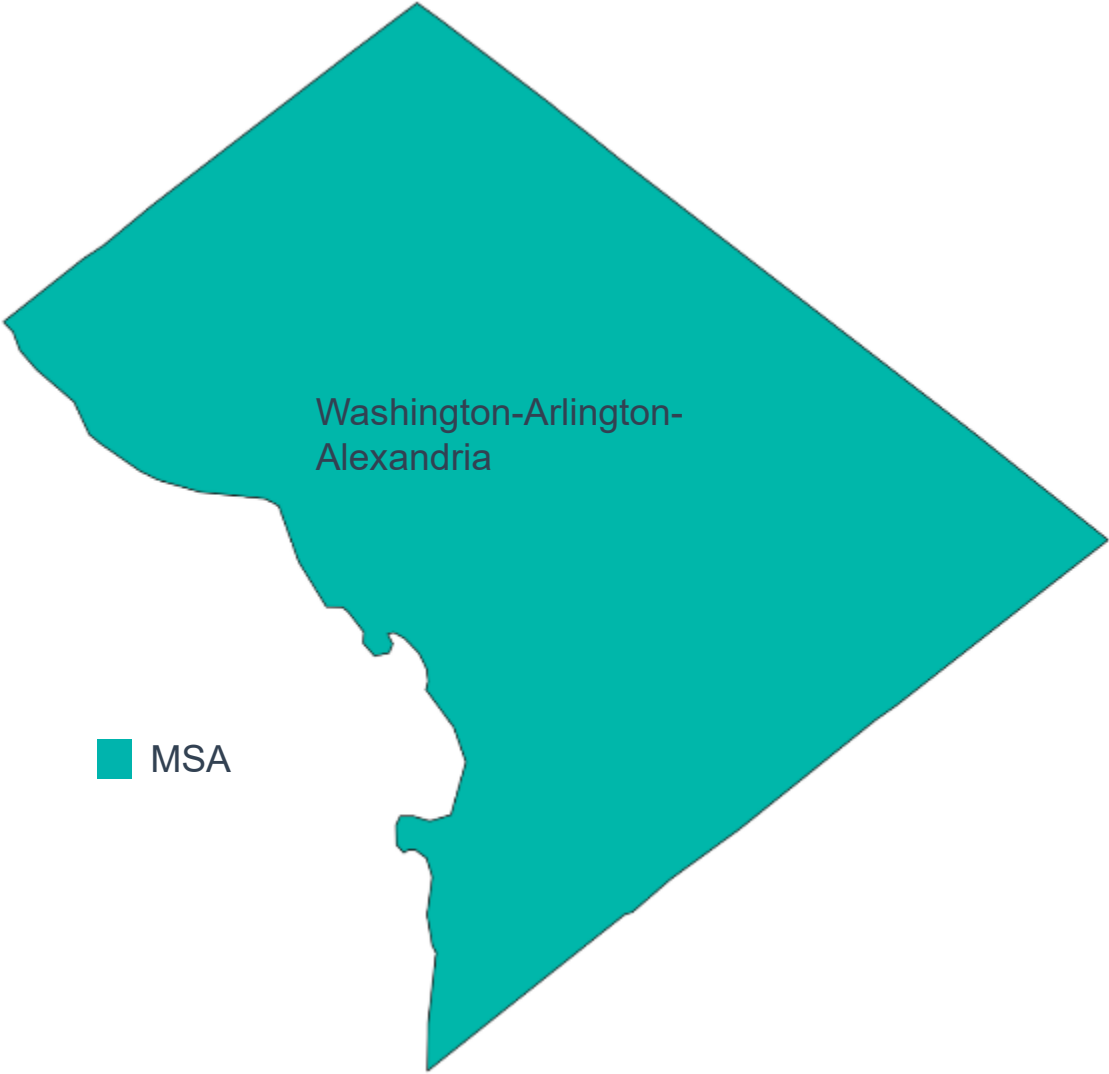
District Of Columbia & U.S. Racial Composition



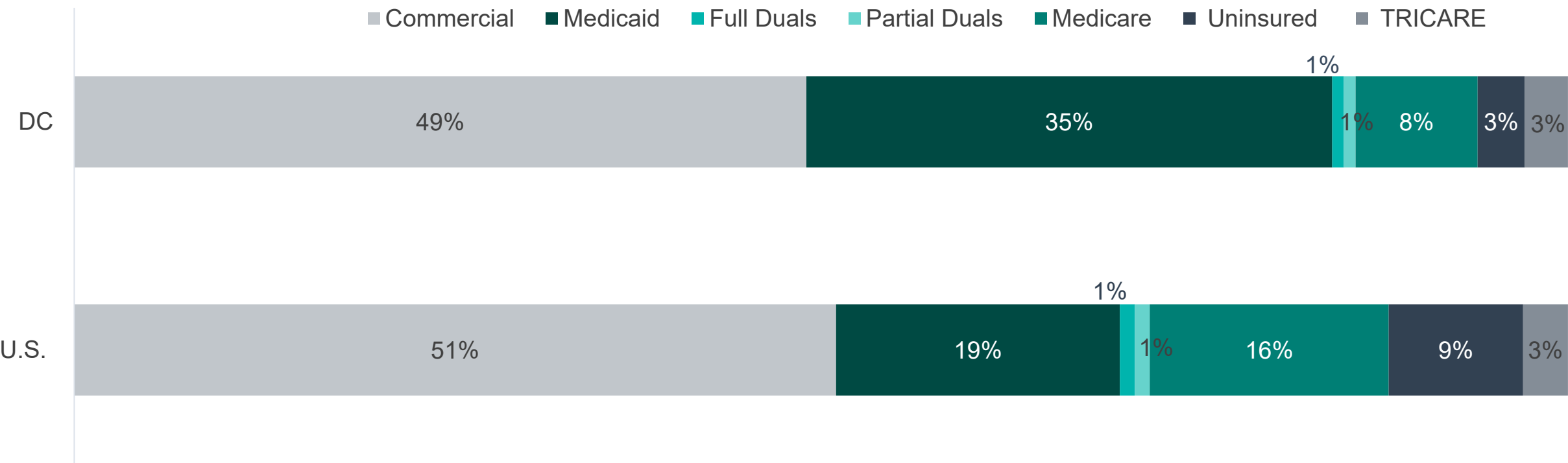
Totals may not equal 100% due to rounding.

B.2. Population Centers

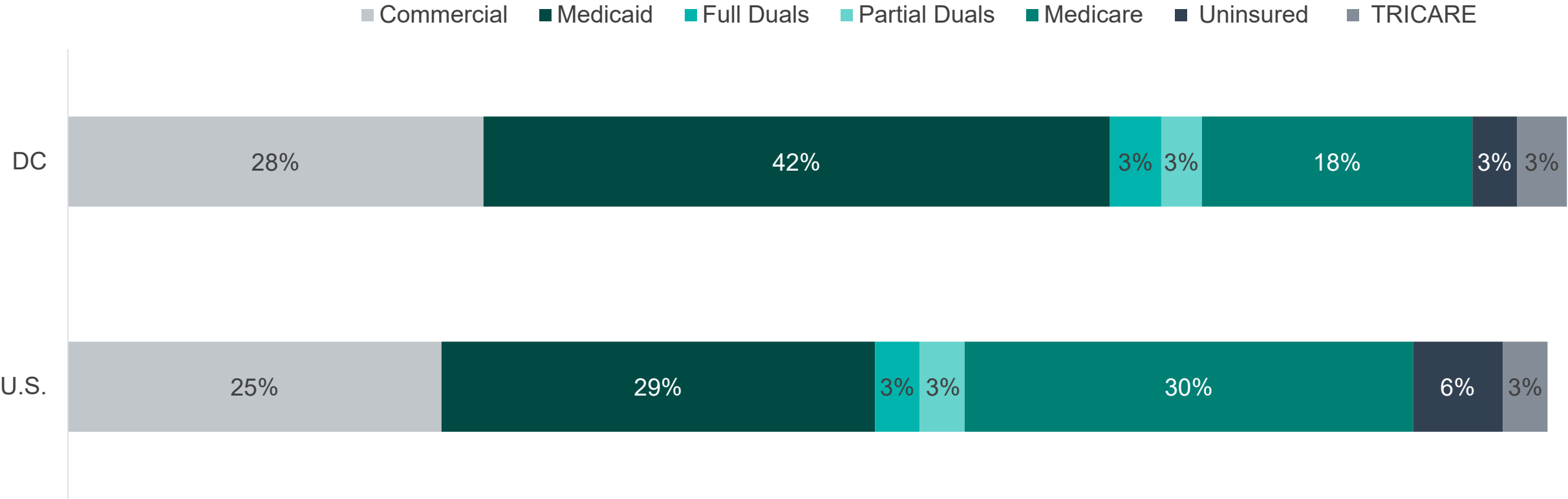
Metropolitan Statistical Areas (MSAs)		
MSA	DC MSA Residents	Percent of Population
Total MSA Population	6,373,756	N/A
Washington-Arlington-Alexandria, DC-VA-MD-WV	6,373,756	N/A



B.3. Population Distribution By Payer: National vs. State



B.3. SMI Population Distribution By Payer: National vs. State



B.4. Largest District Of Columbia Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Aetna	Commercial administrative services organization (ASO)	375,465
CareFirst	Commercial ASO	221,660
Group Hospitalization and Medical Services	Commercial	162,446
Cigna	Commercial ASO	132,989
Aetna Life Insurance Company	Commercial	124,246
UnitedHealthcare Insurance Company	Commercial	118,816
AmeriHealth Caritas District of Columbia	Medicaid managed care	118,422
UnitedHealthcare	Commercial ASO	111,570
CareFirst BlueChoice	Commercial	99,223
Aetna Health	Commercial	94,962

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023. Commercial plan enrollment is based on location of employer; consequently, commercial enrollment figures exceed the residential population of the District of Columbia.

B.4. Largest District Of Columbia Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Aetna	Commercial administrative services organization (ASO)	375,465	15,394
AmeriHealth Caritas District of Columbia	Medicaid managed care	118,422	10,184
DC Medicare Fee-For-Service (FFS)	Medicare	62,446	9,991
CareFirst	Commercial ASO	221,660	9,088
Group Hospitalization and Medical Services	Commercial	162,446	6,660
CareFirst BlueCross BlueShield Community Health Plans	Medicaid managed care	64,480	5,545
MedStar Family Choice	Medicaid managed care	64,146	5,517
Cigna	Commercial ASO	132,989	5,453
Aetna Life Insurance Company	Commercial	124,246	5,094
UnitedHealthcare Insurance Company	Commercial	118,816	4,871

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023. Commercial plan enrollment is based on location of employer; consequently, commercial enrollment figures exceed the residential population of the District of Columbia.

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	2%
Type of Marketplace	District-based
Individual Enrollment Contact	www.dchealthlink.com/individuals
	1-855-532-5465
Small Business Enrollment Contact	www.dchealthlink.com/smallbusiness
	1-855-532-5465

2023 Individual Market Health Plans
- CareFirst HMO - Kaiser of the Mid-Atlantic States - Group Hospitalization and Medical Services

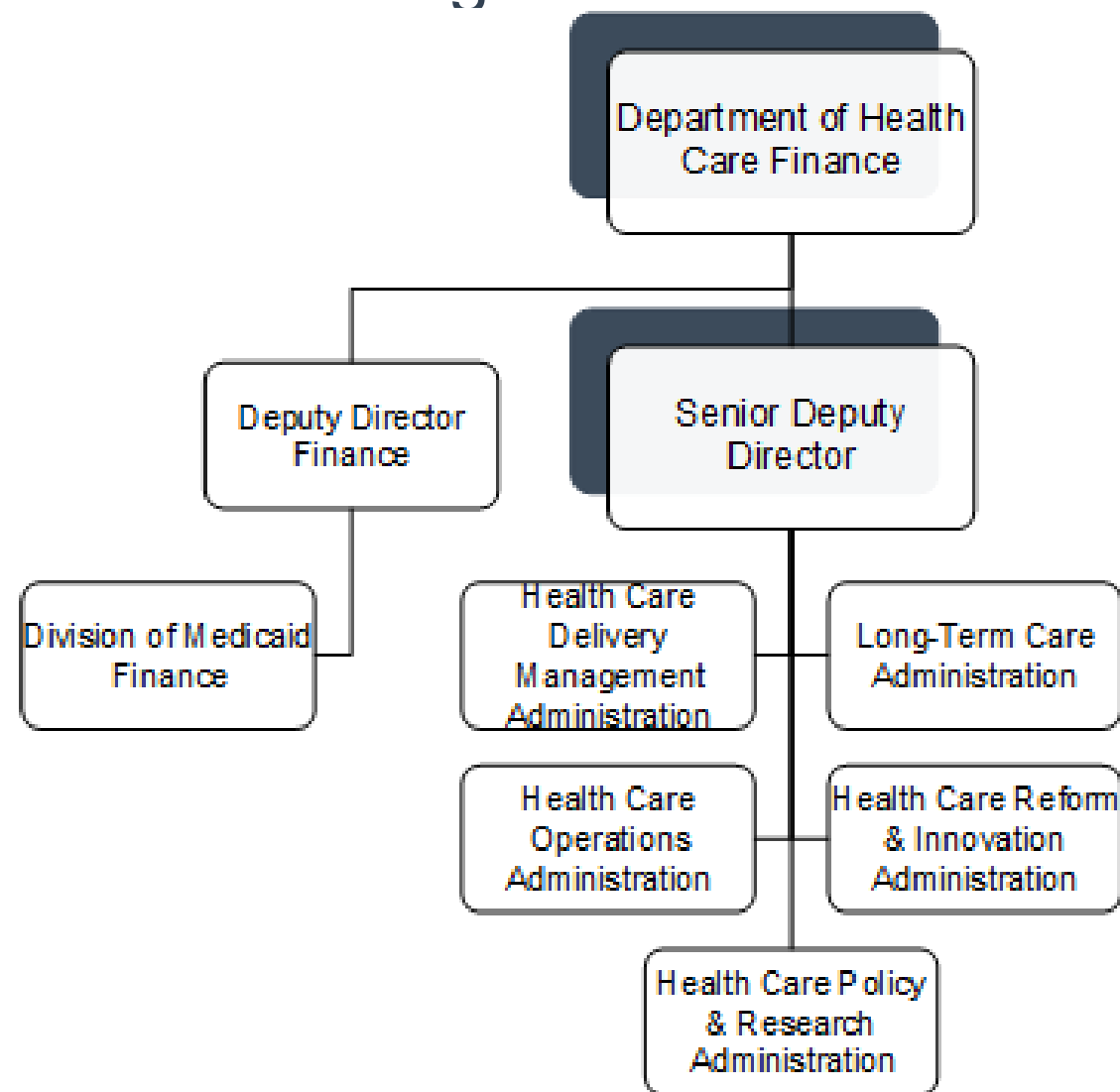
2023 Small Group Market Health Plans
- Care First HMO - GHMSI/CareFirst PPO - Kaiser - Aetna HMO - Aetna PPO - Optimum Choice (a UnitedHealthcare HMO) - UnitedHealthcare of the Mid-Atlantic (HMO) - UnitedHealthcare Insurance Company (PPO)

B.6. Accountable Care Organizations (ACOs)

Medicare Shared Saving Models	
1.	Accountable Care Coalition of Northeast Partners, LLC
2.	GW Health Network
3.	Netrin Primary Care ACO, LLC
4.	Privia Quality Network, LLC

C. Medicaid Administration, Governance & Operations

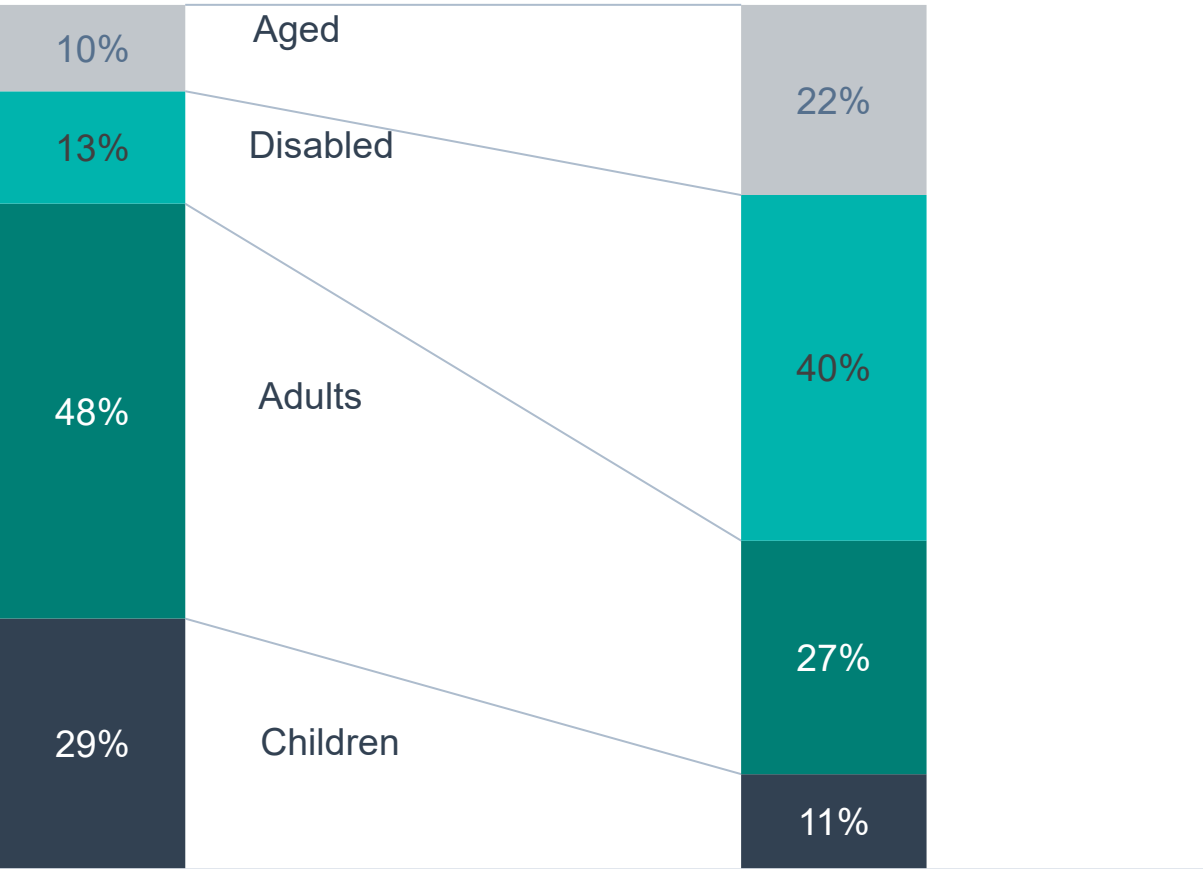
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Wayne Turnage	Director	Department of Health Care Finance (DHCF)	wayne.turnage@dc.gov
Melisa Byrd	Senior Deputy/Medicaid Director	DHCF	melisa.byrd@dc.gov
Melanie Williamson	Chief of Staff	DHCF	Melanie.Williamson@dc.gov
Darrin Shaffer	Agency Fiscal Officer, Office of the Chief Financial Officer	DHCF	darrin.shaffer@dc.gov
Lisa Truitt	Director	DHCF, Health Care Delivery Management Administration	lisa.truitt@dc.gov
Donald Shearer	Director	DHCF, Health Care Operations Administration	donald.shearer@dc.gov
A Weiss	Director	DHCF, Health Care Policy and Research Administration	eugene.simms@dc.gov

C.2. Medicaid Program Spending By Eligibility Group



Percent of Total Medicaid Population
Based on FY 2020 data

Percent of Total Medicaid Spending

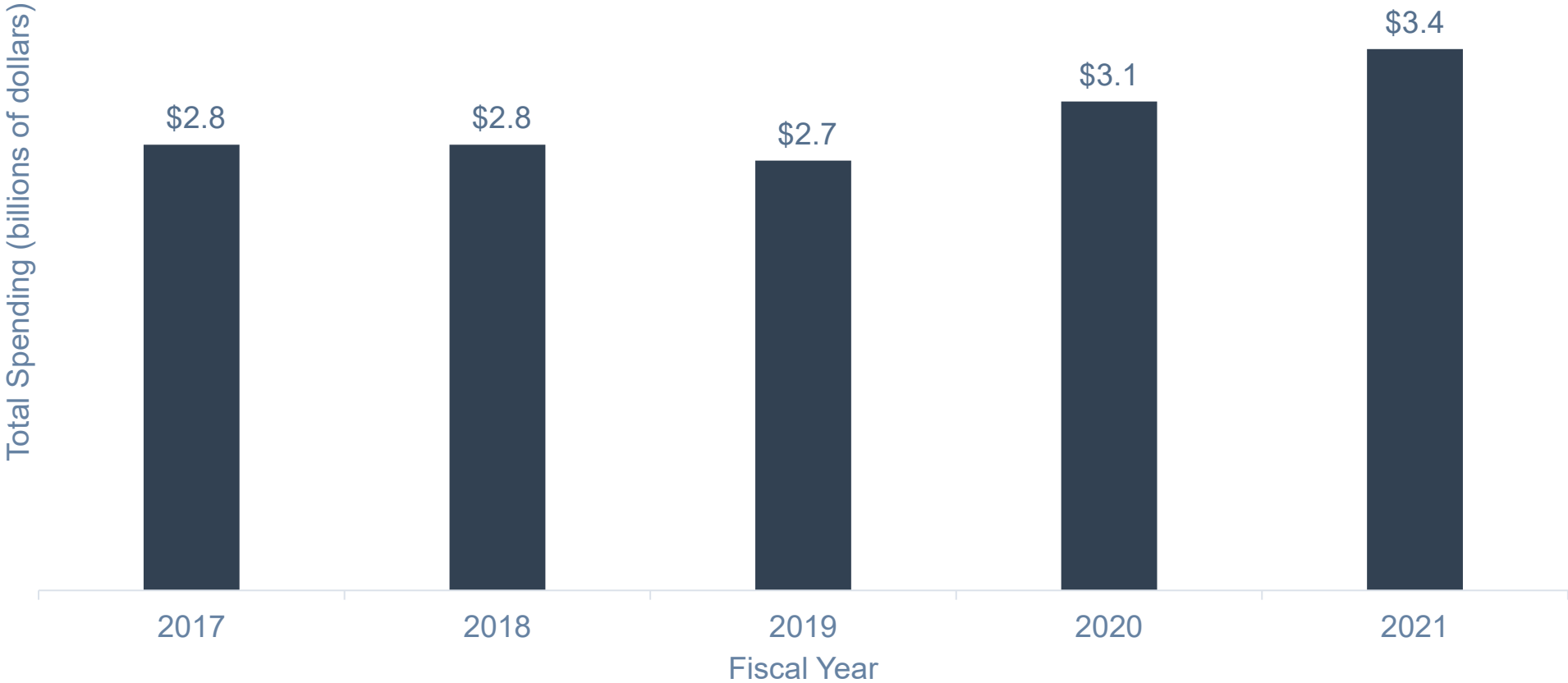
Medicaid Spending Per Enrollee, FY 2020		
	U.S.	DC
All populations	\$8,718	\$12,386
Children	\$3,495	\$4,952
Adults	\$5,461	\$6,848
Expansion adults	\$7,227	\$6,941
Blind and disabled	\$23,123	\$37,849
Aged	\$18,552	\$25,547

C.2. Medicaid Program Spending: Budget

Budget Item	SFY 21 Spending	Percent Of Budget
Managed care and premium assistance	\$1,372,000,000	41%
Home- and community-based LTSS	\$678,000,000	20%
Institutional LTSS	\$421,000,000	13%
Hospital	\$291,000,000	9%
Other acute	\$285,000,000	8%
Clinic and health center	\$136,000,000	4%
Medicare premiums and coinsurance	\$70,000,000	2%
Drugs	\$66,000,000	2%
Physician	\$27,000,000	1%
Dental	\$8,000,000	<1%
Other practitioner	\$4,000,000	<1%
Budget Total: \$3,358,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	76.2%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	N/A

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	216% of the federal poverty level (FPL) for parents and caretakers; 210% of the FPL for childless adults
Legislation Used To Expand Medicaid	§ 1–307.03. Medical assistance expansion program establishment.
Number Of Individuals Enrolled In The Expansion Group (April 2023)	132,397
Number Of Enrollees Newly Eligible Due To Expansion	87,751
Benefits Plan For Expansion Population	The alternative benefit plan is identical to the state plan.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

District Of Columbia's Optional Services

1. Podiatry and optometry
2. Private duty nursing
3. Clinic services
4. Dental services
5. Physical and occupational therapy
6. Services for individuals with speech, hearing, and language disorders
7. Prescribed drugs
8. Dentures, eyeglasses, and prosthetic devices
9. Diagnostic, screening, and preventive services
10. Rehabilitative services
11. Services in IMDs for individuals age 65 and over
12. Intermediate care facility services
13. Public institution services for I/DD
14. Inpatient psychiatric facility for individuals under 22
15. Hospice care
16. Case management
17. Special tuberculosis services
18. Nursing facility services for individuals under 21
19. Personal care services
20. MAT for OUD
21. Kidney or Liver Transplants

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (March 2023)	44,098	239,164
SMI Enrollment	• OPEN MINDS estimates 16% of the SMI population in FFS, 84% in managed care	
Management	Department of Health Care Finance	Three health plans
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	Statewide

Total Medicaid: 283,262 | Total Medicaid With SMI: 24,360

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of March 2023: 16% in fee-for-service (FFS), 84% in managed care
SMI population inclusion in managed care	Estimated 16% of population in FFS, 84% in managed care
Dual eligible population inclusion in managed care	- Dual eligibles are mandatorily enrolled in FFS. - Estimated 100% of population in FFS

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional behavioral health	Covered FFS by the state	Included in the health plan's capitation rate
Specialty behavioral health	Covered FFS by the state	Excluded from the health plan's capitation rate and covered FFS
Pharmaceuticals	Covered FFS by the state	Included in the health plan's capitation rate
Long-term services and supports (LTSS)	Covered FFS by the state	Covered FFS by the state

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	The health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state has two health home programs—one for individuals with multiple chronic conditions, and one for individuals with SMI.
Patient-Centered Medical Home (PCMH)		None
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant		None

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals	X		
Aged individuals	X		
Dual eligibles	X		
Medicaid expansion			X
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Individuals in foster care		X	
Other populations	• Children eligible for Supplemental Security Income • Children under 19 receiving care through a coordinated, community-based system	Members of federally recognized tribes	• Individuals eligible for SSI/SSP • Disabled Widows and Widowers • Disabled Adult Children

D.2. Medicaid FFS Program: Overview

- As of March 2023, FFS enrollment was 44,098.

D.2. Medicaid FFS Program: Behavioral Health Benefits

- Mental health rehabilitative services (MHRS) and addiction treatment benefits, called Adult Substance Abuse Rehabilitative Services (ASARS), are managed by the Department of Behavioral Health. To access ASARS, individuals must be referred through an intake center designated by the Department of Behavioral Health.

FFS Mental Health Benefits	
1.	Inpatient treatment
2.	Diagnostic services and assessment
3.	Medication and somatic treatment
4.	Counseling
5.	Community support
6.	Crisis and emergency services
7.	Day services
8.	Intensive day treatment
9.	Community-based intervention
10.	Assertive community treatment
11.	Inpatient psychiatric facility services for individuals under age 21
12.	Psychiatric residential treatment facility services for individuals under age 22

FFS Addiction Treatment Benefits	
1.	Inpatient detoxification*
2.	Assessment and diagnostic services
3.	Treatment planning
4.	Clinical care coordination
5.	Crisis intervention
6.	Counseling
7.	Medically-monitored intensive withdrawal management
8.	Medication management
9.	Medication assisted treatment

*Inpatient detoxification is not an ASARS service and does not require intake processing.

D.2. Medicaid FFS Program: SMI Population

- As of March 2023, *OPEN MINDS* estimates that 16% of the SMI population was enrolled in FFS.

D.2. Medicaid FFS Program: Pharmacy Benefit

District Of Columbia FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Yes, Magellan Rx Management.
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the state utilizes a PDL.
State Uses A PDL For Mental Health Drugs	Yes, anticonvulsants, antidepressants, and antipsychotics are included on the state's PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, addiction treatment drugs for opioids and smoking cessation are included on the state's PDL.
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are included in the state's PDL.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• Mental health drugs are subject to prior authorization. • Effective April 1, 2019, addiction treatment drugs can be dispensed up to FDA guidelines without a prior authorization and can be dispensed above that level with prior authorization. • For the authorization of non-preferred agents, a preferred agent in the same therapeutic class must have been tried within the previous 90 days.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Individuals enrolled in Medicaid FFS who are suspected of misusing drugs in excess of normal dosage may be locked into a single pharmacy for at least 12 months.

D.3. Medicaid Managed Care Program: Overview

- As of March 2023, managed care enrollment was 239,164.
- The Medicaid managed care program is called DC Healthy Families.
- The three health plans deliver physical health and pharmacy benefits for most families and children.
 - The health plans are available district-wide and individuals have a choice of plan.
- Additionally, the District operates a small health plan for children with special health care needs called the Health Services for Children with Special Needs, Inc. As of July 2020, enrollment in this plan was 5,040.
- In October 2020, the state announced it completed a procurement for their managed care plans. The new plan, MedStar Family Choice DC, is joined by incumbents AmeriHealth Caritas DC, and CareFirst Community Plan (formerly Trusted Health Plan). These went into effect on January 1, 2021.

D.3. Medicaid Managed Care Program: Health Plan Characteristics

AmeriHealth Caritas District Of Columbia
1. Profit status: For-profit
2. Parent company: Independence Health Group
3. Behavioral health subcontractor: PerformCare
4. Pharmacy benefits manager: PerformRx
5. Enrollment share: 47%

Health Services for Children with Special Needs
1. Profit status: Non-profit
2. Parent company: None
3. Behavioral health subcontractor: Dept of Behavioral Health
4. Pharmacy benefits manager: CVS
5. Enrollment share: 2%

CareFirst Community Health Plan (Formerly Trusted Health Plan)
1. Profit status: For-profit
2. Parent company: CareFirst Blue Cross Blue Shield
3. Behavioral health subcontractor: Beacon Health Options
4. Pharmacy benefits manager: Abarca Pharmacy
5. Enrollment share: 26%

Medstar
1. Profit status: For-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: None
5. Enrollment share: 25%

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- Inpatient and outpatient mental health services are included in the health plan's capitation rate.
- Specialty mental health services, called mental health rehabilitative services (MHRS), and all addiction disorder treatment services, called Adult Substance Abuse Rehabilitative Services (ASARS), are excluded from the health plan's capitation rate. These services are covered FFS.
 - MHRS and ASARS are managed by the Department of Behavioral Health.
 - To access ASARS services, individuals must be referred through an intake center designated by the Department of Behavioral Health.
 - Inpatient detoxification is not considered a part of ASARS and is included in the health plan's capitation rate.
- Behavioral health pharmacy services are included in the health plan's capitation rate.
- Health plans are required to contract with the core service agencies (CSAs). CSAs are provider organizations certified by the District to deliver publicly-funded mental health and addiction disorder treatment services.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Mental Health Benefits Provided By The Health Plans	
1.	Care coordination and case management
2.	Physician and mid-level visits: • Individual, group, and family counseling • Diagnosis and assessment • Pharmacologic management
3.	Inpatient hospitalization
4.	Inpatient psychiatric facility services for individuals under age 21
5.	Psychiatric residential treatment facility services for individuals under age 22

Mental Health Benefits Provided By The District	
1.	Community support
2.	Crisis and emergency services
3.	Day services
4.	Intensive day treatment
5.	Community-based intervention
6.	Assertive community treatment

Addiction Treatment Benefits Provided By The Health Plans	
1.	Inpatient detoxification
2.	Evaluations
3.	Referrals to Department of Behavioral Health services

Addiction Treatment Benefits Provided By The District	
1.	Assessment and diagnostic services
2.	Clinical care coordination
3.	Crisis intervention
4.	Medically managed intensive inpatient detoxification
5.	Counseling
6.	Medication management
7.	Medication assisted treatment

D.3. Medicaid Managed Care Program: SMI Population

- As of March 2023, *OPEN MINDS* estimates that 84% of the SMI population was enrolled in managed care.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

District Of Columbia Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plan
Responsible For Financing Mental Health Pharmacy Benefit	Health plan
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	The health plans have the option to create their own PDL and may include both mental health and addiction treatment medications.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	Utilization restrictions vary between the different health plans.
Health Plan Allowed To Implement Pharmacy Lock-In Program	The health plans have the option of implementing a lock-in program but are not required to have one. There are current plans to make this a requirement, but the legislation is pending.

D.4. Medicaid Program: Care Coordination Initiatives

			
Accountable Care Organization (ACO) Program	Affordable Care Act Health Home	Patient-Centered Medical Home (PCMH)	Other Care Coordination Initiatives
None	The state has two health home programs—one for individuals with SMI and one for individuals with chronic conditions.	None	None

D.4. State Medicaid Health Home Characteristics

Chronic Care Management For Individuals With Serious & Persistent Mental Health Conditions Health Home Overview	
Target Population	• Individuals with SMI • Intellectual disabilities, developmental disorders, other seizure disorders, and DSM-V addiction disorders are not qualifying conditions without a co-occurring diagnosable mental illness. • To ensure services are not duplicated, individuals cannot receive community support services (CSS), assertive community treatment (ACT), or waiver case management while enrolled in a health home.
Enrollment Model	Opt-in through letter from the district, and engagement by the health home.
Geographic Service Area	Districtwide
Care Delivery Model	• Community mental health centers designated as Core Service Agencies (CSA)—as defined by DC Municipal Regulations—serve as health homes and establish health home teams. • Delivery of six core health home services, comprehensive needs assessment, and person-centered care plan for each enrollee
Payment Model	The district pays a per member per month (PMPM) rate based on severity of each individual's chronic conditions: • Low acuity: \$349 PMPM for at least one care management service and at least one other encounter per month • High acuity: \$481 PMPM for at least two care management services and at least two other encounters per month
Practice Performance & Improvement	• Utilization: All-cause 30-day readmissions, rate of inpatient hospital utilization, emergency room visits per 1,000 health home enrollees, short-term nursing facility admissions • Spending: Actual spending compared to expected spending based on FY 2015 data • Performance: Enrollment rate, completed assessments rate, completed care plan rate, volume of services received relative to acuity level

D.4. State Medicaid Health Home Characteristics

My Health GPS Health Home Overview	
Target Population	- Individuals with three or more chronic conditions - Qualifying conditions include mental health conditions, addiction disorders, and 19 other diagnoses. - Individuals may not receive waiver case management concurrently with health home services.
Enrollment Model	Automatic enrollment with opt-out
Geographic Service Area	Districtwide
Care Delivery Model	- Clinical practices, clinical group practices, or FQHCs meeting district health home standards and having an embedded health home team - Delivery of six core health home services, comprehensive needs assessment, and person-centered care plan for each enrollee
Payment Model	- Initial PMPM of \$163.63 for the development of the care plan, which can also be claimed annually when the plan is updated - Monthly payment based on acuity: - Group 1 (low acuity) - \$46 PMPM - Group 2 (high acuity) - \$137 PMPM - Beginning in FY 2021 (previously FY 2019), a percentage of the PMPM will be withheld as a pay-for-performance incentive based on readmission and preventable inpatient and emergency room utilization metrics.
Practice Performance & Improvement	- Health homes must have NCQA level 2 PCMH recognition, or at least must have begun the application process. - Emergency room utilization, hospitalization, nursing facility admissions, and pharmacy utilization - Actual spending compared to expected spending based on FY 2014 to FY 2016 data - Health Homes are required to participate in a pay-for-performance incentive program. Institutions can receive 10% in year one, 15% in year two, and 15% in year three.

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
D.C. Behavioral Health Transformation	The waiver authorizes coverage of services in institutions for mental disease (IMD) for individuals with either SMI or addiction disorders. It also temporarily expands the Medicaid behavioral health benefit.	1115	None	01/01/2020	12/31/2024

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
DC Elderly and Persons w/Disabilities (0334.R05.00)	Individuals with a physical disability between the ages of 18 and 64 and individuals over the age of 65.	6,160	Department of Health Care Finance, Division of Long Term Care (DLTC)	No
DC People with Intellectual and Developmental Disabilities (0307.R05.00)	Individuals with I/DD over the age of 18.	1,963	Department of Disability Services, Developmental Disabilities Administration	No
DC Individual and Family Support (IFS) Waiver (1766.R00.00)	Individuals with I/DD who require support in their homes.	90	Department of Disability Services, Developmental Disabilities Administration	No

D.6. Medicaid Program New Initiatives: D.C. Behavioral Health Transformation

- The Centers for Medicare & Medicaid Services (CMS) approved D.C. Behavioral Health Transformation 1115 waiver on November 6, 2019. The waiver expands available behavioral health services and allows for certain services to be provided in institutions for mental disease (IMD).
 - These services began on January 1, 2020.
- Residential services, medically supervised withdrawal, medication assisted treatment (MAT), recovery support services, trauma-informed care, transition planning, services of a licensed behavioral health practitioner, and inpatient services may be provided in IMDs.
 - These services are available in IMDs to individuals with either SMI or addiction disorders. D.C. is the first state to receive approval to provide services in an IMD to individuals with SMI under new guidance issued by CMS.
 - The target statewide average length of stay is 30 days. No federal Medicaid matching funds will be provided for IMD stays lasting longer than 60 days, or for forensic IMD stays.
- This demonstration also expands the current behavioral health benefit to include additional services.
- Copayments have been removed for MAT prescriptions for individuals with addiction disorders.

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics	
Characteristics	Medicaid Fee-For-Service (FFS)
Enrollment (March 2023)	12,120
Estimated SMI Enrollment	3,878
Management	Department of Health Care Finance
Payment Model	FFS
Geographic Service Area	Statewide

Total Dual Eligible Enrollment: 12,120 | Total Dual Eligible Enrollment With SMI: 3,878

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	March 2023 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete	UnitedHealthcare	Medicare Advantage D-SNP	12,038	3,852

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- As of March 2023, dual eligible enrollment was 12,120.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Dual eligible beneficiaries are excluded from enrolling in managed care and are currently enrolled in FFS with the exception of those enrolling in a D-SNP.
- D-SNP enrollment as of March 2023 was 12,038, SMI enrollment for D-SNP was 3,852.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- In November 2019, CMS approved the creation of Highly-Integrated Dual Special Needs Plan (HIDE-SNP) by 2021 to increase the alignment of Medicare and Medicaid benefits for dual eligibles.
 - HIDE-SNP plans are operated by health plans with both a Medicare D-SNP advantage and Medicaid health plan in a single state.
 - The HIDE-SNP must coordinate both Medicare and Medicaid benefits using aligned care management and specialty care networks for high-risk enrollees. The model of care used by the HIDE-SNP must be approved by the National Committee for Quality Assurance.
 - The HIDE-SNP must be part of a Medicare Advantage contract with a 3-star rating or higher.
- In February 2020, CMS approved the creation of a PACE program to better care for the elderly population. The program was expected to launch in 2020, but has been put on hold and is still in the planning/implementation phase.
 - The state has utilized a state plan amendment to facilitate the creation of this PACE program.
 - A selective bidding process will be completed afterwards to identify provider organizations to operate in Wards 7 and 8 only.
 - The state intends to sign a three-way PACE program amendment with CMS.

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

- D.C. does not operate a MLTSS program

LTSS Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (December 2021)	N/A
Estimated SMI Enrollment	N/A
Management	N/A
Payment Model	N/A
Geographic Service Area	N/A

Total LTSS Enrollment: N/A | Total LTSS Enrollment With SMI: N/A

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults	X		
Disabled children	X		
Blind individuals	X		
Aged individuals	X		
Dual eligibles	X		
Individuals with I/DD	X		
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Other HCBS Recipients	X		
Other populations			

F.2. LTSS Medicaid Financing & Delivery System: Overview

- D.C. does not offer MLTSS services and instead all individuals receive care through the FFS system.

F.3. Medicaid LTSS Program: Health Benefits

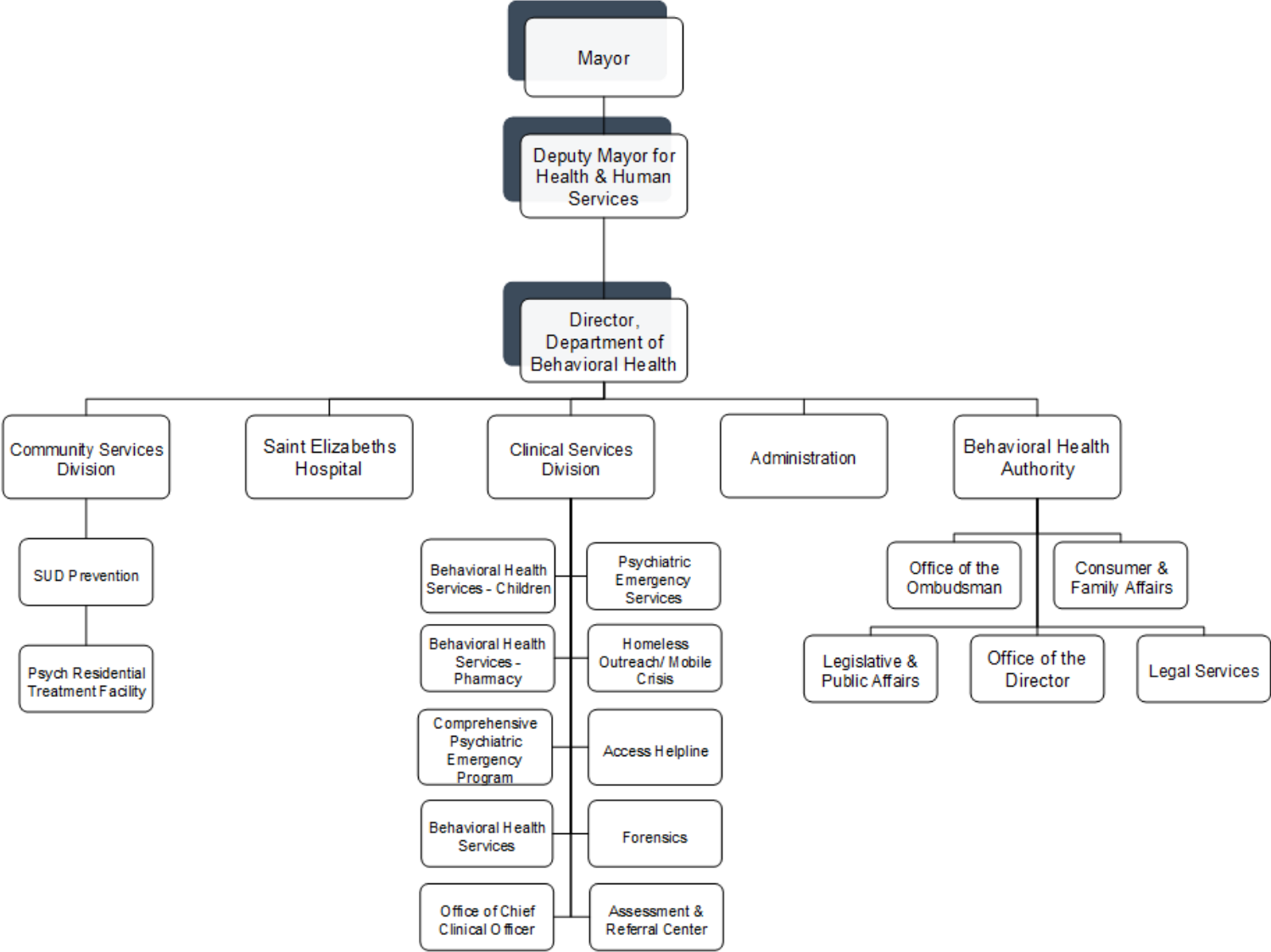
- D.C. does not offer MLTSS services and instead all services are the same as the FFS program.

F.4. LTSS Medicaid Financing & Delivery System: New Initiatives

- D.C. has no pending initiatives that will influence the finance or delivery systems of the LTSS population.

G. State Behavioral Health Administration & Finance System

G.1. Department Of Behavioral Health: Organization Chart



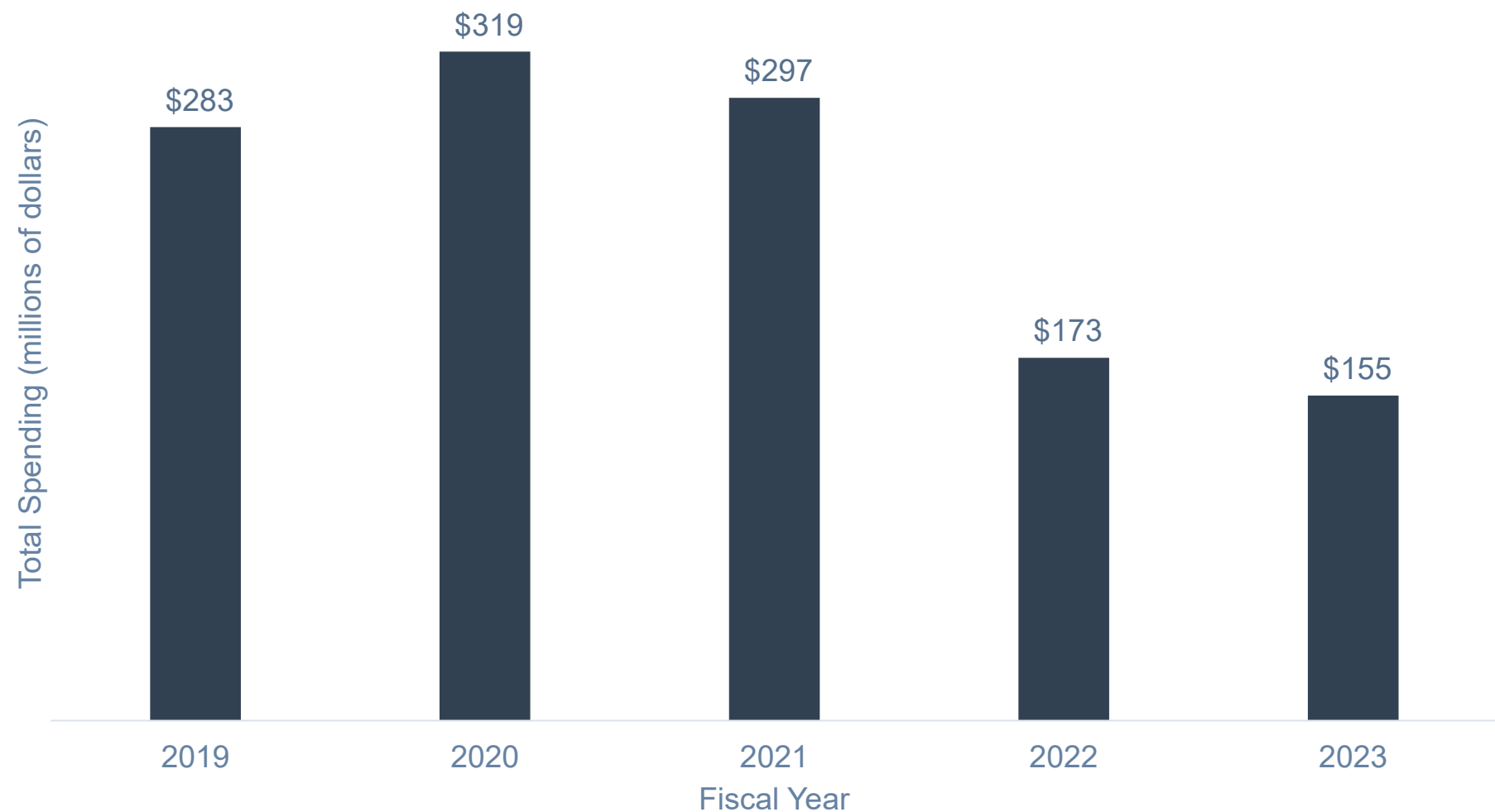
G.1. Department Of Behavioral Health: Key Leadership

Name	Position	Department	Email
Barbara J. Bazron, Ph.D.	Director	Department of Behavioral Health	barbara.bazron@dc.gov
Michael Neff	Chief Operating Officer	DBH	michael.neff@dc.gov
Atiya Jackson	Deputy Director, Accountability	DBH	atiya.jackson@dc.gov
Richard Bebout	Chief of Crisis Services	DBH	richard.bebout@dc.gov
Nancy Black	Interim Chief Clinical Officer	DBH	nancy.black@dc.gov.
Mark J. Chastang	Chief Executive Officer	DBH, St. Elizabeths Hospital	mark.chastang@dc.gov

G.2. Department Of Behavioral Health: Spending

Budget Item	SFY 2023 Approved Budget	Percent Of Budget
St. Elizabeths Hospital	\$104,313,000	67%
Agency management	\$27,315,000	18%
Clinical Services division	\$14,126,000	9%
Behavioral Health Authority	\$6,382,000	4%
Financial operations	\$2,478,000	2%
Budget Total: \$154,614,000		

G.2. Department Of Behavioral Health: Spending Over Time



*FY 2017-2021 actual spending, FY 2022-23 proposed spending.

G.3. State Psychiatric Institutions

State Psychiatric Institutions					
Institution	Location	Beds	May 2023 Average Monthly Admissions	May 2023 Average Monthly Discharges	May 2023 Average Daily Census
St. Elizabeths Hospital	Washington	292	29	26	221

G.4. Behavioral Health Safety-Net Delivery System

- The District of Columbia Department of Behavioral Health (DBH) provides funding for safety-net mental health and addiction treatment services.
- Services are delivered through a network of local provider organizations and financed through a combination of federal, local, and private funds.
- To access mental health treatment services, individuals may directly contact any provider organization certified by DBH.
- Individuals access addiction treatment services through intake centers designated by DBH.

G.4. Physical Health Safety-Net Delivery System: The Alliance

- Known as the “Alliance,” the D.C. Health Care Alliance Program provides limited health benefits via managed care organizations to uninsured residents who are over 21 years old with an income up to 200% FPL, have minimal assets, and who are not eligible for Medicaid or Medicare.
 - Alliance enrollment as of May 2022 was 24,318 individuals.
- The program is funded entirely through the District’s annual operating budget and falls under the purview of the Department of Health Care Finance. The Alliance contracts with the same four health plans as the Medicaid program:
 - MedStar Family Choice DC
 - AmeriHealth Caritas District of Columbia
 - CareFirst Community Health Plan of DC
 - Health Services for Children with Special Needs
- The program provides a limited set of benefits, and does not include services such as behavioral health services, long-term care, vision, etc.
- Alliance beneficiaries do not pay premiums or copayments.

H. Appendices

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	3.6% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2019, August). Results from the 2018 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 16, 2019 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf
Medicaid	35.9% of adults ages 18 to 64, not dually eligible for Medicare, who qualify for Medicaid based on a disability	Medicaid and CHIP Payment and Access Commission. (2012, March). Report to Congress on Medicaid and Chip. Retrieved December 12, 2017 from https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_and_Persons_with_Disabilities.pdf
	8.1% of persons in the Medicaid expansion population	Substance Abuse and Mental Health Services Administration. (2019, August). Results from the 2018 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 16, 2019 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2019). Medicare-Medicaid Coordination Office Report to Congress. Retrieved February 25, 2020 from https://www.cms.gov/files/document/mmco-report-congress.pdf

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved December 12, 2017 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved February 26, 2020 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	8.3% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2019, November 4). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved February 26, 2020 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2019, August). Results from the 2018 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 16, 2019 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(1) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2022, the FPL is \$13,590 for an individual and \$27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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