



District Of Columbia Health & Human Services System Market Profile: 2024



Health & Human Services System Market Profile Overview

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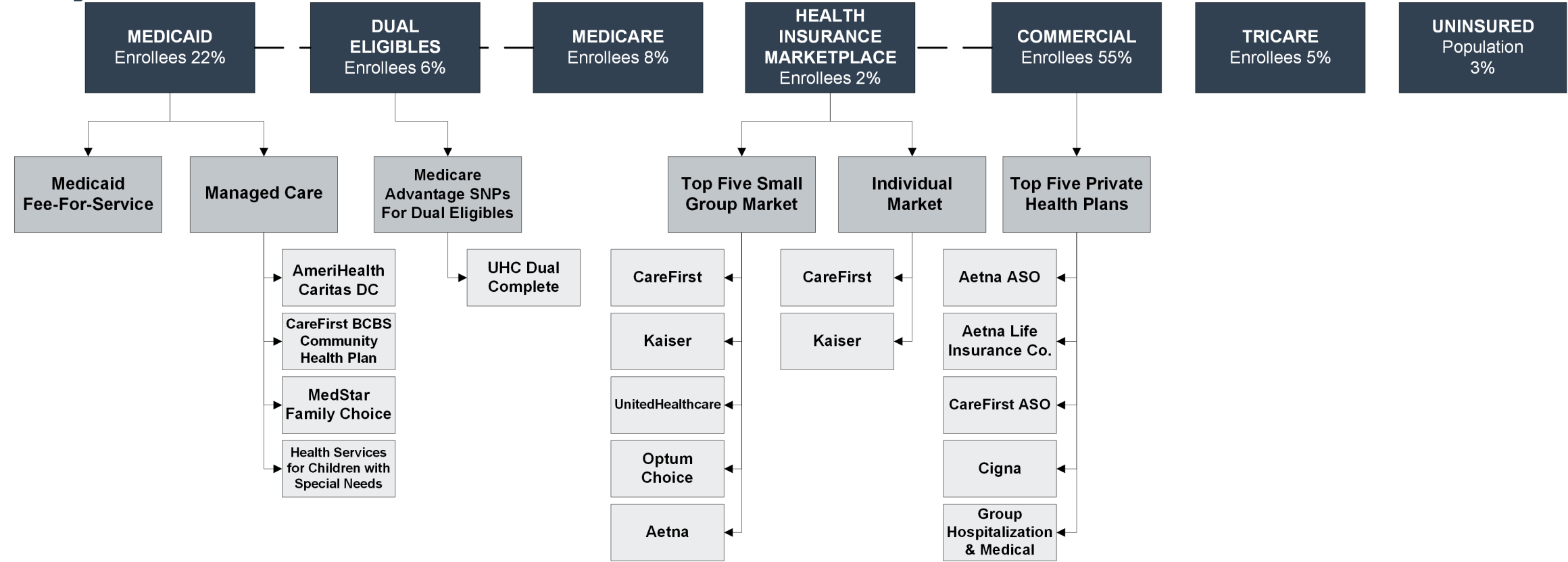
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A. Executive Summary

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

Total District Of Columbia Population- 671,803

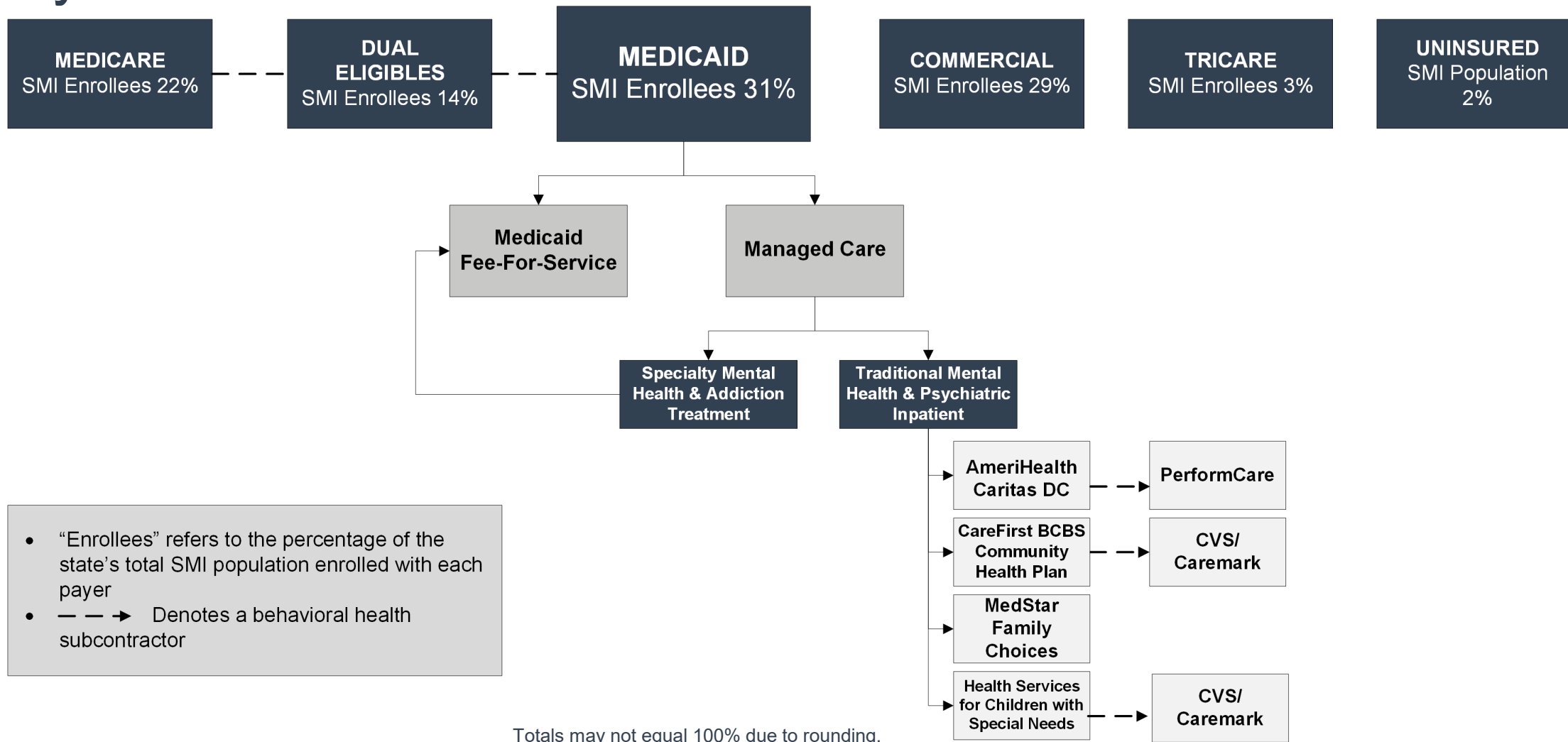
Estimated Serious Mental Illness (SMI) Population- 53,744



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

Totals may not equal 100% due to rounding.

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	✓	D.C. currently has two planning and development grants for CCBHCs.

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 federal poverty level (FPL).
- For all others, the District of Columbia Department of Health provides funding for safety-net physical health services.

Mental Health Services

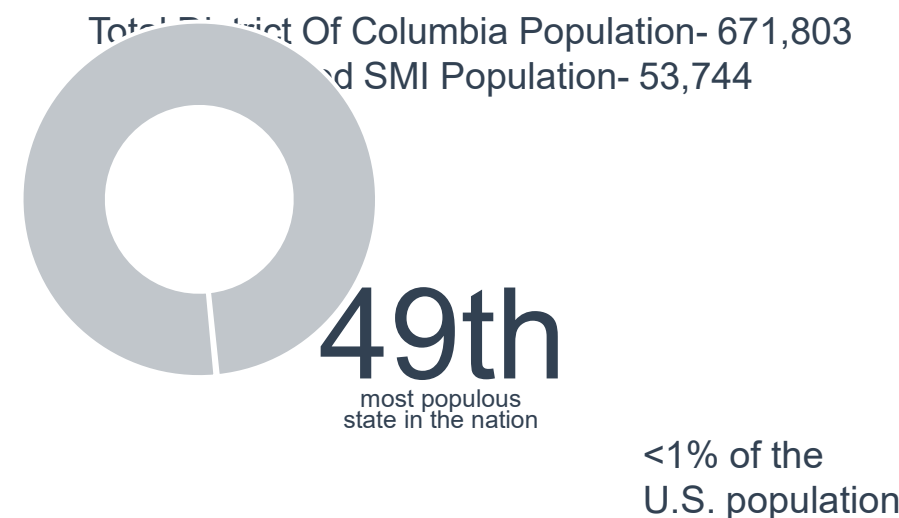
- The Department of Behavioral Health is responsible for mental health safety-net services for the uninsured population.

Addiction Treatment Services

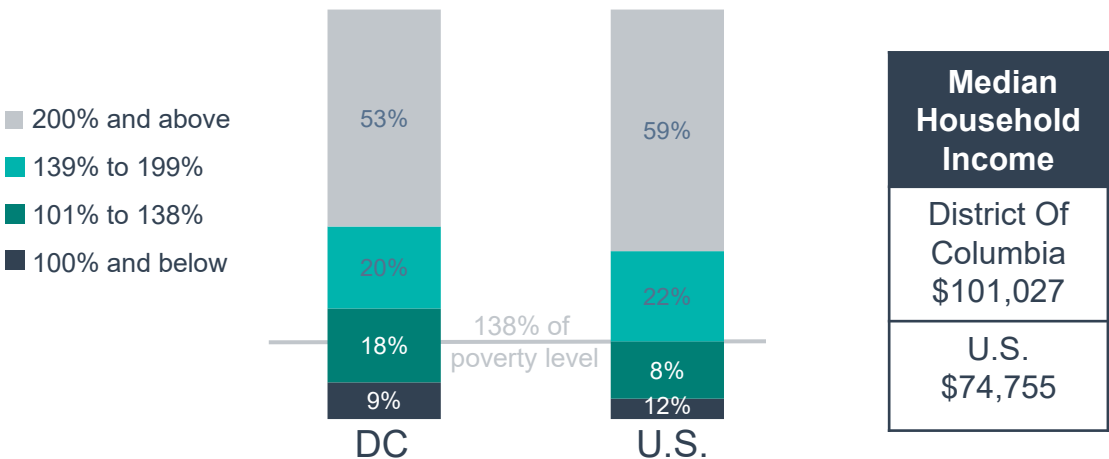
- The Department of Behavioral Health is responsible for addiction treatment safety-net services for the uninsured population.

B. District Of Columbia Health Financing System Overview

B.1. Population Demographics



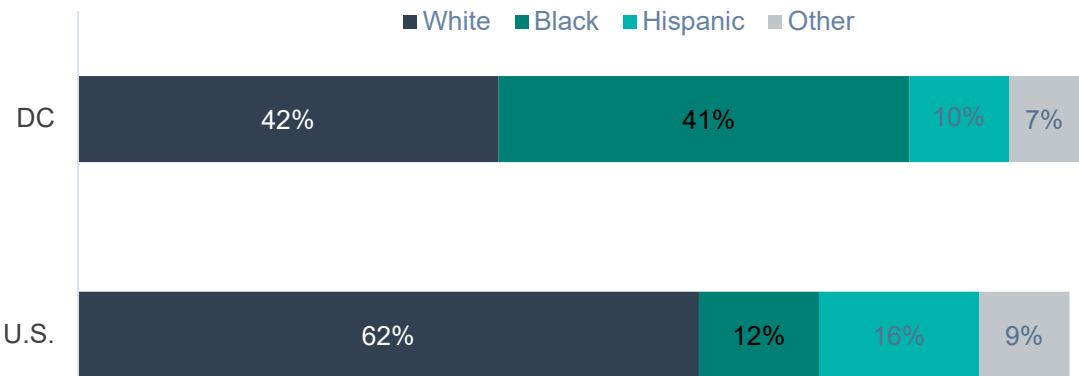
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



District Of Columbia & U.S. Racial Composition

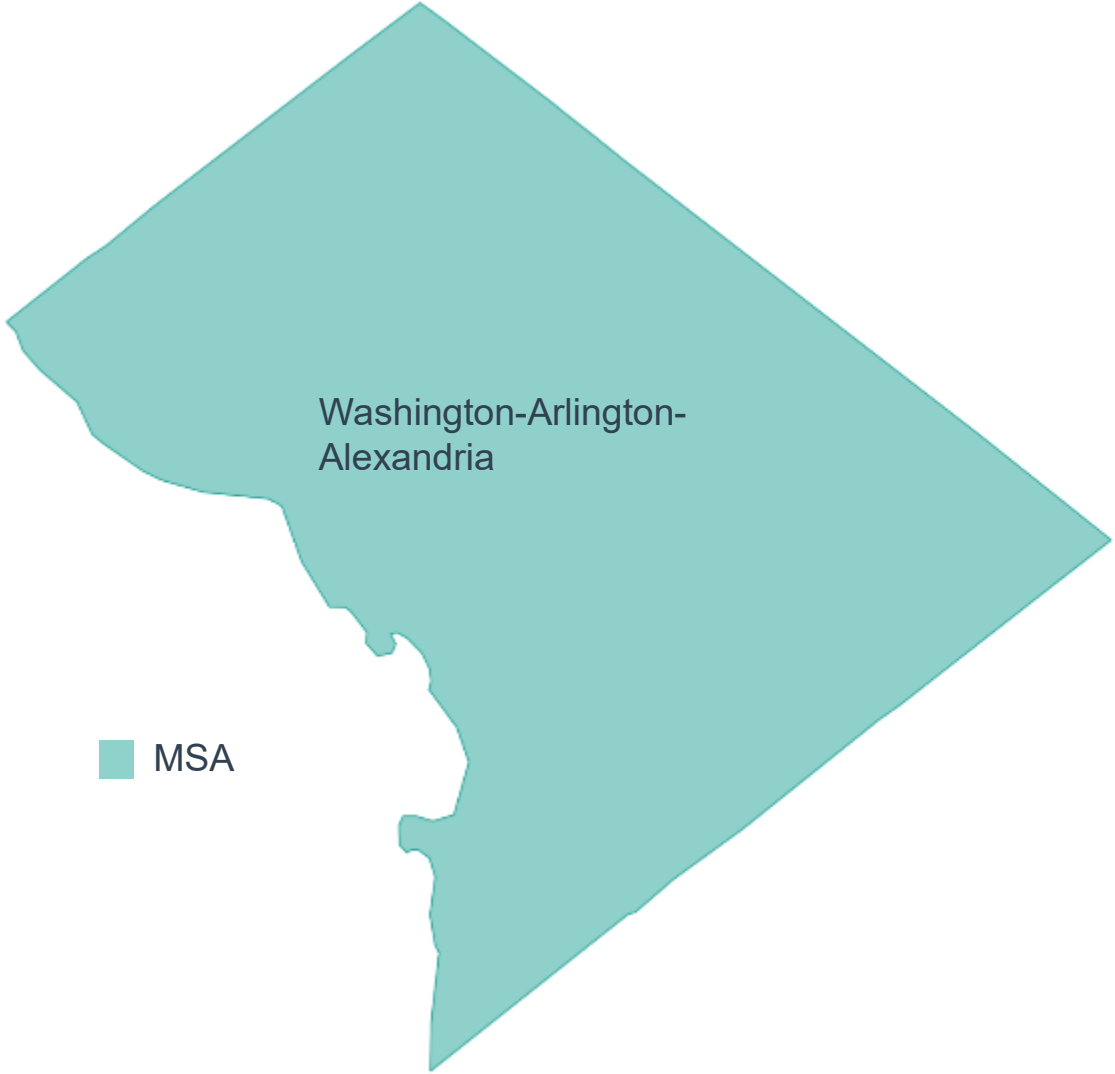


Totals may not equal 100% due to rounding.

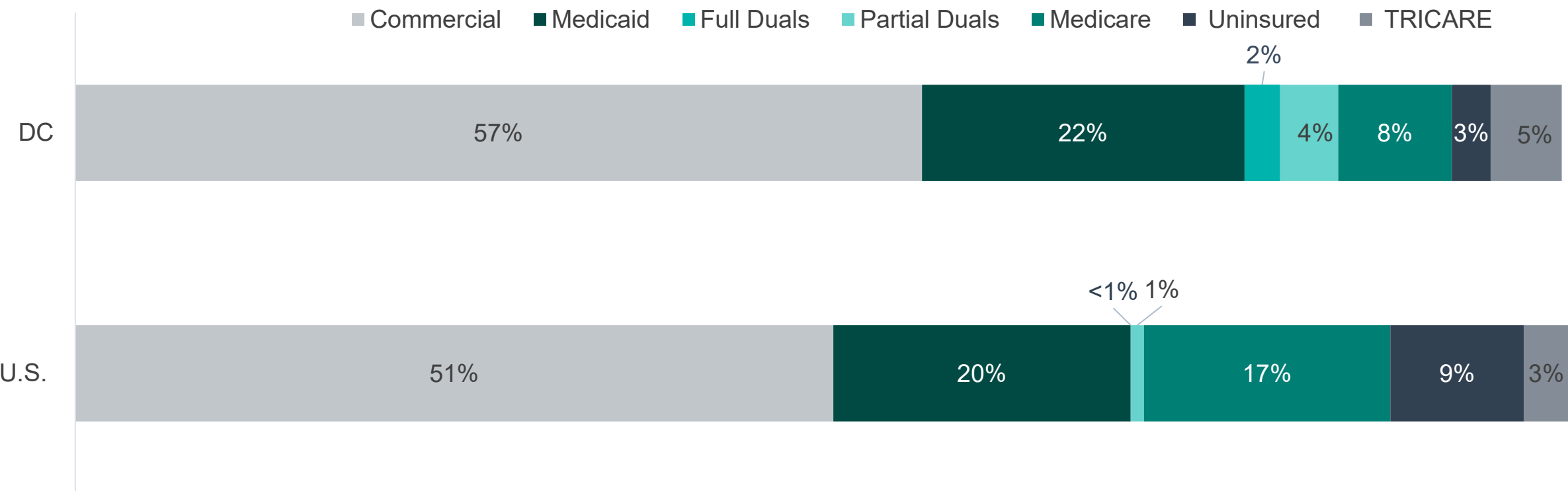
B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	MSA Residents	Percent of Population
Total MSA Population	6,304,975	N/A*
Washington-Arlington-Alexandria, DC-VA-MD-WV	6,304,975	N/A

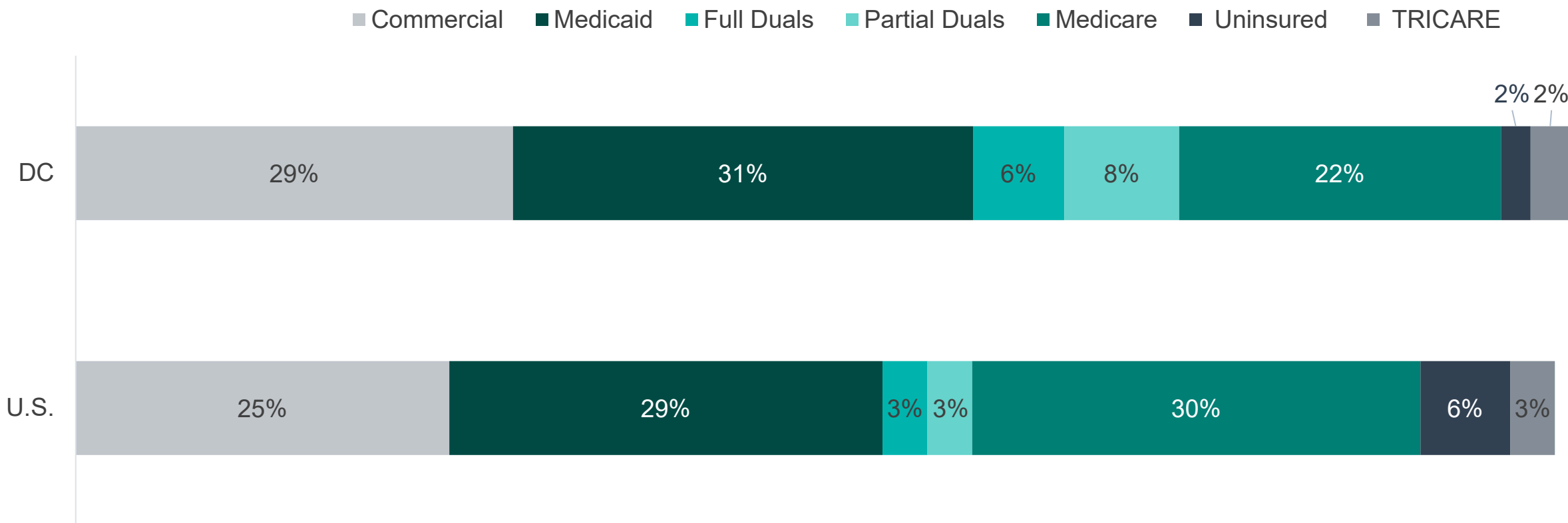
*MSA total is more than the D.C. population total.



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



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



Totals may not equal 100% due to rounding.

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

Plan Name	Plan Type	Enrollment*
Aetna ASO	Commercial administrative services organization (ASO)	379,801
CareFirst ASO	Commercial ASO	225,088
Group Hospitalization and Medical Services	Commercial	167,660
Cigna ASO	Commercial ASO	138,067
Aetna Life Insurance Company	Commercial	128,990
AmeriHealth Caritas District of Columbia	Medicaid managed care	119,924
UnitedHealthcare Insurance Company	Commercial	116,099
UnitedHealthcare ASO	Commercial ASO	111,570
CareFirst BlueChoice	Commercial	104,306
Aetna Health	Commercial	100,650

*Medicaid enrollment as of March 2023; TRICARE as of December 2023; Commercial as of August 2024; Medicare enrollment as of June 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 ASO	Commercial ASO	379,801	15,952
Medicare Fee-for-service (FFS)	Medicare	64,807	14,711
AmeriHealth Caritas District of Columbia	Medicaid managed care	119,924	13,911
CareFirst ASO	Commercial ASO	225,088	9,454
CareFirst BlueCross BlueShield Community Health Plans	Medicaid managed care	65,167	7,559
MedStar Family Choice	Medicaid managed care	64,707	7,506
Group Hospitalization and Medical Services	Commercial	167,660	7,042
Cigna ASO	Commercial ASO	138,067	5,799
Aetna Life Insurance Company	Commercial	128,990	5,418
UnitedHealthcare Insurance Company	Commercial	116,099	4,876

*Medicaid enrollment as of March 2023; TRICARE as of December 2023; Commercial as of August 2024; Medicare enrollment as of June 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

2024 Individual Market Health Plans
- CareFirst HMO - Kaiser of the Mid-Atlantic States

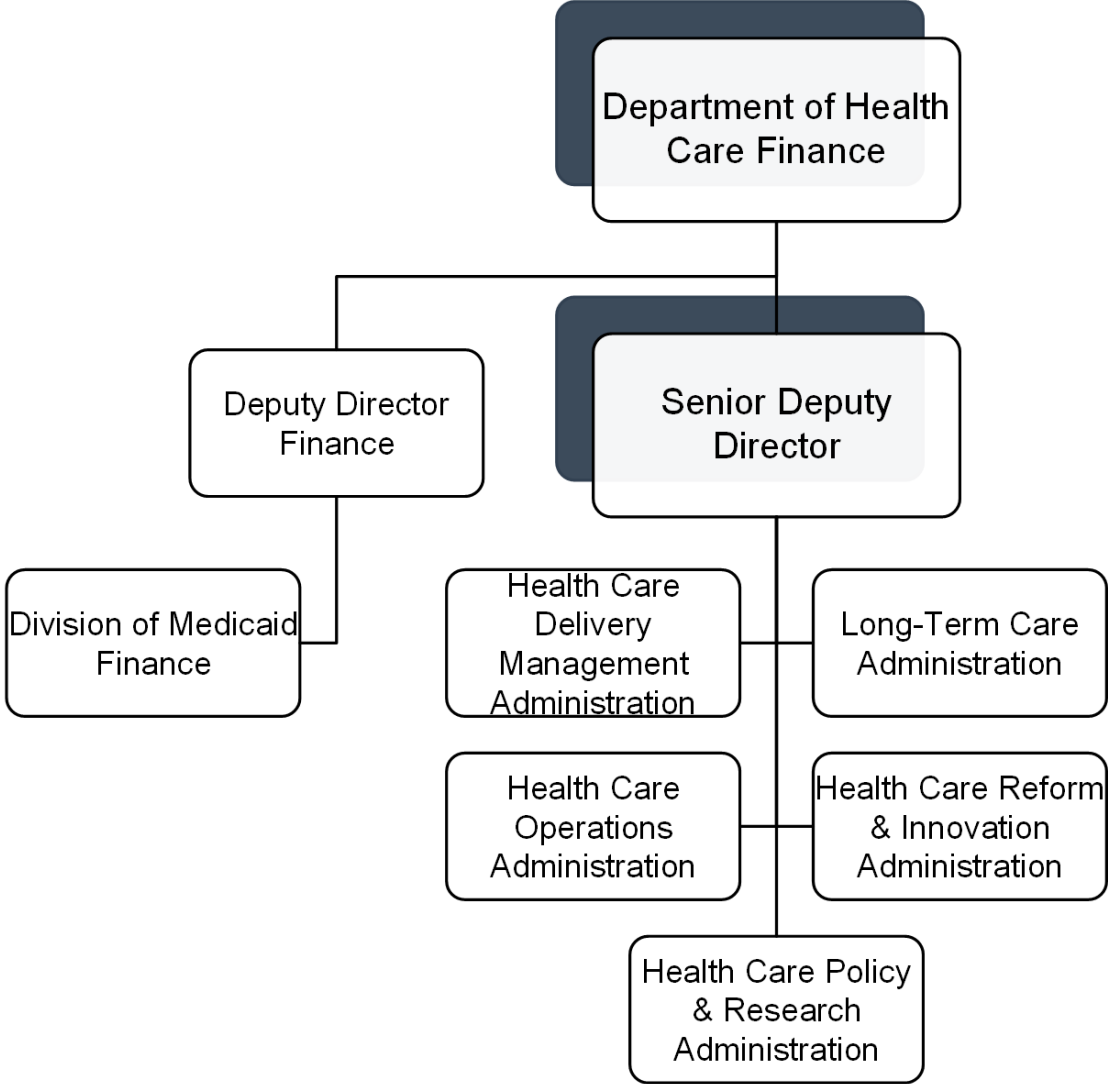
2024 Small Group Market Health Plans
- Care First HMO - GHMSI/CareFirst PPO - Kaiser - Aetna HMO - Aetna PPO - Optimum Choice (a UnitedHealthcare HMO) - UnitedHealthcare of the Mid-Atlantic (HMO) - UnitedHealthcare Insurance Company (PPO)

B.6. Accountable Care Organizations (ACOs)

Medicare Shared Saving Model	
1.	Aledade Chesapeake
2.	Vytalize Health Enhanced ACO
3.	C3 MSSP LLC
4.	Adventist HealthCare ACO, LLC
5.	Privia Quality Network Maryland
6.	Accountable Care Coalition of Northeast Partners, LLC
7.	GW Health Network
8.	Mid-Atlantic Collaborative Care, LLC
9.	Netrin PrimaryCare ACO, LLC
10.	Privia Quality Network, LLC
11.	MD MSSP Enhanced
12.	National MSSP

C. Medicaid Administration, Governance & Operations

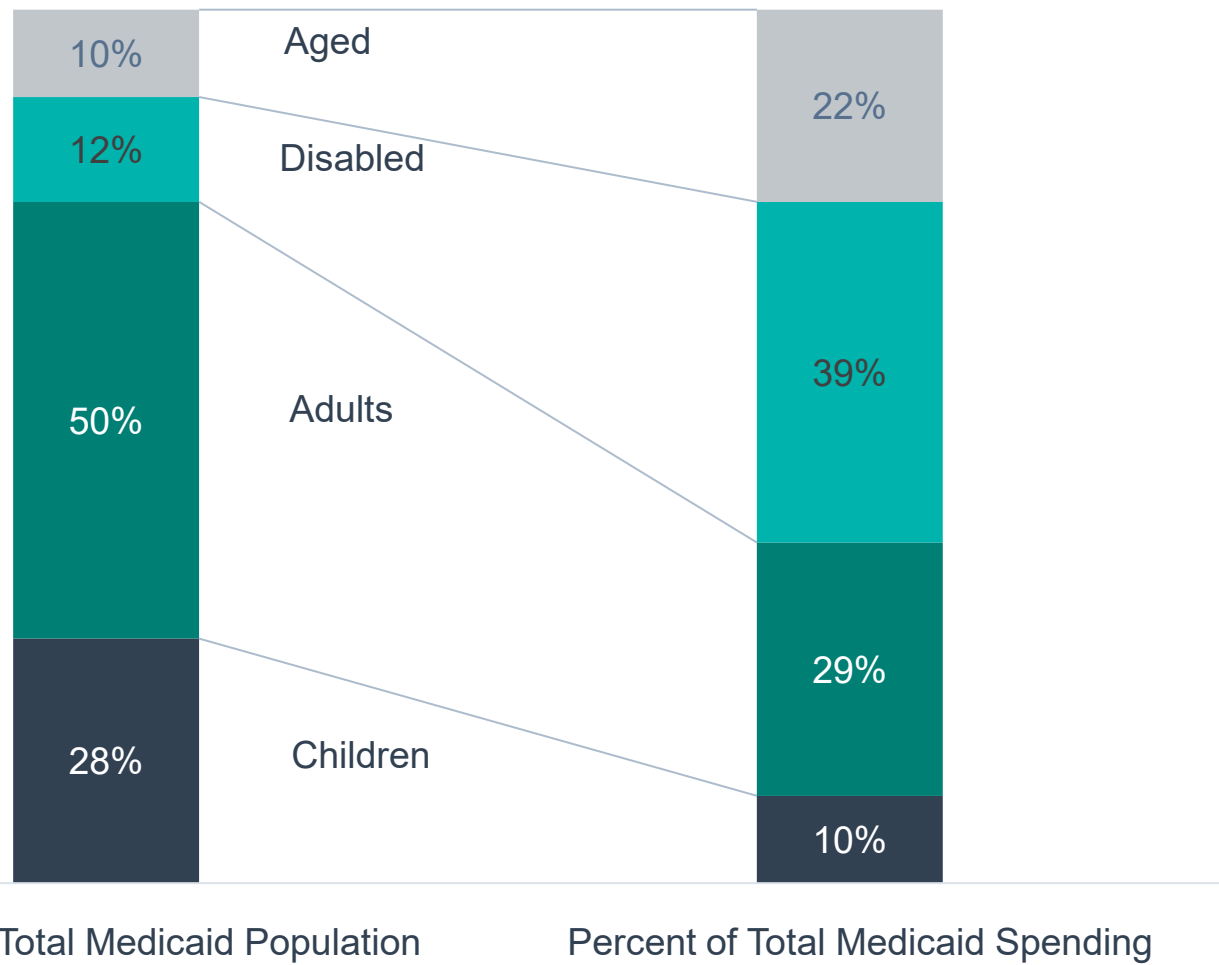
C.1. Medicaid Governance: Organization Chart



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
Vacant	Chief of Staff	DHCF	N/A
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
Eugene Simms	Director	DHCF, Health Care Policy and Research Administration	eugene.simms@dc.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2021		
	U.S.	DC
All populations	\$8,651	\$12,434
Children	\$3,584	\$4,698
Adults	\$5,462	\$7,070
Expansion adults	\$7,486	\$7,205
Blind and disabled	\$23,935	\$39,815
Aged	\$18,514	\$26,788

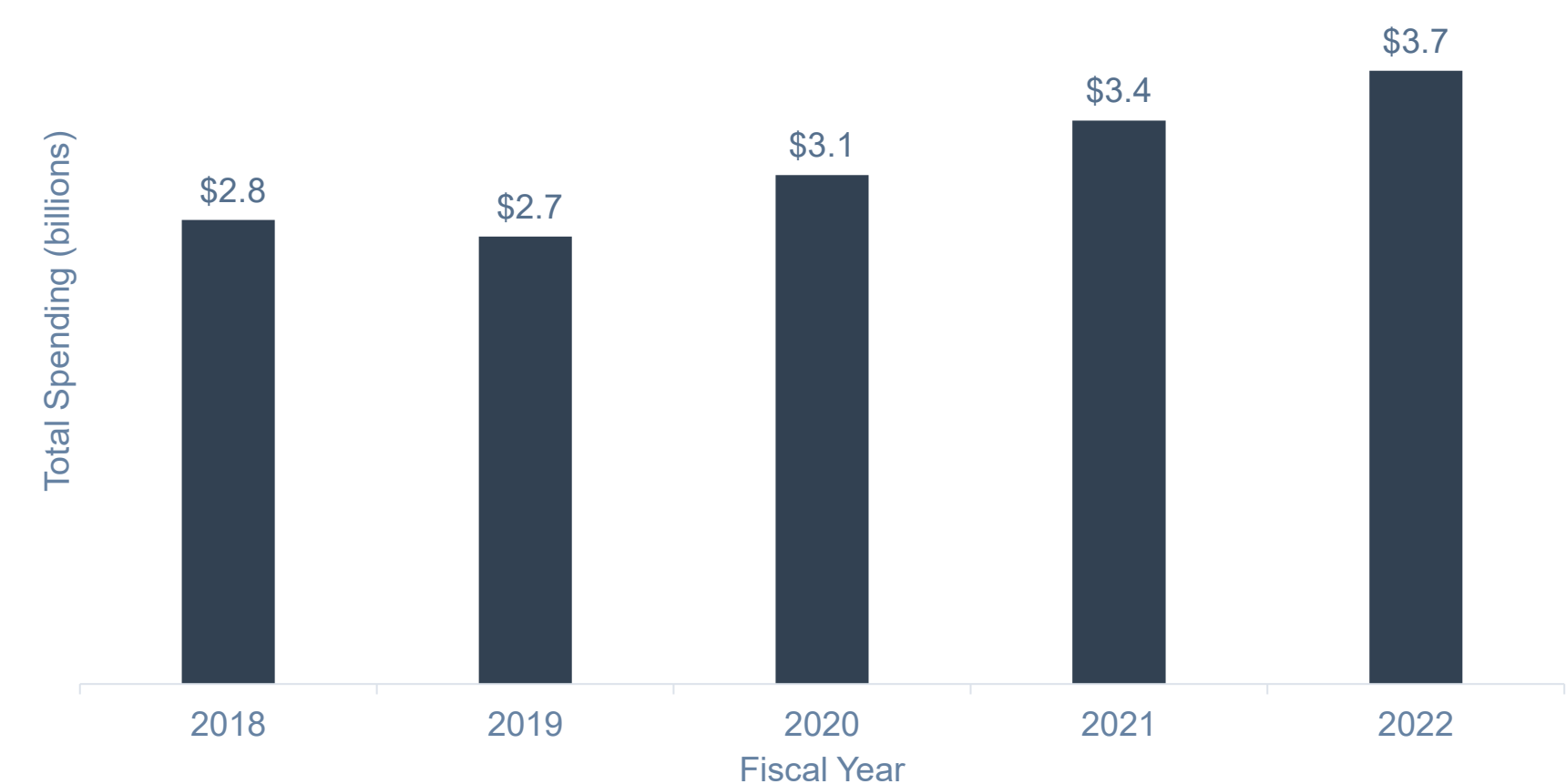
Based on FY 2021 data

C.2. Medicaid Program Spending: Budget

Budget Item	SFY 22 Spending	Percent Of Budget
Managed care and premium assistance	\$1,575,000,000	43%
Home- and community-based LTSS	\$646,000,000	18%
Institutional LTSS	\$442,000,000	12%
Other acute	\$328,000,000	9%
Hospital	\$287,000,000	8%
Clinic and health center	\$164,000,000	4%
Drugs	\$96,000,000	3%
Medicare premiums and coinsurance	\$81,000,000	2%
Physician	\$23,000,000	1%
Dental	\$5,000,000	<1%
Other practitioner	\$5,000,000	<1%
Budget Total: \$3,652,000,000		

Federal & County Financial Participation	
FY 2024 Federal Medical Assistance Percentage (FMAP)	70.0%
CY 2024 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 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 (September 2023)	131,354
Number Of Enrollees Newly Eligible Due To Expansion	87,379
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 (April 2023)	39,301	254,853
SMI Enrollment	• OPEN MINDS estimates 13% of the SMI population in FFS, 87% in managed care	
Management	Department of Health Care Finance	Three health plans
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	Statewide

Total Medicaid: 294,154 | Total Medicaid With SMI: 34,122

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of April 2023: 13% in fee-for-service (FFS), 87% in managed care
SMI population inclusion in managed care	Estimated 13% of population in FFS, 87% 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 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			✓
Children			✓
Blind and disabled individuals	✓		
Aged individuals	✓		
Dual eligibles	✓		
Medicaid expansion			✓
Individuals residing in nursing homes	✓		
Individuals residing in ICF/IDD	✓		
Individuals in foster care		✓	
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.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	✓	D.C. currently has two planning and development grants for CCBHCs.

D.2. Medicaid FFS Program: Overview

- As of April 2023, FFS enrollment was 39,301.

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 April 2023, *OPEN MINDS* estimates that 13% 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. • 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 April 2023, managed care enrollment was 254,853.
- 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 April 2024, enrollment in this plan was 5,055.

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 MHRS, and all addiction disorder treatment services, called 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: 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/ Caremark
- 5. Enrollment share: 2%

Amerigroup

- 1. Profit status: For-profit
- 2. Parent company: CareFirst Blue Cross Blue Shield
- 3. Behavioral health subcontractor: Beacon Health Options
- 4. Pharmacy benefits manager: CVS/ Caremark
- 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 Benefits

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

Addiction Treatment Benefits Provided By 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 April 2023, *OPEN MINDS* estimates that 87% 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 None	Affordable Care Act Health Home The District has two health home programs — one for individuals with SMI and one for individuals with chronic conditions.	Patient-Centered Medical Home (PCMH) None	Other Care Coordination Initiatives 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 • 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 • 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*

*There is a pending extension request in with CMS.

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

Waiver Title	Target Population	2024 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.	6,260	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.	1,983	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.	120	Department of Disability Services, Developmental Disabilities Administration	No

D.6. Medicaid Program: New Initiatives

- There are no new or pending initiatives currently.

E. Medicare Financing & Service Delivery System

E.1. Medicare Financing & Service Delivery System

Medicare System Characteristics		
Characteristics	Traditional Medicare (FFS)	Medicare Advantage
Enrollment (August 2024)	64,807	30,110
SMI Enrollment	<i>OPEN MINDS</i> estimates 32% of the population in Medicare Advantage, 68% in Traditional Medicare.	
Management	- Part A: Inpatient hospital, skilled nursing facility care, nursing home care, hospice and home health care - Part B: Clinical research, ambulance services, durable medical equipment, mental health and limited outpatient prescription drugs	Medicare Advantage Plans provide Part A and Part B benefits, plus additional benefits based on plan chosen
Payment Model	Part A & B cover up to 80%, remaining costs can be paid out of pocket	Fixed amounts paid based on health plan chosen
Geographic Service Area	Statewide	Statewide

Total Medicare: 94,917 | Total Medicare With SMI: 21,546

E.1. Medicare Financing & Service Delivery System

Medicare Financial Delivery System Enrollment	
Total Medicare population distribution	As of August 2024: 32% Medicare Advantage, 68% in traditional Medicare.
SMI population inclusion in managed care	Estimated 32% of population in Medicare Advantage, 68% in traditional Medicare.
Medicare population inclusion in Chronic special needs plan or (C-SNP).	Estimated less than 1% of population enrolled in a C-SNP plan.
Medicare population inclusion in Institutional Special Needs Plan (I-SNP).	There are no I-SNP plans in the District of Columbia.

E.2. Medicare System: Overview

- Medicare enrollment as of August 2024 was 94,917.
- It is estimated around 8% of the state's total population is enrolled in Medicare, compared with about 19.5% of the U.S. population enrolled in Medicare.
 - *OPEN MINDS* estimates approximately 22% of the state's Medicare population has an SMI.
- Nationwide, nearly 49% of Medicare beneficiaries have Medicare Advantage plans. D.C. has 32% of the Medicare population with a Medicare Advantage plan.
 - In 2023, there were seventeen MS plans offering service in the D.C. area.
- There are currently 16 insurers that offer Medigap plans in D.C.
- There are around 60,000 Medicare beneficiaries in D.C. with Part D prescription coverage. The majority had stand-alone Medicare Part D plans, while the rest have Medicare Advantage plans with built-in Part D coverage.
 - Insurers in the District of Columbia are offering 22 stand-alone Medicare Part D plans, with premiums that range from about \$8 to \$112/month.
- Many Medicare beneficiaries receive financial assistance through Medicaid with the cost of Medicare premiums, prescription drug expenses, and services not covered by Medicare – such as long-term care.

E.3. Medicare ACOs

Medicare Shared Saving Model

1. Aledade Chesapeake
2. Vytalize Health Enhanced ACO
3. C3 MSSP LLC
4. Adventist HealthCare ACO, LLC
5. Privia Quality Network Maryland
6. Accountable Care Coalition of Northeast Partners, LLC
7. GW Health Network
8. Mid-Atlantic Collaborative Care, LLC
9. Netrin PrimaryCare ACO, LLC
10. Privia Quality Network, LLC
11. MD MSSP Enhanced
12. National MSSP

E.4. Medicare System: New Initiatives

- There are no new or pending initiatives currently.

F. Dual Eligible Financing & Service Delivery System

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

Dual Eligible* Medicaid System Characteristics	
Characteristics	Medicaid Fee-For-Service (FFS)
Enrollment (June 2023)	16,180
Estimated SMI Enrollment	3,398
Management	Department of Health Care Finance
Payment Model	FFS
Geographic Service Area	Statewide

Total Dual Eligible Enrollment: 16,180 | Total Dual Eligible Enrollment With SMI: 3,398

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

F.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	14,186	1,646

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

- As of June 2023, dual eligible enrollment was 16,180.
- 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 14,186, SMI enrollment for D-SNP was 1,646.
- D.C. began implementation of its PACE program in 2020. It is now available in three zip codes in Wards 7 and 8.

F.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives- PACE

- The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home.
- D.C. began implementation of its PACE program in 2020. It is now available in three zip codes in Wards 7 and 8.
- As of late 2023, there was one PACE program in D.C.: Edenbridge PACE at Skyland Town Center.

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

G.1. LTSS Financing & Service Delivery System

- D.C. does not operate a MLTSS program

LTSS Medicaid System Characteristics	
Characteristics	Medicaid Managed Care
Enrollment (December 2023)	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

G.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			

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

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

G.3. Medicaid LTSS Program: Health Benefits

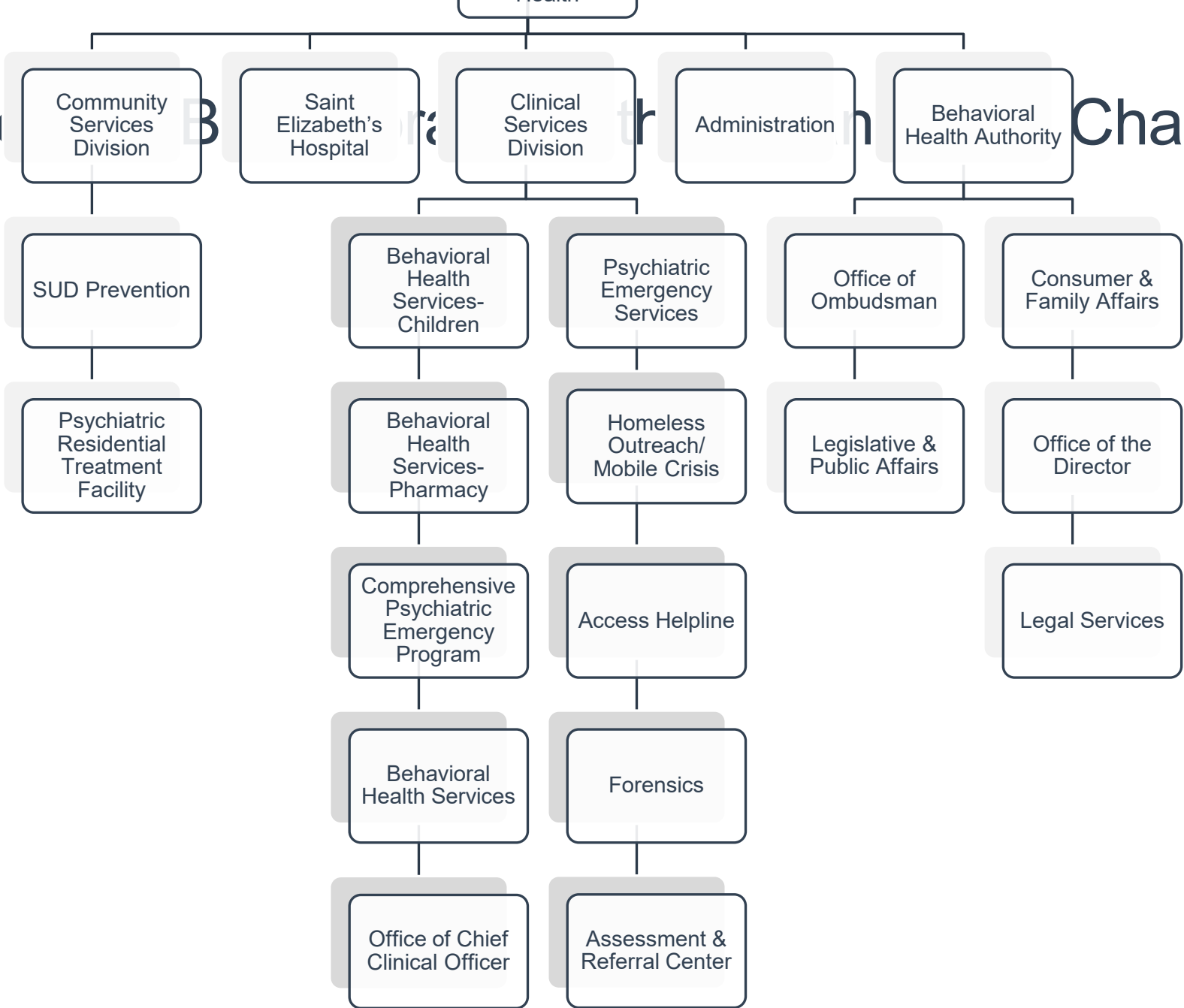
- D.C. does not offer MLTSS services and instead all services are the same as the FFS program.

G.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.

H. State Behavioral Health Administration & Finance System

H.1. Department



H.1. Department Of Behavioral Health: Key Leadership

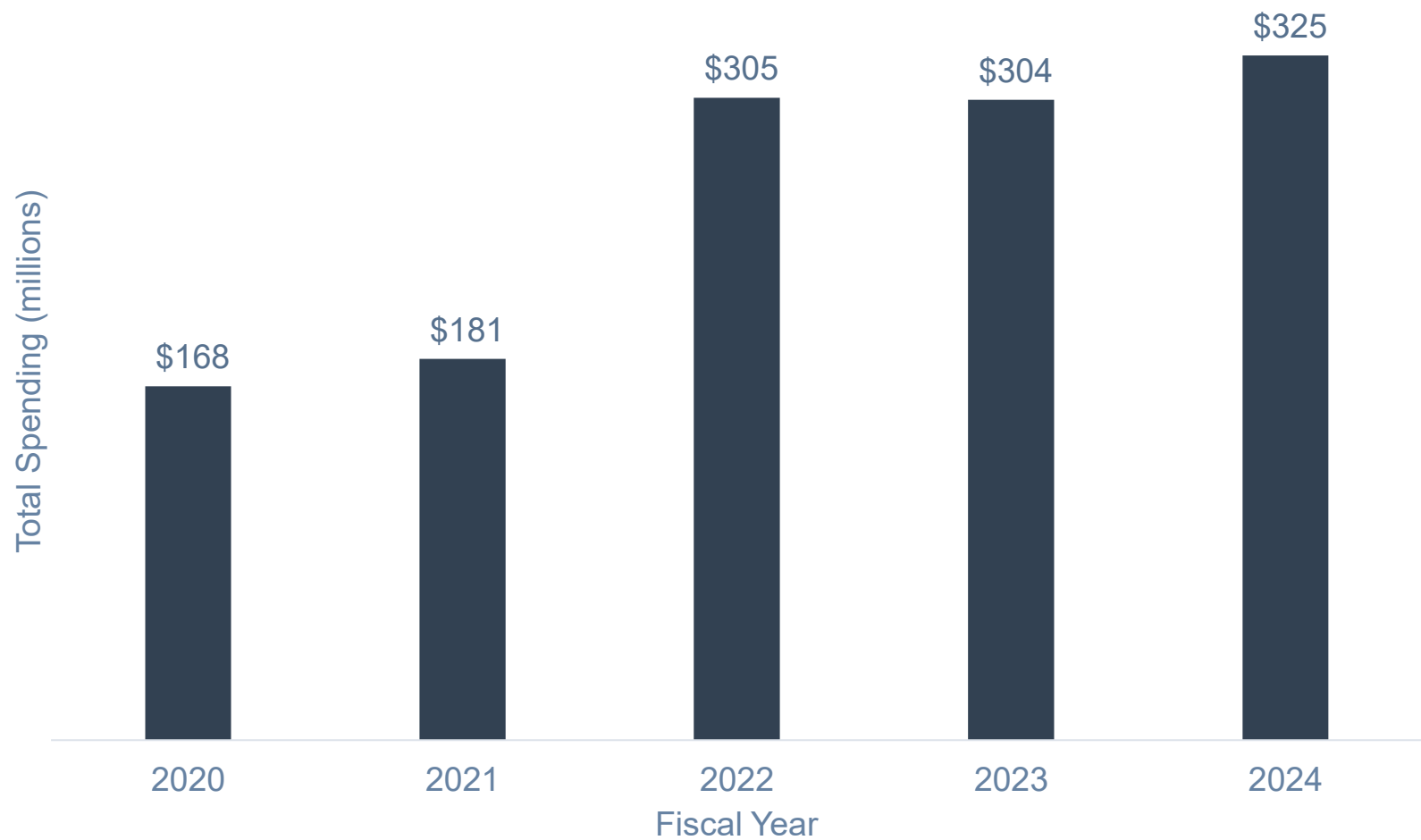
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Michael Neff	Chief Operating Officer	DBH	michael.neff@dc.gov
Atiya Jackson	Deputy Director Data, Quality, & Compliance	DBH	atiya.jackson@dc.gov
Richard Bebout	Chief of Crisis Services	DBH	richard.bebout@dc.gov
Jonathan Shepherd, MD	Chief Clinical Officer	DBH	jonathan.shepherd@dc.gov
Mark J. Chastang	Chief Executive Officer	DBH, St. Elizabeths Hospital	mark.chastang@dc.gov

H.2. Department Of Behavioral Health: Spending

Budget Item	SFY 2024 Budget Request	Percent Of Budget
Adult/ transitional youth services	\$170,877,000	53%
St. Elizabeths Hospital	\$102,966,000	32%
Agency management	\$29,442,000	9%
Clinical Services Division	\$13,114,000	4%
Behavioral Health Authority	\$6,041,000	2%
Financial operations	\$2,495,000	1%
Budget Total: \$324,965,000		

Totals may not equal 100% due to rounding.

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



H.3. District Psychiatric Institutions

Psychiatric Institutions					
Institution	Location	Beds	June 2024 Average Monthly Admissions	June 2024 Average Monthly Discharges	June 2024 Average Daily Census
St. Elizabeths Hospital	Washington	292	29	34	274

H.4. Behavioral Health Safety-Net Delivery System

- The District of Columbia 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.

H.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 March 2023 was 14,429 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.5. Behavioral Health System: New Initiatives

- There are no new or pending initiatives currently.

I. Appendices

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

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.2% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	11.6% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	22.7% of persons in the Medicare population, not dually eligible for Medicaid	Figueroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2024 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

I.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	21% of persons in the Medicare population dually eligible for partial Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
	16% of persons in the Medicare population dually eligible for full Medicaid benefits	
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2022). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2021. Retrieved March 2023 from https://www2.census.gov/programssurveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabSect6pe2021.htm#tab6.8a

I.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.

I.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 2024, the FPL is \$14,580 for an individual and \$30, 000 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.

I.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.

I.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.

I.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.

I.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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