GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

June 3, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: District of Columbia Proposed Section 1115 Behavioral Health Transformation Demonstration

Dear Administrator Verma:

On behalf of the residents of the District of Columbia, I am pleased to submit to the U.S. Department of Health and Human Services the enclosed Section 1115 Medicaid demonstration application for approval.

The District, like many other states in the nation, has experienced an alarming increase in the number of opioid-related overdose deaths among residents over the past five years. Though the District has undertaken numerous efforts to halt overdose deaths and provide residents with meaningful access to behavioral health services, the District can add significant/substantial value to this approach by addressing gaps in Medicaid's coverage of essential behavioral health services.

The proposed demonstration will allow the District to use Medicaid funding to reimburse institutions for mental diseases (IMDs) for inpatient, residential, and other treatment provided to Medicaid-eligible adults with substance use disorders and serious mental illness. Additionally, the proposed demonstration will promote improved access to a broader range of community-based behavioral health services, help the District fight the epidemic of deaths associated with opioid use disorder, and aid the District's efforts to transform Medicaid's behavioral health service delivery system.

In submitting this demonstration application, the District aims to follow CMS guidance to enable states to better serve individuals with serious mental illness, serious emotional disturbance, and substance use disorder through a waiver of Medicaid's historic prohibition of coverage for IMD services. The District is appreciative of your leadership to support states in testing the viability of this service delivery model as part of a continuum of care to improve the lives of residents with serious behavioral health needs. This waiver is an important first step in supporting District residents on their path to recovery and better health outcomes.

My team benefitted greatly from the timely assistance and expertise that CMS provided to help expedite the proposed demonstration development and submission. With the support of our federal partners at the Centers for Medicare and Medicaid Services (CMS), we look forward to working together to implement meaningful behavioral health reforms for the District.

If you have any questions regarding the demonstration, please contact either Melisa Byrd, State Medicaid Director and Senior Deputy Director, Department of Health Care Finance at (202) 442-9075 or melisa.byrd@dc.gov or Alice Weiss, Director, Health Care Policy and Research Administration, Department of Health Care Finance at (202) 442-9107 or alice.weiss@dc.gov.

Sincerely,

[redacted]

Wayne Turnage
Deputy Mayor, Health and Human Services, District of Columbia
Director, District of Columbia Department of Health Care Finance

Cc: Sabrina Tillman-Boyd
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District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program

[June 3, 2019]

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Section I – Summary

The District's current behavioral health system is complex, involving multiple payers, District agencies, and service delivery touchpoints. Although Medicaid funds much of these services, coverage gaps can lead to missed opportunities for treatment and result in an experience of care that is often fragmented, leading to sub-optimal levels of treatment for individuals with serious mental illness (SMI)/serious emotional disturbance (SED) or substance use disorder (SUD).

Through this demonstration, the District is seeking to address ongoing structural challenges and gaps to provide a more seamless experience of care, improve treatment rates and outcomes, and promote healthier lives for District residents.

The District of Columbia Department of Health Care Finance (DHCF) is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration that will combine under a single demonstration authority the ability to reimburse institutions for mental diseases (IMDs) for inpatient, residential, and other services provided to Medicaid-eligible individuals with SMI, SED, or SUD as part of a continuum of care. The demonstration will also allow the District to promote improved access to community-based behavioral health services, provide important new resources to help the District fight the epidemic of deaths associated with opioid use disorder (OUD) and other SUDs, and aid the District's efforts to transform Medicaid's behavioral health service delivery system. The District is requesting that this demonstration be effective immediately upon approval.

Section II – Program Background, Description, Goals, and Objectives

A. Background

The District of Columbia offers a broad array of behavioral health services, ranging from diagnosis and counseling to more intensive interventions for individuals with SMI/SED or SUD. However, key gaps in the Medicaid service array and complex and overlapping oversight have made it harder for the District to manage behavioral health services in a holistic way that is integrated with other medical treatment.

Providers and services are overseen by the District's Department of Health Care Finance (DHCF), Medicaid managed care organizations (MCOs), and the District's Department of Behavioral Health (DBH), with some overlap in authority. In addition, other District agencies provide ancillary behavioral health services and touchpoints including through the school system, foster care and child protective services, and justice system, among others. This division of responsibility has sometimes resulted in service gaps, confusion about points of entry, and a disconnect between beneficiaries' physical and behavioral health care. In addition, the disparate access to Medicaid coverage of IMD services between managed care and fee-for-service (FFS) programs unfairly disadvantages FFS beneficiaries.

The dramatic increase in opioid-related fatalities in recent years has exacerbated and deepened these challenges and catalyzed the District's interest in seeking new authorities to ensure Medicaid can more effectively support residents' needs. This demonstration seeks to strengthen

the District's Medicaid behavioral health system through the addition of a broader array of services and providers designed to improve access to and transitions of care, including coverage for short-term residential and inpatient services provided by IMDs for individuals with SMI and SUD and complementary community-based services.

The Opioid Epidemic in the District

The District, like many other states in the nation, has experienced an unprecedented increase in the number of fatal opioid-related overdoses among residents over the past five years. From 2014 to 2017, the District's opioid-related fatal overdoses increased by 236 percent.[1] In 2017, the District's rate of age-adjusted opioid deaths per capita was the highest among all urban counties and fourth in the nation among all states.[2] While rising opioid-related deaths nationally have largely affected younger, white, non-Hispanic opioid-using adults whose SUD progressed from prescription opioids to heroin, the opioid epidemic in the District has primarily affected older, African-American males who are long-term users of heroin. Approximately 90 percent of opioid users in the District are over 40 years old and approximately 80 percent of all fatal opioid overdoses in the District have been among adults ages 40 to 69. Overall, 8 in 10 (81 percent) of all fatal opioid overdoses were among African-Americans and nearly three-quarters (74 percent) of all individuals with a fatal opioid overdose were men.

The primary opioid used in the District is heroin, and nearly 9 in 10 individuals who use heroin (88 percent) have been using for more than 10 years, while 2 in 10 (22 percent) have been using for over 40 years.[3] While individuals using heroin have represented the majority of those affected by the opioid crisis, the spike in overdose deaths has been attributed to the introduction of fentanyl or fentanyl analogs into the heroin supply. Among all Medicaid beneficiaries in 2017, nearly three percent (2.7 percent) had an opioid use disorder in 2017, representing over 5,600 individuals.

District agencies have taken a number of steps to address the opioid epidemic, including:

- **Opioid Task Force**: In 2017, the District formed a multi-agency Opioid Task Force jointly led by the Department of Behavioral Health and DC Health, to monitor and identify trends and opportunities for policy interventions to reduce the frequency and severity of opioid-related overdoses. The Task Force has met monthly to review public health data and identify cross-agency coordinated strategies to improve outcomes.
- **Opioid Strategic Plan**: In December of 2018, Mayor Bowser released *Live.Long.DC.*, a strategic plan to address the District's unique needs. The plan, which was the result of engagement by District agencies with hospitals, physicians, community-based treatment providers, individuals in recovery, and other stakeholders through an Opioid Workgroup, identified seven goals and related strategies to reduce opioid use, misuse, and related deaths through 2020.

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[1] *Live.Long.DC.: Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths*, Department of Behavioral Health, March 2019.

[2] U.S. Department of Health and Human Services, Centers for Disease Control, National Center for Health Statistics Data Brief #329, https://www.cdc.gov/nchs/data/databriefs/db329_tables-508.pdf#page=3

[3] *Live.Long.DC.: Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths*, Department of Behavioral Health, March 2019.

- **MME Limits**: In 2018, the District's Medicaid program imposed new limits on morphine milligram equivalents (MMEs) in Medicaid prescriptions, designed to reduce the availability and utilization of high MME prescriptions and thereby lessen the risk of substance use disorder and diversion among Medicaid beneficiaries.
- In March of 2019, the District's Medicaid program eliminated prior authorization requirements for buprenorphine and naltrexone for extended-release injectable suspension when used as part of medication-assisted treatment (MAT) goals outlined in the District's Opioid Strategic Plan.-assisted treatment (MAT)[4] goals outlined in the District's Opioid Strategic Plan.
- **Medicaid Opioid Data Dashboard:** In 2018, the District was selected by CMS for participation in the Medicaid Opioid Data Dashboard Innovation Acceleration Program (IAP). Through this program, the District's Medicaid agency has been creating and refining a data dashboard that will present annual metrics on OUD diagnoses, utilization of services, emergency room utilization, and MAT utilization that can be shared with other District agencies to improve and better target service delivery.
- **PDMP Participation Requirement:** In 2018, the District Council required all District providers who prescribe medication to participate in the Prescription Drug Monitoring Program (PDMP). Building on this requirement, the District Medicaid program in March of 2019 issued a policy requiring all prescribers of MAT-related buprenorphine or naltrexone for extended-release injectable suspension to check the DC PDMP and record findings in the patient's medical record to improve monitoring and deter misuse or diversion.[5]
- **Emergency Room MAT Induction Pilot:** Beginning in April 2019, the District implemented a hospital emergency room MAT induction pilot that will screen emergency room patients in four District hospitals for potential SUD risk using the screening, brief intervention, and referral to treatment (SBIRT) model and connect interested at-risk patients to a peer recovery coach to discuss recovery strategies and options, including initiating MAT. Those who are interested will initiate MAT treatment in the hospital, then be provided a warm handoff to community-based care within 48 hours with support from the peer recovery coaches. Individuals needing extra support may be referred to crisis beds, inpatient, or residential treatment.
- **Overdose Survivor's Outreach Program (OSOP):** In 2019, DBH plans to launch a program that targets non-fatal opioid overdose survivors that come into the emergency room and are discharged. Those patients will be identified through the SBIRT process under the MAT Induction Program noted above. Typically, an OSOP patient is someone who arrives by ambulance and is non-verbal or medically unstable and cannot be screened. Under the OSOP, peer coaches will educate the patient on harm reduction and the risk of overdose before they leave the ER. After release, an OSOP coach will follow up to engage the patient in the community. After the intervention, OSOP patients will be followed and tracked for ninety (90) days throughout D.C.

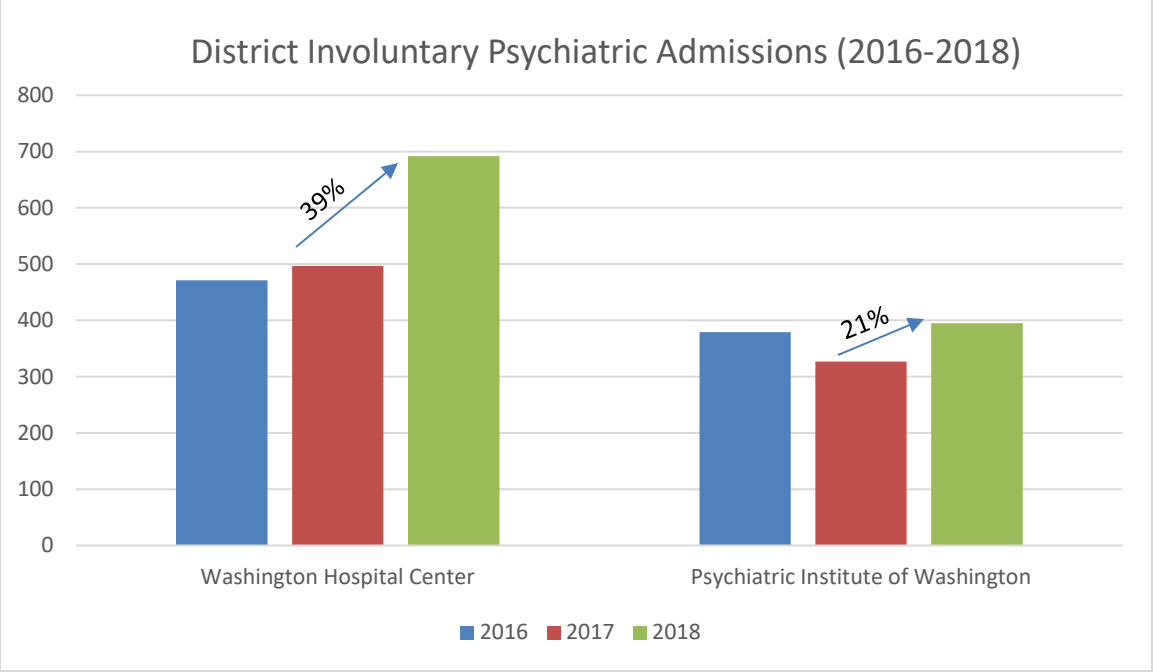
[4] Prior authorization for buprenorphine was eliminated for doses up to 24 mg. Naltrexone may also be provided without prior authorization under the policy for treatment of alcohol use disorder.
[5] https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DG852345_KT0000016252_1.pdf

Health System Challenges

The District has faced challenges in its efforts to combat the opioid epidemic. Among these are gaps in Medicaid's coverage for essential services, including the exclusion of all IMD residential and inpatient services for non-elderly adult fee-for-service beneficiaries and the exclusion of coverage for stays longer than fifteen (15) days for non-elderly adult MCO beneficiaries. Given that behavioral health needs are more prevalent among fee-for-service beneficiaries, this disparate coverage of IMD services creates critical challenges in ensuring Medicaid can provide coordinated behavioral health services for many beneficiaries who have the greatest need for recovery and treatment interventions.

The District's health care safety net has also been facing new pressures arising from increased needs associated with behavioral health conditions and reduced capacity for treatment. In 2017, the District lost one of its two major providers of inpatient psychiatric care when Providence Hospital's psychiatric inpatient unit closed. Since 2017, involuntary psychiatric admissions have increased substantially for one general hospital, Washington Hospital Center, and the remaining private psychiatric hospital, Psychiatric Institute of Washington. See *Figure 1*, below.

Figure 1



Although Medicaid covers both inpatient hospital psychiatric stays at non-IMD facilities and community behavioral health services, advocates and community providers report that individuals being discharged from emergency rooms and hospitals need more support or follow up to ensure a smooth transition to community care. In addition, stabilization and crisis services for Medicaid-covered individuals with serious behavioral health needs frequently occur in the emergency or inpatient hospital setting rather than using community settings. Over-reliance on these acute hospital settings may lead to poorer outcomes for patients with behavioral health

needs.

Overuse of hospitals is also resulting in longer wait times in emergency departments and fewer available beds in inpatient units due to high volume and intensive staffing needed to support a population with more substantial behavioral health needs. The District is already working across the health delivery system to reduce low-acuity emergency room utilization and prevent unnecessary hospitalization through the establishment of key performance metrics and value-based payments for Medicaid-funded federally qualified health centers, MCOs, and nursing facilities. Other initiatives include the implementation of a nurse triage line for 911 callers and two Medicaid health home initiatives targeted to improve coordination of care for the highest utilizers of care, including individuals with serious mental illness and those with three or more chronic conditions.

Despite increases in opioid-related overdoses and fatalities, the District Medicaid program continues to experience insufficient utilization of SUD services including MAT. Advocates have reported concerns regarding access to providers accepting Medicaid patients, including culturally competent and bi-lingual providers, highlighting the need for SUD and SMI/SED provider training. Advocates have also pointed to inconsistent discharge planning and follow up care as possible factors contributing to low treatment utilization for individuals with SUD.

Through this demonstration, the District seeks to more comprehensively promote community-based treatment and prevent more intensive interventions by providing a broader continuum of behavioral health treatment to ensure more efficient and effective service delivery at the lowest burden entry point.

Link Between Serious Mental Illness and Substance Use Disorder

There is often a strong co-occurrence of SUD and SMI. Roughly one-third (34 percent) of adult District residents being treated for SMI in the public health system also have an SUD. Medicaid beneficiary experience underscores this connection. In fiscal year (FY) 2018, nearly one-third of all Medicaid beneficiaries and more than half of FFS Medicaid beneficiaries (53 percent) had a behavioral health diagnosis. Among all Medicaid beneficiaries with behavioral health needs, 16 percent had co-occurring SMI and SUD, while among FFS beneficiaries with behavioral health needs, 26 percent had co-occurring SMI and SUD.

Individuals with SMI also have high rates of risky health behaviors, including use of tobacco products, substance use, physical inactivity, and poor diets. In addition, commonly prescribed antipsychotic medications have metabolic side effects including weight gain. These social risk factors, in concert with medication-mediated risk factors, can lead to higher rates of co-morbid physical illness, resulting in a population at higher risk for premature morbidity and mortality.[6]

Substance use is the most common risk behavior of District residents with SMI. Research suggests that people with mental illness may use drugs or alcohol as a form of self-medication.[7] For individuals with mental illness, brain changes may enhance the rewarding effects of

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4663043/

[7] http://www.mentalhealth.gov/what-to-look-for/mental-health-substance-use-disorders

substances, making an individual more likely to continue using the substance.[8] Thus, in the District, persons with a mental illness are at greater risk of developing a substance use disorder than the general population. Addressing the SUD crisis also requires treatment for the SMI that is likely a contributing factor.

Current Structure of District Medicaid Behavioral Health Benefits

In FY18, roughly three-quarters (72 percent) of Medicaid/CHIP beneficiaries in the District were enrolled in MCOs and just over one-quarter (28 percent) received services through the FFS program. Regardless of coverage type, all District Medicaid/CHIP enrollees are eligible to receive low-acuity behavioral health services, inpatient, outpatient, emergency, and pharmacy services for medically necessary behavioral health needs, although non-elderly adults aged 21-64 cannot receive Medicaid-covered IMD services unless they are enrolled in an MCO and only for up to fifteen (15) days per month. Based on results of an assessment, beneficiaries may be eligible to receive State Plan mental health and SUD rehabilitative benefits, which include a range of diagnostic and therapeutic services. *Table 1*, below, summarizes the full spectrum of Medicaid behavioral health services.

Oversight of Medicaid behavioral health services is divided, with overlapping authority, primarily among DHCF, Medicaid MCOs, and DBH, although other sister agencies also provide ancillary behavioral health services and supports.[9] DHCF has authority over Medicaid's reimbursement of clinic services (free-standing mental health clinics (FSMHCs) and federally qualified health centers (FQHCs)), hospitals, and outpatient services. MCOs serving District Medicaid beneficiaries contract with a behavioral health provider network providing low-acuity behavioral health services, including assessment, counseling, and medication/somatic treatment. However, most intensive services and supports for individuals with SMI/SED/SUD are carved out of MCO contracts and delivered through FFS by providers operating under the oversight and certification of DBH.

Medicaid MCOs manage their own network of behavioral health service providers who offer lower level, non-rehabilitative behavioral health services, including those provided by stand-alone psychiatrists, psychologists, FSMHCs, FQHCs, and other providers. MCOs also provide inpatient, emergency, pharmacy, and psychiatric residential treatment facility (PRTF) services. MCOs are subject to State Plan requirements and accountable to DHCF through the MCO contract and oversight.

Under the District Medicaid State Plan, rehabilitative services are organized into two distinct programs: Mental Health Rehabilitative Services (MHRS) and Adult Substance Abuse Rehabilitation Services (ASARS). These services are delivered on a fee-for-service basis through DBH-certified providers.

For District of Columbia residents with a diagnosis of SMI/SED, the Medicaid program (via

[8] Santucci K. Psychiatric disease and drug abuse. *Current Opinion Pediatrics* 2012;24(2):233-237. doi:10.1097/MOP.0b013e3283504fbf

[9] Other agencies that frequently provide behavioral health services to Medicaid-eligible individuals, including children, include DC Public Schools (DCPS), the Office of the Superintendent of Education (OSSE), Children and Family Services Administration (CFSA), the Division of Youth Rehabilitative Services (DYRS), the Department of Corrections (DOC), and others.

MHRS) provides an array of mental health services and supports, including: (1) Diagnostic/Assessment, (2) Medication/Somatic Treatment, (3) Counseling, (4) Community Support, (5) Crisis/Emergency, (6) Day Services, (7) Intensive Day Treatment, (8) Community-Based Intervention, and (9) Assertive Community Treatment, (10) Child-Parent Psychotherapy for Family Violence, and (11) Trauma-Focused Cognitive Behavioral Therapy. The District also offers a health home program for individuals with SMI/SED that provides care coordination and wrap-around services and supports.

A variety of additional evidence-based services and promising practices are offered to those enrolled in the MHRS system of care through local funding, including wrap-around support, transition support services, school mental health services, early childhood services, suicide prevention, and services for justice-involved individuals who are ordered to receive behavioral health assessments or treatment.[10] DBH contracts with 57 providers of mental health services. DBH also operates adult and child clinics that provide urgent care and crisis emergency services and provides homeless outreach and treatment services.[11]

In 2011, Medicaid-covered SUD services administered by DBH expanded with the implementation of the ASARS program, including: (1) Assessment/Diagnostic and Treatment Planning, (2) Clinical Care Coordination, (3) Crisis Intervention, (4) Substance Abuse Counseling, (5) Short-term Medically Monitored Intensive Withdrawal Management, (6) Medication Management, and (7) Medication Assisted Treatment. DBH contracts with 33 providers of substance use services. In addition, DBH has 10 providers that provide both mental health and substance use services.

Because of overlapping oversight of separate delivery systems and provider networks by DHCF, MCOs, and DBH, providers and beneficiaries are sometimes not well informed about available benefits and coverage. Through this demonstration, the District is beginning a process that aims to further improve coordination of coverage and services, beginning with a focus on strengthening transitions of care among participating providers.

[10] District of Columbia Department of Behavioral Health Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) January, 2019
[11] Ibid.

Table 1. District Medicaid State Plan MH/SUD Benefit Package and Related Covered Services

Emergency	Inpatient/Residential MH and SUD	Outpatient
• Crisis Emergency (MH) • Crisis Intervention (SUD)	• Hospitalization based on MH or SUD diagnosis • SUD: Inpatient hospital detoxification • IMD residential and inpatient services for children and adults 65 years old or older • MCO-enrolled non-elderly adults for first 15 days[12]	*Clinic and Physician (DHCF/MCO Managed)* • Diagnostic/Assessment/Treatment Planning • Medication/Somatic Treatment (MH services) • Counseling/Medication Management • EPSDT services for children, including screenings and treatment for SUD and other behavioral health needs
		Mental Health Rehabilitative Services (DBH Managed) • Diagnostic/Assessment • Medication/Somatic Treatment (Individual and Group) • Counseling (Individual On-Site, Individual Off-Site and Group) • Community Support (Individual and Group) • Crisis/Emergency • Day Rehab • Intensive Day Treatment • Community-Based Intervention • Assertive Community Treatment • Child-Parent Psychotherapy for Family Violence • Trauma-Focused Cognitive Behavioral Therapy
		Adult Substance Abuse Rehabilitative Services (DBH Managed) • Assessment/Diagnostic and Treatment Planning • Clinical Care Coordination • Crisis Intervention • Substance Abuse Counseling • Short-Term Medically Monitored Intensive Withdrawal Management • Medication Management • Medication Assisted Treatment

[12] IMD residential and inpatient services are not covered under the State Plan, but are allowable for MCO beneficiaries under the "in lieu of services" provision of federal Medicaid Managed Care rules.

Current Behavioral Health Diagnoses and Utilization, Including IMD Stays

Under current policy, Medicaid MCOs are able to cover and claim reimbursement for up to fifteen (15) days per month for non-elderly adult MCO enrollee IMD inpatient and residential services through the "in lieu of services" provision. IMD services for non-elderly adults are not Medicaid-reimbursable for beneficiaries covered under the FFS program but are covered locally by DBH on a limited basis.

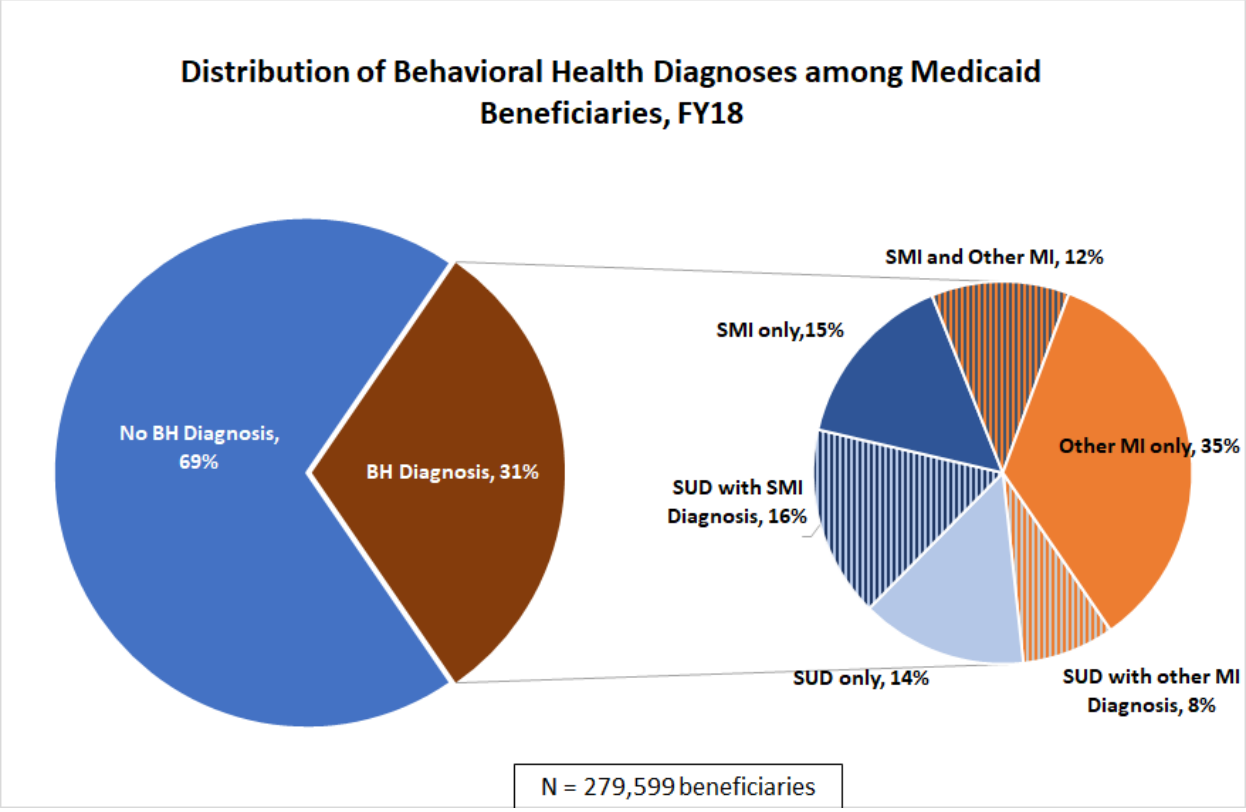
In FY18, nearly one-third (31 percent) of all Medicaid beneficiaries had a behavioral health diagnosis and an estimated 20 percent (55,919) of all Medicaid beneficiaries had an SMI/SED or SUD diagnosis. The rate of behavioral health diagnosis is higher for fee-for-service beneficiaries – in FY18, more than half (53 percent) of all FFS beneficiaries had a behavioral health diagnosis and an estimated 41 percent (19,166) of all FFS beneficiaries had an SMI/SED or SUD diagnosis. See Figures 2 and 3 below. Sixty percent of Medicaid beneficiaries with an SMI received behavioral health treatment.

In 2017, six percent of beneficiaries with an SUD had a non-tobacco SUD, including OUD, alcohol, cannabis, or other substance use disorder.[13] Five percent of all Medicaid beneficiaries had an alcohol use disorder and three percent had an opioid use disorder in 2017. In FY2018, 41% of individuals who received SUD treatment services through DBH-certified providers cited alcohol as their primary drug of choice; 21.1% cited heroin; 14.2% cited cocaine/crack; 10.4% cited marijuana; and 6% cited PCP.[14] DHCF research suggests there was a wide gap between those who had an SUD diagnosis and those receiving treatment – in 2017, only one-third of individuals with a non-tobacco SUD received SUD treatment (either counseling or MAT).

[13] Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral Health Barometer: District of Columbia, 2015.

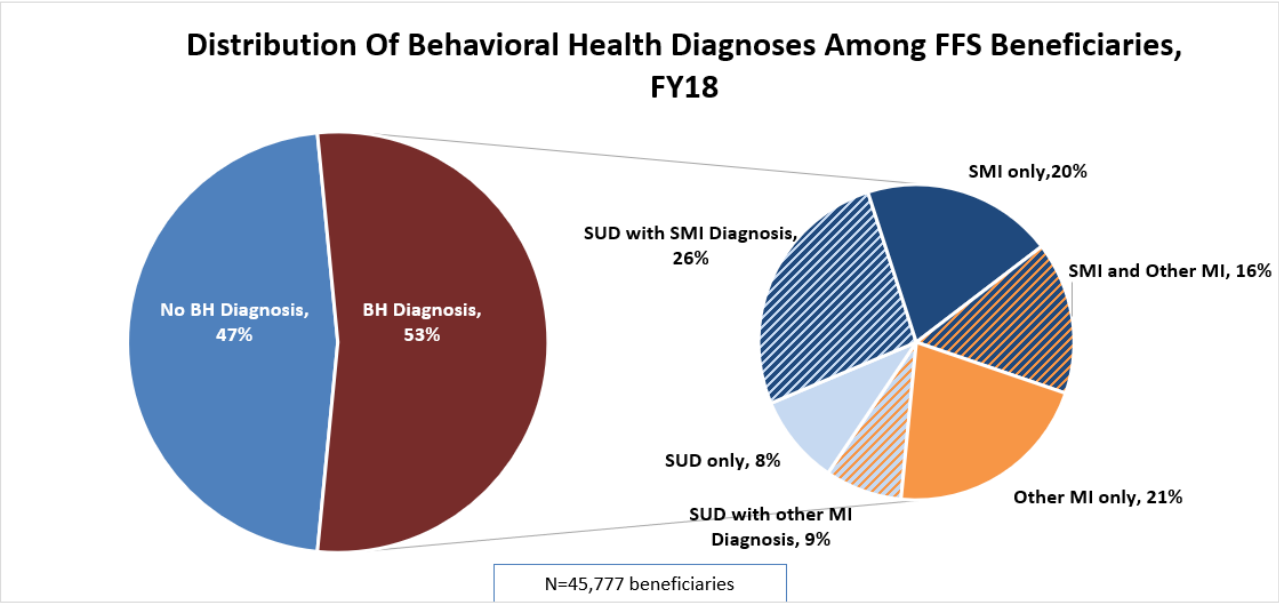
[14] District of Columbia Department of Behavioral Health Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) January, 2019

Figure 2: Distribution of Behavioral Health Diagnoses Among Medicaid Beneficiaries, FY18:



Source: DC Medicaid Management Information System (MMIS) data extracted in April 2019.

Figure 3: Distribution of Behavioral Health Diagnoses Among Medicaid Fee-For-Service Beneficiaries, FY18:



Source: DC Medicaid Management Information System (MMIS) data extracted in April 2019.

The District was one of 12 states that participated in the Medicaid Emergency Psychiatric Demonstration (MEPD) program authorized under the Affordable Care Act from 2012 to 2015. Under that demonstration, the District was permitted to provide limited Medicaid coverage for adult Medicaid beneficiaries in need of psychiatric inpatient IMD stays. Under the MEPD, the District provided IMD services to 559 individuals for a total of 857 stays over the three years of the program. The MEPD created referral patterns and delivery system practices that have left a gap in service since the demonstration's end.

In FY18, 2,933 adult Medicaid beneficiaries and those likely eligible for Medicaid had SUD or mental health-related IMD stays, resulting in $16.5 million in total District spending, $11.2 million of which was locally funded. The restrictions on Medicaid reimbursement for the treatment provided in IMDs has resulted in access gaps for Medicaid beneficiaries. Medicaid reimbursement of these stays provides a critical part of the District's behavioral health safety net.

Assessment of the Availability of Mental Health Services

The District conducted an assessment of the availability of mental health services to provide a baseline understanding of current rates of utilization, provider participation, and Medicaid enrollment against which to measure as the demonstration is implemented. The assessment, which follows a federally-provided template, includes information on the number of District providers of mental health services and a brief overview of the District's population with SMI, and is available in *Attachment 2*. For more information on the District behavioral health system, interested stakeholders can review the District of Columbia Uniform Application FY 2018/2019 - State Behavioral Health

Assessment and Plan Substance Abuse Prevention and Treatment Block Grant.[15] Other District government materials that analyze the behavioral health system include the District Medicaid Program's *2016 Access Monitoring Review Plan*[16] and the District Department of Health's *2014 Community Health Needs Assessment,*[17] which are also available for reference. Federal resources include the Mental Health National Outcome Measures reporting from the HHS/Substance Abuse and Mental Health Services Administration.[18]

In completing the assessment of the availability of mental health services, DHCF was unable to compare DHCF's network to the total number of providers in the District for several categories of providers who treat mental illness. Over the course of the demonstration, DHCF will work with other District agencies to improve the data for future assessments.

B. Vision for Improving Treatment of Serious Mental Illness and Substance Use Disorders

The District is planning to use the 1115 demonstration to strengthen the continuum of care and move the District's Medicaid program toward a more integrated model of behavioral health care delivery by expanding treatment options for SMI/SED and SUD, delivering better quality care, identifying and treating behavioral health issues at earlier stages, and supporting improved data collection and reporting in the District's behavioral health system. The demonstration will also assist the District in advancing key goals within its Opioid Strategic Plan. Specifically, the demonstration will expand access to SUD treatment and providers, improve the quality of behavioral health treatment, improve the beneficiary experience after discharge through follow up, and prevent emergent and acute hospitalizations by scaling up crisis treatment programs.

Through this demonstration, DHCF aims to reduce regulatory silos and barriers to care across agencies and programs, more effectively engage providers to support early intervention and treatment regardless of payer and promote equitable and timely access to SUD treatment and recovery services and SMI/SED assessment, treatment, and supports. Combining under a single demonstration authority the ability to use IMDs for SUD and SMI/SED residential and inpatient treatment provides the District with the most comprehensive approach to improving access to IMD services. The District is also hoping the demonstration will allow District agencies to better track and support transitions of care between IMD and other community-based services to promote better health outcomes for high need, high cost beneficiaries.

The demonstration will align with several ongoing local and federally funded initiatives and system reforms, providing the District with an opportunity to better target Medicaid funding to address critical care needs in the community to protect and strengthen the behavioral health system overall.

Expanding Service Continuum for SMI/SED and SUD

The cornerstone of this demonstration is expanding the continuum of care by providing Medicaid reimbursement for individuals with SMI or SUD in residential and inpatient IMD settings.

To complement new residential and inpatient IMD services, the District plans to bolster the

[15] https://dbh.dc.gov/page/behavioral-health-services-block-grants
[16] https://dhcf.dc.gov/page/read-dhcf%E2%80%99s-first-access-monitoring-review-plan-ffs-medicaid-program
[17] https://dchealth.dc.gov/page/dc-community-health-needs-assessment
[18] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/DistrictofColumbia-2017.pdf

availability of community-based interventions, including:

- Crisis stabilization, including psychiatric residential stabilization services, and mobile crisis and outreach services in the community;
- Recovery supports:
    - For SUD - recovery support services, including services delivered by certified peer specialists, and
    - For SMI and/or co-occurring SMI/SUD - a new peer-partnered Clubhouse model providing day rehabilitative treatment;
- Vocational supported employment services for individuals with SMI and a pilot for supported employment services for individuals with SUD, to ensure that behavioral health needs do not pose a barrier to continuing or initiating employment, which is a major factor in promoting self-reliance and recovery;
- Behavioral health services provided by independent and hospital-affiliated psychologists and other licensed behavioral health providers to individuals with SMI/SED and SUD, subject to the limitations noted in Section IV.B, below;
- Elimination of the current one dollar ($1) copayment requirement for prescriptions associated with MAT to ensure this treatment is broadly accessible without any barrier; and
- Transition planning services to permit certain behavioral health providers to participate in the discharge treatment planning process for individuals with SMI/SED or SUD within thirty (30) days of being discharged from an inpatient, residential, criminal justice, or other institutional setting.

System Redesign

The demonstration is part of an ongoing effort to strengthen and integrate the District's behavioral health system and move the Medicaid program toward a more holistic, integrated approach to delivering person-centered care and improving outcomes. By increasing Medicaid's behavioral health service array, the demonstration will facilitate improved care coordination and promote greater collaboration and efficiency among participating behavioral and medical providers.

The demonstration will complement ongoing District efforts under the Medicaid State Plan and administration operations to transition provider claims administration for behavioral health services from DBH to DHCF, enhance MHRS and ASARS services, and identify opportunities for system improvements. The District is also increasing investments in health information technology (HIT) systems and has received approval from CMS for several programs to increase provider participation in District-wide Health Information Exchange. The District's overall goal is to build a system of care that provides a greater continuum of behavioral health services; reduces substance use, misuse, and overdose fatalities; and moves Medicaid toward a more holistic, integrated approach to health care treatment.

Relationship to Current DBH Activities

The demonstration will also complement and leverage U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration State Opioid Response (SOR) funding, a two-year grant designed to reduce OUD related deaths by increasing prevention, treatment, and recovery activities for OUD. DBH was recently awarded $53 million in SOR funds for FY19 and FY20. Over the grant period, the District of Columbia's Opioid Response (DCOR)

program will test strategies to increase access to MAT, reduce unmet treatment needs, and reduce OUD related overdose deaths in the District. To improve accessibility of services, the District will implement a Hub and Spoke model with multiple access points (including a 24-hour intake and assessment site) to a coordinated network of treatment and recovery support services (RSS) providers who will collaborate around the assessment, stabilization, and ongoing treatment of individuals with OUD. The Hub will facilitate communication and provide education and SBIRT. The program will employ motivational interviewing to help individuals access treatment through the network and peer support specialists will provide outreach throughout the continuum of care, foster engagement, and service connection. The DCOR program will also use training, technical assistance, and Extension for Community Healthcare Outcomes (ECHO) consultation using the Health Resources and Services Administration's opioid use treatment curriculum with health care professionals to increase their ability to address the needs of clients with more intense challenges. The demonstration's proposed expansion of services and focus on transitions and community-based services complements these ongoing efforts. The waiver may also provide a future pathway to sustainability of these initiatives. The District plans to monitor the impact of DCOR-funded interventions and determine their applicability to Medicaid. In this way, the District is looking to leverage federal investments under the demonstration to promote sustainability of proven interventions.

In addition, DBH is promoting a series of systemic reforms that will complement the waiver by improving access to community-based interventions and supports. DBH is seeking to provide short-term medically monitored intensive withdrawal management services (ASAM level 3.7-WM) for individuals receiving Comprehensive Psychiatric Emergency Program (CPEP) services in community settings. This change will increase capacity to treat individuals with SUD for short-term, intensive stays in the community.

In Summer 2019, DBH will launch the Integrated Community Response Team (ICRT), a multidisciplinary approach to improve behavioral health outcomes in the District with a focus on proactive service offerings and tailored responses for individuals experiencing a behavioral health crisis. The ICRT is a multi-site 24/7 model of care consisting of a multidisciplinary team of licensed clinicians, community behavioral health specialists, and individuals with lived experience. The ICRT is designed to support communities by providing:

(1) critical incident response, including deploying responders to any other situations requiring behavioral health supports;

(2) targeted community outreach intended to improve the utilization of services and support the identified needs of communities;

(3) supportive behavioral health services, including regular engagement with individuals showing signs of mental health and/or substance use disorder to connect them to treatment and other services and persuade them to seek a safe environment; and

(4) community education, including participating in a wide array of community support requests, trainings, educational outreach efforts and community stakeholder meetings, to provide recommendations on behavioral health needs and engagement strategies to promote the wellness of District residents.

In addition, DBH is decentralizing its substance use disorder assessment and referral center (ARC)

services, which will allow multiple community-based SUD providers to provide intake, assessment, and referrals. Previously, the ARC provided a centralized, single point of entry to treatment. With this change, individuals in need of SUD services will have multiple points of entry into the District's system of care. DBH is also working to transition free-standing mental health clinics (FSMHCs) from DHCF oversight to DBH oversight. By October 2019, DBH will certify and monitor all publicly funded clinic-based mental health services provided in a FSMHC, thereby improving the consistency of oversight of mental health providers in the District.

Section III – Demonstration Goals and Objectives

The District has three overarching goals for this demonstration:

- Increasing Medicaid's service array to improve coverage of a broader continuum of behavioral health treatment for individuals with SMI/SED/SUD.
- Advancing the District's goals for reducing opioid use, misuse, and deaths outlined in the District's Opioid Strategic Plan, *Live.Long.DC*.
- Supporting the District Medicaid program's movement towards a more integrated health care experience that facilitates coordinated treatment of behavioral and physical health needs.

The District's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible beneficiaries. The District's goals also support the specific goals for the SUD and SMI/SED demonstrations outlined by CMS in SMD 17-003 and 18-011, including:

- Increasing enrollee identification of, access to, and utilization of appropriate SUD treatment services based on the ASAM Criteria, with a focus on community settings;
- Increasing enrollee access to and utilization of appropriate SMI/SED treatment services based on nationally recognized criteria, with a focus on community settings;
- Increasing adherence to and retention in SUD treatment;
- Decreasing use of medically inappropriate and avoidable high-cost emergency department and hospital services by enrollees with SUD and/or SMI/SED;
- Increasing timely initiation of follow up after discharge from emergency department, inpatient or residential treatment for SMI/SED or SUD, and timely transition to community-based behavioral health services;
- Reducing readmission rates for inpatient SUD and/or SMI/SED treatment;
- Ensuring that beneficiaries being treated in an IMD setting are also being assessed for and accessing treatment for their physical health conditions; and
- Improving the availability of crisis stabilization services including through call centers and mobile crisis units, and through intensive outpatient, inpatient, and residential settings.

The District will provide detailed information on its strategy for meeting demonstration milestones (as identified in SMD 17-003 and 18-011) in its implementation plan. The District will also provide additional information on its strategy to promote and leverage HIT in support of the demonstration's goals in its HIT plan. The District will finalize and submit its Implementation and HIT plans following submission of this application to CMS within ninety (90) days of approval of this proposed demonstration.

Section IV – Eligibility, Benefits, Cost Sharing, and Delivery System

A) Eligibility

Broadly, this demonstration will impact all children and adults eligible to receive Medicaid benefits under the District of Columbia Medicaid State Plan who are diagnosed with an SMI/SED or an SUD, or self-identified with an SUD.

Medicaid beneficiaries will qualify for services outlined in this demonstration based upon their medical need for services. Medicaid beneficiary eligibility requirements will not differ from the approved Medicaid State Plan and DHCF is not proposing changes to Medicaid eligibility standards in this demonstration application.

Specifically, the District is seeking authorization to reimburse for clinically appropriate care delivered in residential and inpatient treatment settings that qualify as IMDs to increase the scope of services and treatment options available to District Medicaid adults aged 21- 64 diagnosed with an SMI or an SUD, who have traditionally had decreased access to these services as a result of the IMD exclusion.

The District also plans to add new and expand existing Medicaid services that would otherwise be coverable under the State Plan. These additional services will ensure greater access to outpatient and community-based services for all Medicaid-eligible children, youth, and adults diagnosed with an SMI/SED or an SUD, or self-identified with an SUD, with the goal of improving health outcomes for these individuals.

B) Benefits

In addition to services authorized under the Medicaid State Plan, this 1115 demonstration proposal will authorize the reimbursement of:

IMD Services

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

SMI and SUD inpatient and residential treatment under this demonstration is proposed for clinically appropriate care based on placements using nationally recognized level of care and utilization criteria. SUD Residential and Inpatient Treatment under this demonstration program would be included for clinically appropriate care associated with ASAM Levels 3.1, 3.3, 3.5, 3.7, 3.7WM, and 4.0.

Eligible inpatient and residential providers will be certified in accordance with District requirements - for SUD treatment, these providers will deliver care in accordance with ASAM criteria and for treatment of SMI, these providers will be accredited by a national organization (or otherwise meet Medicare conditions of participation). Treatment staff will be certified or licensed in accordance with District requirements or otherwise credentialed or regulated by DBH.

The District also seeks to expand and add new Medicaid services that could be otherwise covered under the State Plan, including:

Crisis Stabilization Services

The demonstration proposes to expand the availability of crisis stabilization services available in the Medicaid program for individuals experiencing behavioral health crises through changes to existing Comprehensive Psychiatric Emergency Program (CPEP) and mobile crisis and outreach services and the addition of psychiatric residential crisis stabilization services.

Comprehensive Psychiatric Emergency Program (CPEP)

The demonstration proposes to change the reimbursement methodology for CPEP services to individuals experiencing a behavioral health crisis, to more appropriately account for and value the services provided. Instead of billing in 15-minute increments, Brief Crisis Emergency Visits will be reimbursed at an hourly rate for up to four hours, and 23-Hour Crisis and Extended Observation Crisis Visits will be reimbursed at a per diem rate.

Mobile Crisis and Outreach Services

The demonstration will add mobile crisis and outreach services as separate and distinct services from those provided and billed under CPEP to more appropriately account for and value the services provided. Instead of billing in 15-minute increments, providers will be able to bill for crisis intervention mental health services at an hourly rate and for behavioral health outreach services at a per encounter rate.

Psychiatric Residential Crisis Stabilization Services

The demonstration proposes to add coverage for psychiatric residential crisis stabilization services as a treatment alternative to psychiatric inpatient hospitalization for persons living in the community who are (1) in need of support to ameliorate psychiatric symptoms; (2) voluntarily participating in treatment; and (3) deemed appropriate for outpatient services within a structured, closely monitored temporary setting (based upon a psychiatric assessment conducted on-site). Staffing requirements include a psychiatrist, a psychiatric nurse, and a social worker or counselor. Psychiatric residential crisis stabilization service providers will be certified by DBH.

Recovery Support Services

The demonstration proposes to add a recovery support services (RSS) benefit for SUD. RSS are non-clinical services and supports designed to support and maintain ongoing recovery. RSS would be available to individuals: 1) with an SUD who are currently in treatment or who have completed treatment, or 2) individuals who have self-identified with an SUD. For transitional housing supports, individuals must have a diagnosed SUD. A recovery support evaluation is used to determine an individual's needs, develop a comprehensive recovery support plan, and monitor progress. Services proposed for coverage include: 1) Care Coordination Services; 2) Recovery Coaching and Mentoring; 3) Life Skills Support; 4) Education Support Services; and 4) Transitional Housing Supports. RSS providers will be certified by DBH.

Clubhouse Services

The demonstration proposes to fund services offered in a peer-partnered facility for adults with SMI and/or co-occurring SUD. Clubhouse services are psychosocial rehabilitation services that utilize

behavioral, cognitive, or supportive interventions to help individuals develop social networking, independent living, budgeting, self-care, and other skills. The goal is to assist individuals with successfully living in the community and preparing for and maintaining employment. Clubhouse services are provided in a collaborative setting where clubhouse staff and members work side by side. Clubhouse service providers will be certified by DBH.

Trauma-Informed Services

The demonstration proposes to reclassify two trauma-informed services for children, adolescents, and adults—the Trauma Recovery and Empowerment Model (TREM) and Trauma Systems Therapy (TST)—and change the reimbursement methodology. Currently, these services are provided and billed under the MHRS Counseling service definition. Creating a separate service definition for TREM and TST will allow for better tracking of service utilization. Increasing the reimbursement rates to be on par with other trauma-informed services is intended to promote additional service availability. Trauma-informed service providers will be certified by DBH.

TREM serves individuals who survived trauma and have substance use and/or mental health conditions. The model draws on cognitive-behavioral, skills training, and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse. TREM consists of three major parts: empowerment; trauma experience and its consequences; and skills building, with an emphasis on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

TST is a phase-based treatment program for children and adolescents who have experienced traumatic events or who live in environments with ongoing stress or traumatic reminders. TST is designed to address the complicated needs of traumatized children or adolescents who have difficulty regulating their emotions and behavior and the caregivers and systems of care who are not able to adequately respond to the youth's needs.

Supported Employment Services

The demonstration proposes to add vocational services to currently covered therapeutic supported employment services for individuals with SMI whose plan of care has identified the need for these services. The demonstration also proposes a pilot to provide supported employment services to individuals with SUD to determine how to best adapt the service model to this population. The pilot for supported employment for individuals with SUD would be limited to two providers designated by DBH.

Supported employment targets adults for whom competitive employment has either not occurred, been interrupted, or is intermittent as a result of a significant behavioral health disorder. Ongoing supports help the individual prepare for, obtain, and maintain a part-time or full-time job in a competitive employment setting as a component of their recovery. Supports to be covered under the demonstration would include intake and assessment, coordination with the individual's treatment team, and job development and coaching. Supported employment service providers for individuals with SMI will be certified by DBH.

Psychologist and Other Licensed Behavioral Health Provider Services

The demonstration proposes to reimburse for screening, behavioral health assessment/diagnostic,

counseling, and other behavioral health treatment provided to individuals with SMI/SED or SUD by psychologists and other licensed behavioral health providers (including Licensed Independent Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists) within the scope of their licensure. Under the Medicaid State Plan, psychologists and other licensed behavioral health providers can currently deliver Medicaid-reimbursable services through free-standing mental health clinics, core service agencies, and federally-qualified health centers. Under the demonstration, psychologists and other licensed behavioral providers practicing independently, either in a separate practice or hospital setting, would be able to enroll in Medicaid and bill for services. Services associated with screening or treatment of Autism Spectrum Disorder (ASD) are carved out from this benefit and will not be included as a waiver-covered service. The District is considering other policy interventions for ASD that will offer more comprehensive access to the services and providers needed to treat this condition.

Transition Planning Services

The demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain behavioral health providers for individuals with SMI/SED and/or SUD being discharged into their care from an inpatient, residential, criminal justice, or other institutional setting. The discharge planning process assesses an individual's situation, strengths, and needs, and identifies the availability of needed services and supports after release and links the individual to them. In addition to addressing physical and mental health care needs, links may be created to non-clinical supports related to housing or other social service benefits. Enabling these providers to be part of plan development with the individual and the institution's treatment team promotes continuity of care and helps ensure that appropriate treatment services and/or supports are available and accessed after discharge.

This service will help meet CMS' goals and implementation plan requirements of intensive and coordinated discharge planning as well as timely follow-up, post-discharge. It is also consistent with Congress' requirement under Section 5032 of the SUPPORT Act (P.L. 115-271) that CMS allow states a waiver to provide services to incarcerated individuals within thirty (30) days of their release to improve connections to care and reduce the likelihood of relapse upon return to the community.

Under the demonstration's proposed reimbursement, transition planning services would consist of up to eight (8) hours per enrollee for services provided within thirty (30) days of an individual being discharged. These services can be provided in person, remotely via telemedicine, and/or outside of the care delivery setting. Providers authorized to bill for these services would be DBH-certified MHRS and ASARS providers, FSMHCs, and Federally Qualified Health Centers.

C) Cost Sharing

The District is not planning to impose any cost-sharing under this 1115 demonstration. The District is also seeking to waive existing cost-sharing requirements for some individuals eligible to receive services under the 1115 demonstration, specifically to change cost-sharing requirements for individuals who are using prescription drugs associated with MAT.

- *Remove Cost-Sharing Requirement for Prescriptions Associated with MAT:* The demonstration proposes to remove $1 co-payment cost-sharing requirements now in effect under the State Plan for individuals receiving services under the demonstration who are

also using prescription medications associated with MAT.

D) Delivery System

The District of Columbia currently utilizes both FFS and managed care systems as specified under its state plan for delivering Medicaid benefits. No changes to the current FFS and managed care delivery systems are being proposed in this demonstration application. There will be no differences in the delivery system used to provide benefits to demonstration participants than those provided under the State Plan.

For SUD and SMI/SED services provided through DHCF's FFS system under this demonstration, DHCF expects to follow the State Plan with respect to SUD and SMI/SED payment rates except in cases indicated above where rate methodology changes are proposed. For the services being added where there is no established rate, DHCF intends to develop a rate. DHCF also expects that MCO capitation rates may need to be adjusted in light of changes regarding the administration and coverage of IMD services. Clinical SUD treatment services must have been determined necessary for a beneficiary based on the ASAM criteria. Beneficiary receipt of recovery support services would be determined through completion of an assessment and recovery support plan. Supported employment for individuals with SUD will be based on the individual's plan of care. Depending on the clinical SMI/SED treatment service, beneficiary's placement and treatment will be based on a combination of criteria based on the individual's treatment plan; District-approved level of care (LOC) determination tools, such as the LOCUS and CAFAS; clinically relevant information submitted by the provider; and other nationally recognized criteria. For supported employment services for individuals with SMI, availability will be based on the individual's plan of care. Clubhouse services provision is based on the enrollee's diagnostic assessment and plan of care. Crisis services will be available to individuals presenting with a behavioral health crisis.

Other than the cost-sharing and benefits described above, this 1115 demonstration does not otherwise modify other program features of the DC Medicaid program.

Section V – Demonstration Hypothesis and Evaluation

The demonstration will test whether the expenditure authority granted under this demonstration, in addition to other concurrent behavioral health delivery system enhancements and re-design efforts, results in increased access to health care services and improved health outcomes for individuals with SUD and SMI/SED.

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

In the tables below, DHCF presents a preliminary evaluation plan. DHCF identified some of the most important goals of the demonstration to potentially explore in the evaluation. Each goal is linked to potential research questions and performance measures that would allow researchers to

analyze whether the demonstration met its identified goals. All components of the preliminary plan (including goals, research questions, and measures) are subject to change, as the program is implemented, and an evaluator is identified.

Goal: Increase enrollee identification of, access to, and utilization of SUD and/or SMI/SED treatment services in a community setting

Research Question	**Examples of Measures**	**Data Source**
Was there a change in utilization of SUD and/or SMI/SED community-based treatment services (including MAT)?	- Number and percent using SUD and/or SMI/SED community-based treatment services (including MAT)	MMIS
Was there an increase in enrollees being treated in a general hospital or IMD setting?	- Number and percent with stays in a hospital or IMD - Average length of stay in a hospital or an IMD	MMIS

Goal: Reduce emergency department (ED) and hospital visits among enrollees with SUD and/or SMI/SED for SUD and/or SMI/SED treatment

Research Question	**Examples of Measures**	**Data Source**
Has emergency department use decreased among Medicaid enrollees with SUD and/or SMI/SED?	- Number and percent of Medicaid enrollees with SUD and/or SMI/SED with an ED visit - Ratio of ED visits to community-based treatment for Medicaid enrollees with SUD and/or SMI/SED	MMIS
Have hospitalizations decreased among Medicaid enrollees with SUD and/or SMI/SED?	- Number and percent of Medicaid enrollees with SUD and/or SMI/SED with an inpatient admission - Number and percent of Medicaid enrollees with SUD and/or SMI/SED with a readmission	MMIS

Goal: Diagnose and treat co-morbid physical health conditions among enrollees with SUD and/or SMI/SED in an IMD setting

Research Question	Examples of Measures	Data Source
Are IMD providers providing assessments and treatment of physical health conditions?	Number and percent of episodes of care where IMD providers billed for assessments or treatment of physical conditions	MMIS

Goal: Increase timely initiation of follow up after discharge from ED, residential, or inpatient treatment for SMI or SUD and timely transition to community-based behavioral health services.

Research Question	Examples of Measures	Data Source
Were transition services used within 30 days of discharge?	- Number and percent of transition service billing by community providers per discharges	MMIS
Did the discharged beneficiary receive contact from the facility within 72 hours of discharge?	- Number and percent of facilities that documented contact within 72 hours of discharge	Provider records
Did the discharged beneficiary receive community-based services within 7 days following discharge? 30 days?	- Number and percent of discharged beneficiaries who received services	MMIS

Goal: Improve the availability of crisis stabilization services including through call centers and mobile crisis units and through intensive outpatient and residential or inpatient settings.

Research Question	Examples of Measures	Data Source
Was there an increase in the number of individuals accessing crisis stabilization services, including CPEP, mobile crisis and outreach, and psychiatric residential crisis stabilization?	- Number and percent of individuals accessing services	MMIS
Was there a decrease in the number of individuals presenting with a behavioral health crisis in hospital emergency rooms?	- Number and percent of individuals accessing services	MMIS, hospital records

Evaluation Indicators:

To the greatest extent possible, the District will use nationally recognized, standard quality measures (such as CMS core) to evaluate the success of the SUD and SMI/SED components of the demonstration and will work to streamline reporting and minimize administrative burdens for District providers. In addition, the District will work collaboratively with MCOs, providers, and facilities to ensure performance measures are appropriate and reportable.

Section VI – Waiver and Expenditure Authorities

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

- Comparability requirements described in section 1902(a)(17): this demonstration program includes benefits and cost-sharing specific to eligibility criteria as described in Section IV.A that may not be comparable to benefits and cost-sharing provided under the State Plan.

- Amount, Duration, and Scope requirements described in section 1902(a)(10)(B): to enable the District to offer a different benefit package to demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

- Any Willing Provider requirements described in section 1902(a)(23) and 42 CFR 431.51(b)(1): to enable the District to limit provider participation in the Medicaid program with respect to services offered as Supported Employment as described in Section IV.B.

DHCF requests the following Expenditure Authority: Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment or withdrawal management services for SUD or primarily receiving treatment for SMI/SED, who are short-term residents/inpatients in facilities that meet the definition of an IMD.

Section VII – Impact on Program Expenditures and Enrollment

This demonstration would permit the District to expand coverage of IMD residential and inpatient treatment services for individuals with SMI/SED or SUD and to add and adjust services targeted to provide community and residential services for Medicaid beneficiaries with behavioral health needs that would otherwise be covered under the State Plan or demonstration authority.

In FY18, there were 279,600 individuals enrolled in the Medicaid program. This demonstration is not expected to increase or decrease annual enrollment. Of those enrolled in the Medicaid program in FY18, approximately 31 percent (85,967) were diagnosed with behavioral health disorders, including 20 percent (56,000) who were diagnosed with a SMI/SED or SUD. Those who are Medicaid enrolled and diagnosed with SMI/SED or SUD are largely the target of this demonstration program. Additionally, the demonstration is not expected to increase or decrease annual expenditures over the lifetime of the demonstration, as compared with hypothetical expenditures associated with services added under the demonstration or those that could be otherwise covered under the State Plan or established waiver authorities. Table 4 below reflects current enrollment data and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration. The enrollment and expenditures estimated through 2024 noted here (and included in *Attachment 2*) reflect the program as currently approved because the demonstration is not expected to have a material impact on Medicaid enrollment or expenditures. The District will ensure that it maintains current spending on outpatient, community-based mental health services consistent with historical spending at the local level.

Table 2: **Projected IMD Member Months/Caseloads and Enrollment**

		DEMONSTRATION YEARS (DY)					
	Trend Rate	2020	2021	2022	2023	2024	Estimated Enrollment
SUD IMD Services MCO	4.5%	902	942	984	1,029	1,075	451
SUD IMD Services FFS	3.1%	1,298	1,339	1,381	1,425	1,469	718
SMI IMD Services MCO	4.5%	54	57	59	62	65	27
SMI IMD Services FFS	3.1%	2,369	2,443	2,520	2,599	2,681	1,329
Non-IMD Services CNOM Limit MEG	4.2%	60,913	63,459	66,111	68,873	71,751	16,809

Table 3: Demonstration 5 Years Expenditures

Supplemental Test #1: IMD Services Cost Limit						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD Services MCO	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644
With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD Services MCO	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644
Net Overspend	$0	$0	$0	$0	$0	$0
Supplemental Test #2: Non-IMD Services CNOM Limit						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025

With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
Net Overspend	$0	$0	$0	$0	$0	$0

MEGs	Trend Rate	2020	2021	2022	2023	2024
SUD IMD Services MCO	3.0%	$1,690	$1,741	$1,793	$1,847	$1,903
SUD IMD Services FFS	3.0%	$2,455	$2,529	$2,605	$2,683	$2,763
SMI IMD Services MCO	3.0%	$10,769	$11,092	$11,425	$11,768	$12,121
SMI IMD Services FFS	3.0%	$8,128	$8,372	$8,623	$8,882	$9,149
Non-IMD Services CNOM Limit MEG	3.0%	$214	$221	$227	$234	$241

Section VIII – Public Notice

A. Public Engagement and Demonstration Development

The District took the following actions to support public notice and awareness of this demonstration before the draft waiver application was released on April 12, 2019:

DHCF discussed the draft demonstration application with the following interest groups during the development of the waiver:

- District of Columbia Medical Care Advisory Committee (MCAC) on February 26, 2019
- DC MCAC Health System Redesign Subcommittee on March 27, 2019
- DC Behavioral Health Waiver Stakeholder Meeting on March 28, 2019
- DC Behavioral Health Planning Council on March 29, 2019
- Medicaid MCO Medical Directors on April 8, 2019
- DC MCAC Access Subcommittee on April 9, 2019
- DC Behavioral Health Provider Meeting on April 10, 2019

B. Notice of Draft Waiver Application

DHCF published an abbreviated notice of public comment in the April 12, 2019 issue of the District of Columbia Register (DCR) at 65 DCR 004860. The abbreviated notice can be found online at https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N0081563. The abbreviated notice provided interested stakeholders with the date, times, and locations of public hearings; informed stakeholders how to submit public comments; and linked directly to the demonstration website containing full notice.

On April 12, 2019, DHCF published full notice on the DHCF website at http://dhcf.dc.gov/1115-waiver-initiative. The draft demonstration application, an executive summary, and information on how interested stakeholders could give feedback on the proposed demonstration were available on the DHCF website at or before 6:00 PM EST. DHCF also emailed the draft application, the executive summary, and a link to the DHCF website to a listserv of approximately two-hundred and fifty (250) interested members of the public.

The public comment period was open from April 12, 2019 through 6:00 PM EST on May 13, 2019, allowing for thirty (30) days of public comment on the demonstration application. Written comments were accepted by mail, email, and in person. Oral comments were recorded during each public hearing.

During the public comment period, DHCF presented on the proposed demonstration and offered opportunity for public input at public hearings offered on different dates, times, and locations to maximize opportunity for public input. Teleconference and web-conference access was available during each public hearing. DHCF held public hearings at the date and times listed below:

Public Hearing #1
Date: Thursday April 18, 2019
Time: 4 to 5:30 pm
Location: Room 284/285 at 64 New York Avenue NE, Washington, DC 20002

Public Hearing #2
Date: Thursday April 25, 2019
Time: 5:30 to 7 pm
Location: Room 2023 at 2235 Shannon Place SE, Washington, DC 20020

Public Hearing #3 (Virtual)
Date: Tuesday April 30, 2019
Time: 1:30 to 3 pm
Location: Web conference and Teleconference only

DC MCAC Meeting
DHCF also presented information and heard feedback on the proposed demonstration during the April 26, 2019 meeting of the DC MCAC. The DC MCAC is a forum for key participants and stakeholders in the Medicaid program, including consumers, advocates, providers, and District officials to review the program's operations and offer advice for improvements directly to DHCF. Information on the April 2019 meeting of the DC MCAC is available on the DHCF website at https://dhcf.dc.gov/node/1401616.

Additional notice materials and electronic copies of comments received during the notice period are included in *Attachment 3*.

C. Common Themes in Public Comment and District Response

DHCF and DBH received 20 written as well as additional oral comments, during the comment period during the comment period. The majority of stakeholders indicated their appreciation that the District is pursuing the demonstration to address the behavioral health needs of Medicaid beneficiaries. A summary of common themes and District responses is outlined below.

Demonstration Eligibility/Impacted Population

Several commenters submitted feedback on the scope of the eligibility criteria defined in the draft waiver application. Several commenters recommended that DHCF use a broad eligibility criterion in order to ensure the demonstration program is able to provide a full scope of behavioral health services to as many Medicaid beneficiaries as possible.

Specifically, one commenter suggested that "traumatic brain injury" be clearly included as a diagnostic category within the demonstration's definition of SMI.

Commenters also requested that the scope of eligibility criteria include those "at risk" for developing SMI/SED or SUD. Specifically, a request was made to provide a broader definition of those who are eligible via "self-identification" to be more inclusive of (1) self-reported symptoms, (2) evidence of active substance use that could include formal drug testing results, (3) witnessed current or recent substance use, (4) evidence of impairment reasonably suspected to be due to substance use, (5) recent or current admission into a formal detoxification program or sobering station, or (6) presence of drug paraphernalia on the person or in the immediate setting of a person suspected to have an SUD.

District Response

DHCF has clarified the target population for the demonstration and included additional clarity on how individuals will qualify for services outlined under this demonstration in Section IV.A and Section IV.B. Depending on the service, any beneficiary with a mental illness, SED, SUD, or generally who meets medically necessity criteria may be eligible for services under the demonstration.

For example, recovery support services (except for transitional housing supports service) would also be available to beneficiaries self-identified with an SUD. Supportive housing requires an SUD diagnosis. Mobile crisis outreach services would be available to individuals experiencing a behavioral health crisis.

By focusing on medically necessary services, DHCF aims to ensure that eligibility for waiver services will be clearly understood and appropriate to meet the needs of the community. If the demonstration is approved, the District will further refine any criteria in future guidance and rulemaking to support implementation.

Medicaid Enrollment of Psychologists/LICSW and Other Stand-Alone Providers

Several comments indicated that there should be an expansion of the provider types eligible to enroll as stand-alone providers and provide services in the Medicaid program. Specifically, commenters sought consideration of for behavioral health professionals with similar licensure to LICSWs, such as Licensed Professional Counselors and Licensed Marriage and Family Therapists.

Commenters also asked for clarification on psychologists' and LICSWs' ability to enroll as stand-alone providers under the demonstration. A number of commenters recommended that the demonstration include language deeming psychologists and LICSW as qualified provider types under "DC Medicaid eligible to provide services in all clinical settings, including hospitals."

District Response

The demonstration proposes to allow Medicaid to pay for behavioral health services to individuals with SMI/SED and SUD within the scope of each provider's licensure and scope of practice, as appropriate, with the goal of increasing access to low acuity, outpatient services. The demonstration will provide Medicaid reimbursement for psychologists and LICSWs practicing independently, either in an independent practice or hospital setting. Medicaid already covers psychologist and LICSW services when the provider affiliates and bills through core service agency, a free-standing mental health clinic, or a federally qualified health center. The District is not proposing additional changes to Medicaid's current reimbursement for CSAs, FSMHCs, FQHCs, or other providers with regard to services provided by psychologist and LICSWs at this time.

With respect to other licensed providers, the District agrees that comparable providers should be permitted to enroll to provide Medicaid-covered services. In response to public comment, the District amended Section IV.B of the proposed demonstration to permit Medicaid reimbursement of services provided by Licensed Professional Counselors and Licensed Marriage and Family Therapists.

The District is also proposing to carve out services associated with assessment, diagnosis, or treatment for Autism Spectrum Disorder (ASD) from the services authorized under the waiver. The District is considering other policy interventions for ASD that will offer more comprehensive access to the services and providers needed to treat this condition.

Peer Support Specialists

Commenters encouraged creation of a single standard of care for peer support services that would serve both the mental health and substance abuse services. Commenters also sought coverage of peer support services as a stand-alone benefit.

District Response

DBH maintains guidance and regulation on the appropriate scope of services able to be provided by peer support specialists in the District behavioral health system. The demonstration provides multiple opportunities for peers to be part of an improved behavioral health system. Specifically, the waiver proposes to create and expand services which certified peer specialists play a role in providing (i.e. Clubhouse services, recovery support services). However, the District is not proposing the creation of a stand-alone peer support benefit or substantive changes to the scope of peer practice under the demonstration at this time.

Workforce Development/Specialty Training

Commenters urged exploration of training and workforce development programs to increase availability of skilled providers able to deliver culturally competent care in the District.

District Response

If approved, the demonstration's required annual behavioral health system assessments of gaps and services will help identify workforce needs that can be addressed in future policymaking. While there are no specific provisions in this phase of the demonstration that support workforce training or health IT improvements, there are a number of ongoing Medicaid-funded and District-led initiatives that address these needs, including some under the DBH-administered SOR grant, the DHCF-administered Health Information Exchange grants, DC Health's Prescription Drug Monitoring Program, DC Health's workforce incentive and loan repayment programs, and other local and federal grants. In addition, DBH hosts a series of routine meetings with behavioral health providers, which can be leveraged to communicate, educate, and provide technical assistance as needed. If the demonstration is approved, the District will continue to explore and consider existing mechanisms and other opportunities for additional support to ensure provider success in implementation.

Transition Services/Discharge Planning and Follow-Up After Discharge

Several commenters highlighted the need to improve the transition process for beneficiaries discharged from inpatient, residential, criminal justice, or other institutional settings. Commenters mentioned that programs and community benefits which provide support through various methods such as transitional housing, supportive housing services, integrated wellness programs, and other ancillary services should be included under the demonstration.

One commenter suggested the discharge requirements be more stringent. The commenter recommended the seventy-two (72) hour requirement for follow-up care required under the demonstration be shortened; providing that such a long lapse in time has a potential to result in a high number of relapses or potential overdoses.

District Response

Improved care coordination and transitions between levels of care is a milestone identified by CMS in SMD 17-003 and 18-011. Implementation of policies to ensure residential and inpatient facilities link beneficiaries with services and supports following stays in these facilities will be vital to the success of the demonstration.

In response to public comment, Section IV.B of the proposed demonstration was updated to include transition planning services under the scope of this demonstration program. The demonstration proposes to add Medicaid reimbursement for transition planning services provided by certain behavioral health providers for individuals with SMI and/or SUD being discharged into their care from an inpatient, residential, criminal justice, or other institutional setting. Enabling these providers to be part of plan development with the individual and the institution's treatment team promotes continuity of care and ensures that appropriate treatment services and supports are available and accessed after discharge in a timely manner.

SBIRT Service Definition

Commenters requested clarification on how reimbursement and codes for SBIRT under the demonstration will differ from the current SBIRT billing codes and reimbursement authorized under the State Plan.

District Response

The draft waiver application proposed a pilot to reimburse for SBIRT services in emergency departments of hospitals that participate in a SOR-funded MAT induction pilot, as well as eight trained primary care provider sites. After additional review in response to the comments, the District has determined that there is already sufficient authority under the District's Medicaid State Plan to reimburse emergency departments and primary care providers for SBIRT services. For this reason, the District is withdrawing the proposed pilot from the demonstration.

Scope of IMD Services

Commenters requested additional specificity on the scope of IMD services provided under the demonstration. Specifically, commenters asked for clarification of levels of care and lengths of stay covered under the demonstration.

District Response

In response to the interest in additional clarity on the scope of IMD services, the District amended Section IV.B of the demonstration application to include more information on covered levels of care. The demonstration proposes reimbursement for services associated with clinically appropriate, short term stays for acute care delivered in residential and inpatient treatment settings that qualify as IMDs to District of Columbia Medicaid beneficiaries with SUD and SMI/SED. Eligible IMD stays will be medically appropriate, short-term, acute stays. Reimbursement for long-term, residential stays is not being proposed under this demonstration. The District believes this scope of coverage proposed under this demonstration is aligned with the scope of coverage for IMD stays outlined by CMS in SMD 17-003 and 18-011. While the District is not proposing a cap on IMD length of stays, CMS guidance (SMD 17-003 and 18-011) requires a statewide average of no more than thirty (30) days for covered IMD stays. The District believes medically appropriate treatment of acute stays, in the aggregate, will average under thirty (30) days across eligible IMDs.

Continuum of Care

Commenters mentioned a number of services that the District should consider adding to the continuum of care, including: transitional housing services, targeted case management for individuals with SMI/SUD, integrated wellness programs, behavioral health crisis beds, and services designed that focus on prevention and early intervention, such as maternal and early childhood health services.

District Response

The District recognizes the need for a broader range of behavioral health benefits that would help address the social determinants of health that are cost drivers and contributing to poor health

outcomes. The District is seeking approval of transitional housing supports within recovery support services under the demonstration. The District is also seeking approval of additional behavioral health crisis services within the expanded CPEP and mobile crisis and outreach services proposed under the demonstration.

In response to public comment, the District is also proposing an amendment to Section IV.B to include Psychiatric Residential Crisis Stabilization services under the demonstration. The inclusion will add coverage for psychiatric residential crisis stabilization beds as a treatment alternative to psychiatric inpatient hospitalization. If the demonstration is approved, the District will continue to monitor implementation to determine whether other services or supports are needed to ensure the District's goals for the demonstration can be met.

Managed Care

Commenters highlighted the hurdles to integration of care and care coordination within the current siloed structure of the District's Medicaid benefit. A number of commenters indicated that behavioral health services should be carved in to managed care contracts. Specifically, commenters recommended the carve-in of mental health and substance use recovery treatment services to managed care contracts to allow for the promotion of more innovation and incentive-oriented value-based care models. Commenters also highlighted that carving behavioral health services into managed care contracts would improve the transitions of care and care coordination and allow a single entity to be accountable for health outcomes.

District Response

MCOs will play an important role in ensuring that beneficiaries have access to the full range of behavioral health services. MCOs will also be important partners in promoting community-based treatment, deterring unnecessary emergency room utilization or readmissions, and providing seamless transitions and follow up from emergency, inpatient, and residential care.

Through this demonstration, the District is seeking to address ongoing structural challenges and gaps to provide a more seamless experience of care, improve treatment rates and outcomes, and promote healthier lives for District residents. The District is taking a phased approach to addressing behavioral health system transformation. The next phase of the demonstration is intended to allow the District to consider broader reforms that may be needed to improve the Medicaid program and provider capacity. The District will continue to consider these and other recommended reforms as part of this process if the proposed demonstration is approved.

ASARS/MHRS Integration

Similarly, many additional comments were made regarding structural challenges posed by the division of SMI/SED treatment under MHRS from SUD treatment under ASARS. Commenters remarked that in considering health system redesign, DHCF should focus on providing flexible, patient-centered, accessible care in the community. Commenters suggested ASARS and MHRS systems be better integrated to address the current complexity and bifurcation of the District's Medicaid behavioral health system.

District Response

The rehabilitative services benefit the District established as MHRS/ASARS follows a model established under federal Medicaid guidance. DBH is already considering and working with DHCF to implement ways to expand and improve MHRS/ASARS services under the Medicaid State Plan on a separate parallel track. The second phase of demonstration development will provide more opportunity for stakeholder input on additional needed reforms to improve the range of and access to behavioral health services.

As mentioned above, the District is hoping to better integrate data-sharing between substance use disorder and mental health service providers. The District hopes to work with interested stakeholders to identify opportunities for data-sharing within the limitations of federal and District law.

Demonstration Evaluation

A number of commenters highlighted the opportunity to use the demonstration and its evaluation to assess and address historic challenges within the District behavioral health system.

Commenters also highlighted the importance of accurate baseline data regarding provider and service capacity, the current rate of overdose of Medicaid-eligible individuals, and current treatment adherence and retention rates to ensure accurate evaluation of the demonstration.

Commenters requested that DHCF evaluate the racial and cultural implications of how the District Medicaid program is administered and the impact on underserved populations.

District Response

Primarily, the evaluation will study whether the expenditure authority granted under this demonstration, in addition to other concurrent behavioral health delivery system enhancements and re-design efforts, results in increased access to health care services and improved health outcomes for individuals with SUD and SMI/SED. The District will work with an independent evaluator and CMS to finalize its evaluation plan as the demonstration moves into implementation.

The District also supports the need for accurate baseline data and the concept of baseline assessment is echoed in CMS guidance (SMD 17-003 and 18-011). The District has conducted an assessment of the availability of mental health services as part of the application and will provide annual assessments to measure progress from the baseline, if approved. Through these assessments, the District seeks to continue to improve its understanding of barriers to treatment in the behavioral health system.

D. Summary of Key Service Changes Following Public Notice of Draft Waiver Application

The District made a number of key changes to the proposed demonstration after review and consideration of public comments received.

- Crisis Stabilization: In response to public comment and ongoing structural reforms within DBH, the District proposes to change the rate methodology for some crisis services in order to more the appropriately account for and value the services. Also, in response to public comment, the District proposes to include psychiatric residential crisis stabilization services to the demonstration. The inclusion will add coverage for psychiatric residential crisis stabilization

beds as a treatment alternative to psychiatric inpatient hospitalization.

- Supported Employment: In response to provider inquiries regarding provider requirements, the proposed demonstration clarifies that supported employment services provided to individuals diagnosed with SUD will be piloted through two providers designated by DBH.

- Psychologist and LICSW Services: In response to public comment, the proposed demonstration was updated to also permit Medicaid reimbursement of services provided by Licensed Professional Counselors and Licensed Marriage and Family Therapists.

- Transition Planning Services: In response to public comment, the proposed demonstration was updated to include transition planning services under the scope of this demonstration program. This demonstration will enable certain behavioral health providers to participate in the discharge treatment planning process for individuals who are being discharged from an inpatient, residential, criminal justice, or other institutional setting. In October of 2018, the SUPPORT for Patients and Communities Act was signed into law.[19] Section 5032(b) of the SUPPORT Act requires the Secretary to issue guidance on how states can use Section 1115 demonstrations to improve health care transitions for individuals being released from prison or jail, including assistance with Medicaid enrollment and coverage of services thirty (30) days prior to release. The District looks forward to working with our federal partners to increase our ability to reconnect justice-involved individuals with the Medicaid health system prior to release.

- SUD Residential Services for Children and Youth: In the draft waiver application, the District proposed to add residential services for children and youth with SUD to District Medicaid's current coverage of psychiatric residential treatment facilities (PRTF) for children and youth with SED. Youth SUD residential is a covered State Plan benefit, though there is limited capacity among providers in the District. Because this is already a covered benefit, the District removed this proposal from the proposed demonstration. DHCF and DBH are instead considering other policy initiatives to increase capacity to provide residential treatment for children and youth with SUD in the District.

- SBIRT Pilot: The draft waiver application proposed a pilot to reimburse for SBIRT services in emergency departments of hospitals that participate in a SOR-funded MAT induction pilot, as well as eight trained primary care provider sites. Because the District believes it has sufficient authority under the District of Columbia Medicaid State Plan to reimburse emergency departments and primary care providers for SBIRT services, the District removed the proposed pilot from the demonstration.

Section IX – Demonstration Administration

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[19] P.L. 115-271, text available at: https://www.congress.gov/bill/115th-congress/house-bill/6

IMD Historical

Representative Data Year:	2018
Type of State Years:	State Fiscal

SUD IMD Services MCO	**2018**
TOTAL EXPENDITURES	$1,325,895
ELIGIBLE MEMBER MONTHS	826
PMPM COST	$1,605.20

SUD IMD Services FFS

TOTAL EXPENDITURES	$2,846,673
ELIGIBLE MEMBER MONTHS	1,221
PMPM COST	$2,331.43

SMI IMD Services MCO

TOTAL EXPENDITURES	$511,304
ELIGIBLE MEMBER MONTHS	50
PMPM COST	$10,226.07

SMI IMD Services FFS

TOTAL EXPENDITURES	$17,189,401
ELIGIBLE MEMBER MONTHS	2,227
PMPM COST	$7,718.64

Non-IMD Services CNOM MEG

TOTAL EXPENDITURES	$11,413,369
ELIGIBLE MEMBER MONTHS	56,124
PMPM COST	$203.36

Continue MEGs from Above, As Needed

						2018					
			Managed Care PMPM (Replicate Column, as Necessary)			Choose "Included" from Drop-Down(s) to Link Services with MEG(s)					
Alternate Development: IMD Services + Non-IMD & Non-Hypo CNOMs	Estimated Total Expenditures for Medical Assistance Provided in an IMD that are:					CURRENT State Plan Service(s)				NOT CURRENT State Plan Svc(s)	
IMD Services	Currently State Plan FFS (e.g. Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)	Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)	Capitated PMPM for Currently Approved, non-IMD, State Plan or Other Title XIX Services	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost for All Services Provided in an IMD	SUD IMD Services MCO	SUD IMD Services FFS	SMI IMD Services MCO	SMI IMD Services FFS	Non-IMD Services CNOM Limit MEG	Non-Hypothetical Services CNOM MEG
SUD Residential Treatment (MCO)		$1,325,895	$0	826	$1,605.20	Included					
SUD Residential Treatment (FFS)		$1,476,783	$0	920	$1,605.20		Included				
Detox (FFS)		$1,369,890	$0	301	$4,551.13		Included				
Psych Residential Treatment (St. E's) (MCO)		$120,828	$0	10	$12,082.81			Included			
Psych Residential Treatment (St. E's) (FFS)		$410,816	$0	34	$12,082.81				Included		
Other Psych Stays (MCO)		$390,476	$0	40	$9,761.89			Included			
Other Psych Stays (FFS)		$16,778,585	$0	2,193	$7,650.97				Included		
CPEP	$1,168,869	$1,414,292	$0	3,048	$847.49					Included	
Crisis Stabilization		$1,649,003	$0	3,443	$478.94					Included	
Mobile Crisis and Support Services		$1,447,700	$0	4,074	$355.35					Included	
Pre-Arrest Diversion		$17,754	$0	75	$236.72					Included	
Recovery Support Services		$355,271	$0	5,304	$66.98					Included	
Supported Employment		$56,887	$0	459	$123.94					Included	
Trauma Informed Care	$308,321	$1,237,424	$0	2,240	$690.06					Included	
Clubhouse		$612,750	$0	300	$2,042.50					Included	
Medication Assisted Therapy		$153,328	$0	27,276	$5.62					Included	
Psychologists and Social Worker Services		$428,817	$0	4,738	$90.51					Included	
Transition Services		$2,562,952	$0	496	$5,167.04					Included	
Totals	**$1,477,190**	**$31,809,450**		**55,777.02**		**$1,605.20**	**$6,156.33**	**$21,844.70**	**$19,733.79**	**$10,105.16**	**$0.00**

IMD Caseloads

Projected IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	2020	2021	2022	2023	2024
SUD IMD Services MCO	4.5%	902	942	984	1,029	1,075
SUD IMD Services FFS	3.1%	1,298	1,339	1,381	1,425	1,469
SMI IMD Services MCO	4.5%	54	57	59	62	65
SMI IMD Services FFS	3.1%	2,369	2,443	2,520	2,599	2,681
Non-IMD Services CNOM Limit MEG	4.2%	60,913	63,459	66,111	68,873	71,751
Non-Hypothetical Services CNOM MEG			0	0	0	0

IMD With Waiver

ELIGIBILITY GROUP	LAST HISTORIC YEAR	PB TREND RATE	DEMONSTRATION YEARS (DY) 2020	2021	2022	2023	2024	TOTAL WW
SUD IMD Services MCO								
Eligible Member Months			902	942	984	1,029	1,075	
PMPM Cost	$ 1,605	3.0%	$ 1,690	$ 1,741	$ 1,793	$ 1,847	$ 1,903	
Total Expenditure			$ 1,524,289	$ 1,640,461	$ 1,765,485	$ 1,900,041	$ 2,044,848	$ 8,875,125
SUD IMD Services FFS								
Eligible Member Months			1,298	1,339	1,381	1,425	1,469	
PMPM Cost	$ 2,331	3.0%	$ 2,455	$ 2,529	$ 2,605	$ 2,683	$ 2,763	
Total Expenditure			$ 3,188,045	$ 3,386,680	$ 3,597,691	$ 3,821,841	$ 4,059,964	$ 18,054,221
SMI IMD Services MCO								
Eligible Member Months			54	57	59	62	65	
PMPM Cost	$ 10,226	3.0%	$ 10,769	$ 11,092	$ 11,425	$ 11,768	$ 12,121	
Total Expenditure			$ 585,113	$ 629,707	$ 677,700	$ 729,351	$ 784,939	$ 3,406,811
SMI IMD Services FFS								
Eligible Member Months			2,369	2,443	2,520	2,599	2,681	
PMPM Cost	$ 7,719	0.0%	$ 8,128	$ 8,372	$ 8,623	$ 8,882	$ 9,149	
Total Expenditure			$ 19,256,547	$ 20,456,311	$ 21,730,837	$ 23,084,759	$ 24,523,034	$ 109,051,488

Continue MEGs from Above, As Needed

Non-IMD Services CNOM Limit MEG

Eligible Member Months			60,913	63,459	66,111	68,873	71,751	
PMPM Cost	$ 203	3.0%	$ 214	$ 221	$ 227	$ 234	$ 241	
Total Expenditure			$ 13,045,207	$ 13,997,752	$ 15,020,349	$ 16,117,743	$ 17,294,974	$ 75,476,025

Main Budget Neutrality Test (i.e. NOT Hypothetical)

Non-Hypothetical Services CNOM MEG

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Eligible Member Months	n.a.	n.a.	n.a.	$ -	$ -	$ -	$ -	$ -	
PMPM Cost	3.0%		$ -	$ -	$ -	$ -	$ -	$ -	
Total Expenditure				$ -	$ -	$ -	$ -	$ -	$ -

IMD Without Waiver

PB Trend Rate(s) Used:

SUD IMD Services MCO	3.00%
SUD IMD Services FFS	3.00%
SMI IMD Services MCO	3.00%
SMI IMD Services FFS	3.00%
Non-IMD Services CNOM Limit MEG	3.00%

Start DY

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) 2020	2021	2022	2023	2024	TOTAL WOW
SUD IMD Services MCO									
Eligible Member Months	n.a.	n.a.	826	902	942	984	1,029	1,075	
PMPM Cost	3.0%	21	$ 1,605	$ 1,690	$ 1,741	$ 1,793	$ 1,847	$ 1,903	
Total Expenditure			$1,325,895	$ 1,524,289	$ 1,640,461	$ 1,765,485	$ 1,900,041	$ 2,044,848	$ 8,875,125
SUD IMD Services FFS									
Eligible Member Months	n.a.	n.a.	1221	1,298	1,339	1,381	1,425	1,469	
PMPM Cost	3.0%	21	$ 2,331	$ 2,455	$ 2,529	$ 2,605	$ 2,683	$ 2,763	
Total Expenditure			$2,846,673	$ 3,188,045	$ 3,386,680	$ 3,597,691	$ 3,821,841	$ 4,059,964	$ 18,054,221
SMI IMD Services MCO									
Eligible Member Months	n.a.	n.a.	50	54	57	59	62	65	
PMPM Cost	3.0%	21	$ 10,226	$ 10,769	$ 11,092	$ 11,425	$ 11,768	$ 12,121	
Total Expenditure			$511,304	$ 585,113	$ 629,707	$ 677,700	$ 729,351	$ 784,939	$ 3,406,811
SMI IMD Services FFS									
Eligible Member Months	n.a.	n.a.	2,227	2,369	2,443	2,520	2,599	2,681	
PMPM Cost	3.0%	21	$ 7,719	$ 8,128	$ 8,372	$ 8,623	$ 8,882	$ 9,149	
Total Expenditure			$17,189,401	$ 19,256,547	$ 20,456,311	$ 21,730,837	$ 23,084,759	$ 24,523,034	$ 109,051,488
Non-IMD Services CNOM Limit MEG									
Eligible Member Months	n.a.	n.a.	56,124	60,913	63,459	66,111	68,873	71,751	
PMPM Cost	3.0%	21	$ 203	$ 214	$ 221	$ 227	$ 234	$ 241	
Total Expenditure			$11,413,369	$ 13,045,207	$ 13,997,752	$ 15,020,349	$ 16,117,743	$ 17,294,974	$ 75,476,025

Estimated Growth Rates per MEG

SUD IMD Services MCO	17.42%
SUD IMD Services FFS	16.39%
SMI IMD Services MCO	18.53%
SMI IMD Services FFS	4.31%
Non-IMD Services CNOM Limit MEG	PB Trend

IMD Summary

Supplemetal Test #1: IMD Services Cost Limit
Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD Services MCO	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644

With-Waiver Total Expenditures

	2020	2021	2022	2023	2024	TOTAL
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD Services MCO	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644
Net Overspend	$0	$0	$0	$0	$0	$0

Supplemental Test #2: Non-IMD Services CNOM Limit
Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025

With-Waiver Total Expenditures

	2020	2021	2022	2023	2024	TOTAL
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
Net Overspend	$0	$0	$0	$0	$0	$0

Main Budget Neutrality Test (i.e. NOT Hypothetical)
With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

MEGs	Trend Rate	2020	2021	2022	2023	2024
SUD IMD Services MCO	3.0%	$1,690	$1,741	$1,793	$1,847	$1,903
SUD IMD Services FFS	3.0%	$2,455	$2,529	$2,605	$2,683	$2,763
SMI IMD Services MCO	3.0%	$10,769	$11,092	$11,425	$11,768	$12,121
SMI IMD Services FFS	3.0%	$8,128	$8,372	$8,623	$8,882	$9,149
Non-IMD Services CNOM Limit MEG	3.0%	$214	$221	$227	$234	$241
Main Test: With Waiver "Coster(s)" (Amendments Only)						
Non-Hypothetical Services CNOM MEG	3.0%	$0	$0	$0	$0	$0

	Fiscal Year 2018			Fiscal Year 2019 (Est)			Fiscal Year 2020 (Est)			
SUD IMD MCO										
Service	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Comments**
Res Treatment	826	1,325,895	1,605.20	863	1,426,845	1,653	902	1,536,066	1,703	Member months calculated by multiplying beneficiaries by 2. ALOS was 20 days so monthly overlap assumed. Did not assume MCOs cover 1st 15 days for this service.
Detox										MCOs cover up to 15 days so no demonstration impact.
Total SUD IMD MCO	826	1,325,895	1,605.20	863	1,426,845	1,653.36	902	1,536,066	1,702.96	
SUD IMD FFS										
Service	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	
Res Treatment	920	1,476,783	1,605.20	949	1,569,034	1,653	979	1,667,194	1,703	Member months calculated by multiplying beneficiaries by 2. ALOS was 20 days so monthly overlap assumed. See SUD - DBH Res Treatment tab for methdology.
Detox	301	1,369,890	4,551.13	310	1,453,175	4,688	320	1,545,053	4,828	Assumed 1 member month per beneficiary based on ALOS. Member months equal episodes less withdrawal management FFS stays.
Total SUD IMD FFS	1,221	2,846,673	2,331.43	1,259	3,022,209	2,400.48	1,299	3,212,247	2,472.86	
SMI IMD MCO										
Service	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	
Psych Hospitalization	40	390,476	9,761.89	42	422,299	10,055	44	455,681	10,356	Inpatient psych stays in excess of 15 days. 1st 15 days covered by MCOs. 2 member months per beneficiary based on ALOS.
Psych Residential Treatment	10	120,828	12,082.81	10	124,453	12,445	10	128,187	12,819	Split out beneficiaries based on crosswalk between DBH and DHCF data. Ratios used to determine FFS and MCO proportions. Member months equal beneficiary count multiplied by 2 based on average length of stay.
Total SMI IMD MCO	50	511,304	10,226.07	52	546,752	10,514.47	54	583,868	10,812.36	
SMI IMD FFS										
Service	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	
Psych Hospitalization	2,193	16,778,585	7,650.97	2,262	17,825,697	7,881	2,333	18,936,769	8,117	Member months equal to total number of episodes based on average length of stay. Non-IMD psych hospitalization data. Assumption is these stays will shift to IMD hospitals with approval of demonstration. Split out beneficiaries based on crosswalk between DBH and DHCF data. Ratios used to determine FFS and MCO proportions. Member months equal beneficiary count multiplied by 2 based on average length of stay.
Psych Residential Treatment	34	410,816	12,082.81	35	435,585	12,445	36	461,472	12,819	
Total SMI IMD FFS	2,227	17,189,401	7,718.64	2,297	18,261,283	7,950.06	2,369	19,398,241	8,188.37	
Non-IMD Services Blended										
Service	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	**Member Months**	**Expenditures**	**PMPM**	
CPEP	3,048	2,583,162	847.49	3,175	2,771,517	873	3,308	2,974,244	899	Includes traditional CPEP as well as withdrawal management. CPEP rate of $240 per hour up to 4 hours then per diem rate of $1095 kicks in. Withdrawal management offsets Detox in SUD IMD FFS MEG.
Clubhouse	300	612,750	2,042.50	313	658,482	2,104	326	706,406	2,167	$95 per day per beneficiary. Scheduled to begin with the start of this waiver in January 2020.
Medication Assisted Therapy	27,276	153,328	5.62	28,416	164,528	6	29,603	176,543	6	Waives the current $1 copay requirement.
Mobile Crisis & Outreach Services	4,074	1,447,700	355.35	4,244	1,553,353	366	4,421	1,666,681	377	
Pre-Arrest Diversion	75	17,754	236.72	78	19,018	244	81	20,342	251	Though listed as 2 separate services, pre-arrest diversion is a benefit billed under mobile crisis and outreach. The integrated community crisis response team (ICCRT) will provide all these services.
Psychologist , Licensed Clinical Social Workers, and Affiliated Providers	4,738	428,817	90.51	4,936	460,139	93	5,142	493,723	96	Allows the identified providers to bill independently. This will only be allowable for SUD/SMI/SED beneficiaries. MCOs already paying for this benefit.
Recovery Support Services	5,304	355,271	66.98	5,526	381,245	69	5,757	409,097	71	

Supported Employment	459	56,887	123.94	478	61,019	128	498	65,479	131	Extends therapeutic and rehabilitative employment supports to the SUD population, while also building in vocational supports for the SUD and SMI populations.
Trauma Informed Care	2,240	1,545,745	690.06	2,334	1,658,929	711	2,432	1,780,442	732	Increases rate for Trauma Recovery Empowerment Model as well as Trauma Systems Therapy. Adds Cognitive Behavioral Therapy and Child-Parent Psychotherapy.
Transition Services	5,167	2,562,952	496.02	5,383	2,750,173	511	5,608	2,951,079	526	Allows for transition planning within 60 days of release from jail and 30 days of release from inpatient or residential setting. Incarcerated population data pulled from DHCF data and residential data pulled from detox , res treatment, and psych hospitalization data. SED data pulled from MDW information utilized for Psycholgists service above.
Crisis Stabilization	3,443	1,649,003	478.94	3,587	1,769,510	493	3,737	1,898,812	508	
Total Non-IMD Services Blended	56,124	11,413,369	203.36	58,470	12,247,914	209.47	60,913	13,142,849	215.76	
Total Waiver Expenditures		**33,286,641**			**35,505,004**	**6.66%**		**37,873,271**	**6.67%**	

Notes and Assumptions

1. IMD services are broken down into 2 groups, SMI (group 1) and SUD (group 2)
2. Non-IMD Services are broken out individually
3. Red Tabs are for SUD IMD Services
4. Salmon Tabs are for SMI IMD Services
5. Blue Tabs are for Non-IMD Services
6. Did not use CAP rates since all services addressed in this demonstration are outside of MCO coverage

Explanation of Estimates

CPEP

	FY16	FY17	FY18	FY19	FY20	2018	
Comprehensive Psychiatric Emergency Beneficiaries			1380				
Withdrawal Management Beneficiaries			288			Medicaid Member Months	3,048
Total Beneficiaries			**1,668**			Medicaid Expenditures	2,583,162
Comprehensive Psychiatric Emergency Beneficiaries			855,679			CPEP PMPM	847.49
Withdrawal Management Beneficiaries			1,727,482				
Total Expenditures			**2,583,161.70**				17.3%

Expenditures based on data provided from DBH displayed on "Beh Health Back-Up" tab. Estimated Medicaid population 95% based on DBH experience. Applied FY20 projection to FY18 to get added to Historical Baseline for inclusion in the waiver projections. Inflated beneficaires and expenditures by 36% to account for increase to 15 beds from 11.

Assumed hourly rate of $240 per hour for episodes under 4 hours, $1,095 per diem rate for longer episodes.

Mobile Crisis & Outreach

Mobile Crisis Services S9484(MC)	FY16	FY17	FY18	FY19	FY20		
15 Minute Units	71,209	67,913	104,784		6,500	Medicaid Member Months	2,724.00
Unique Beneficiaries	2,411	2,480	2,795		3,630	Medicaid Expenditures	1,154,646
Medicaid Beneficiaries	2,170	2,232	2,516		2,724	MCS PMPM	423.88
Total Expenditures	4,214,149	4,019,091	6,201,117		1,538,680		
Medicaid Expenditures	3,792,908.55	3,617,182.21	5,582,114.73		1,154,645.82		

Mobile Support Services (H0023)	FY16	FY17	FY18	FY19	FY20		
Recommended Rate	203.51					Medicaid Member Months	1,350.00
Unique Beneficiaries	853	1,110	1,321		450	Medicaid Expenditures	293,054
Medicaid Beneficiaries	256	333	396		270	MCS PMPM	217.08
Total Expenditures	173,594.03	225,896.10	268,836.71		488,424.00		5.00
Medicaid Expenditures	52,078.21	67,768.83	80,651.01		293,054.40		

	106,584.80		
	(28,564.73)		
	(57,768.96)		

Pre-Arrest Diversion

Beneficiaries			75				
Expenditures			$17,754.00				
Member Months			75				
PMPM			$236.72				

Recovery Support Services

	16	18	17	19	20		
Unique Beneficiaries	667	365	1,767	1,841	1,918	Medicaid Member Months	5304
Medicaid Beneficiaries	501	274	1,326	1,381	1,439	Medicaid Expenditures	355,271
Total Expenditures	473,426	370,233	1,158,652	493,210	513,820.62	RSS PMPM	66.98
Medicaid Expenditures	355,270.73	277,928.54	870,291.76	370,006.70	385,546.44		

Due to belief there is unmet need for RSS services, used the FY17 figures as the starting point for estmate. Part of the drop in clients is related to the ATR III grant ending. Assumed 75% of projected beneficiaries are Medicaid based on FY18 CPEP total users provided in write up from DBH vs CPEP users in DHCF MDW (2547/3395).
Enrollment and expenditures grown by blended MCO/FFS growth rate on enrollment tab.

Supported Employment

Therapeutic	FY16	FY17	FY18	FY19	FY20		
SMI Beneficiaries	287	143	128	134	140	Medicaid Member Months	459
Current Medicaid Covered Expenditures	51,152	20,803	24,044	25,171.19	26,298.26	Medicaid Expenditures	56,887
Estimated SUD Beneficiaries			39	41	43	Supported Empl PMPM	123.94
Estimated SUD Beneficiary Medicaid Cost			7,326	7,702	8,077		
Vocational Services Cost						Vocational Cost per Person	81.34
Vocational Services Beneficiaries (SMI)	152	85	92	96	101	Vocational Member Month	3
Vocational Services Cost SMI	13,563	5,875	7,321	7,808.27	8,214.95		
Estimated SUD Beneficiaries			21	22	23	RSA Cost per Bene	1931.84
Estimated SUD Beneficiary Medicaid Cost			1,671	1,789	1,871	RSA Member Months	2
RSA							
RSA SMI Beneficiaries (assumed same population as Vocational)	152	85	92			SUD % for Therapeutic	1.31%
RSA SMI Beneficiary Cost	293,639.68	164,206.40	177,729.28				
Estimated SUD RSA Beneficiaries			21	22	23		
RSA Expenditures			40,569	41,786	43,039		

Clubhouse

	FY18	FY19	FY20		
Medicaid Benes	25	25	25	Medicaid Member Months	300
Expenditures	$612,750.00	$612,750.00	$612,750.00	Medicaid Expenditures	612,750
				Supported Empl PMPM	2,042.50

Psychologists and LICSWs for Medicaid or SMI/SUD/SED Beneficiaries

Provider Type	**Number of Claims**	**Number of Mbrs**	**MCO Paid Amount**	**% of Mbrs**	**Cost/Bene**	FY18 Enrollment
Psychologists	1,804	272	$166,658.03	0.14%	$612.71	191,451
Licenced Clinical Professional Counselor	3,486	600	$376,941.31	0.31%	$628.24	
LICSW	6,515	675	$572,429.86	0.35%	$848.04	
Licensed Marriage and Family Therapist	174	47	$10,208.20	0.02%	$217.20	
Totals	**11,979**	**1,594**	**$1,126,237.40**	**0.83%**	**$706.55**	

	Beneficiaries	Cost per Bene	Cost per Provider	Claims per Bene	MM Factor	Member Months
FY18 FFS Enrollment	72,897					
Psychologists	104	$612.71	$63,722.19	7	7	728
Licenced Clinical Professional Counselor	228	$628.24	$143,237.70	6	6	1,368
LICSW	257	$848.04	$217,947.37	10	10	2,570
Licensed Marriage and Family Therapist	18	$217.20	$3,909.52	4	4	72
Estimated FY18 Cost	$428,817		658.8057747			
FY18 Member Months	4,738					

FY18 PMPM	$90.51	
Medication Assisted Therapy		
FY18		
Beneficiaries	2,723	2955.400535
Member Months	27,276	
Expenditures	$153,328.00	
PMPM	$5.62	
Trauma Informed Care		
FY20 Estimates		
Beneficiaries	270	293.0437548
Expenditures	1,545,744.60	
Member Months	2,240	
PMPM	690.06	
Transition Services		
Beneficiaries	5,167	5608.036775
Expenditures	$2,562,952.44	
Member Months	5,167	
PMPM	$496.02	
Crisis Stabilization		
Beneficiaries	462	501.4304249
Expenditures	$1,649,003.40	
Member Months	3,443	
PMPM	$478.94	

Section 1115 Medicaid Waiver - Behavioral Health Service 2019

SUD RESIDENTIAL TREATMENT (age 21 - 64)
DBH Data Source

SUD Residential Treatment - Patients with Medicaid IDs

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total Spending
FY2014	426	10,387	569	18	1	46	$ 2,069,961
FY2015	460	11,429	681	17	1	54	$ 1,803,113
FY2016	721	20,795	1,057	20	1	147	$ 3,363,159
FY2017	869	25,924	1,325	20	1	113	$ 4,389,422
FY2018	873	27,648	1,394	20	1	195	$ 4,818,217

Room and Board	Revised Spending	FFS Benes	FFS Expenditures	MCO Benes	MCO Expenditures	Person Month Factor	FFS Member Months	FFS PMPM	MCO Member Months	MCO PMPM	Growth Rate	
757,212.30	1,312,748.83	224	690,271.69	202	622,477.14	2	448	1,540.79	404	1540.79		
833,174.10	969,939.08	242	510,272.30	218	459,666.78	2	484	1,054.28	436	1054.28	2,108.56	
1,515,955.50	1,847,203.04	380	973,560.55	341	873,642.49	2	760	1,281.00	682	1281.00	2,562.00	0.215046066
1,889,859.60	2,499,562.10	458	1,317,375.65	411	1,182,186.45	2	916	1,438.18	822	1438.18	2,876.37	0.122702745
2,015,539.20	2,802,677.75	460	1,476,783.24	413	1,325,894.51	2	920	1,605.20	826	1605.20	3,210.40	0.116129964

1101.835122
52.26% 3 year total growth
17.42% annualized growth

NOTE: Data were retrieved from DBH Data 02/27/19
Providers include: Salvation Army, Holy Comforter St. Cyprian, Samaritan Inns, Federal City Recovery, Clean and Sober, Safehaven Outreach Ministry, RAP, PIW.
True IMD*

IMD Codes and Their Prices. Note: The (CHP 23) Codes are Detox and the Others are SUD Residential

Cost	IMD Codes	Description
$40.04	H0006/V9	(Ch23) Case Management (High Risk)-
$605.00	H0010/UD	(Ch23) Detoxification Residential Acute care-
$85.00	H0002/HF/UD	(Ch23) Behavioral Health Screening - Determine Eligibility-
$140.00	H0002/TG/UD	(Ch23) Behavioral Health Screening- Evaluate Risk Rating-
$26.60	H2027/HQ	Counseling-Group Psycho-Educational-
$32.00	H0005	Counseling group-
$72.90	H0043	Residential Treatment-Long Term Room & Board-
$8.80	H0048/LR	Urinalysis Collection-
$79.26	H0004/HF	Counseling Individual On-Site, Behavioral Health Therapy-
$44.65	H0016	Medication Management Adult-
$73.86	H0007/HF	Crisis Intervention-
$256.02	H0001	Diagnostic Assessment Comprehensive Adult-
$26.60	H2027/HQ/HF	Counseling-Group Psycho-Educational (HIV)-
$85.34	H0001/TS	Diagnostic Assessment, Brief, Modify Tx Plan-
$43.94	H0006/HK/HF	Case Management HIV-

DETOX at PIW (FFS or uninsured) (age 21 - 64)
DBH Data Source

Medicaid Per Diem 1,060.19

Detox - Patients with Medicaid IDs

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total Spending
FY2014	167	634	195	3	1	6	439,143
FY2015	165	719	203	4	1	7	$ 558,728
FY2016	159	835	229	4	1	8	$ 655,675
FY2017	97	466	125	4	1	7	$ 392,999
FY2018	260	1,674	364	5	1	9	$ 1,045,986

Episodes/Bene	Per Diem		DBH Per Diem	Ancillary	Medicaid Per Diem	MPD w/ Ancillary	Proj Medicaid Exp	Person Month Factor	Member Months	PMPM	Growth Rate
1.17		692.65	605.00	87.65	1,060.19	1,147.85	727,734.30	1	195	3,731.97	2,629.60
1.23		777.09	605.00	172.09	1,060.19	1,232.28	886,010.15	1	203	4,364.58	3,386.23
1.44		785.24	605.00	180.24	1,060.19	1,240.43	1,035,759.27	1	229	4,522.97	4,123.74
1.29		843.35	605.00	238.35	1,060.19	1,298.54	605,117.99	1	125	4,840.94	4,051.54
1.40		624.84	605.00	19.84	1,060.19	1,080.03	1,807,976.06	1	364	4,966.97	4,023.02
											$1,393.42
		57.85%									52.99%
											13.25%

NOTE: Data were retrieved from DBH Data 02/27/19
Providers include: PIW only.
True IMD*
Need to have an edit created to ensure PIW does not bill as a specialty hospital claim for these waiver services

DETOX (age 21 - 64) at PIW, MCO only
DHCF (MMIS) Data Source

Detox - MCO Encounter Claims

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total MCO Encounter Spending	Episodes/Bene	
FY2014	455	2,401	583	4	1	9	$ 1,311,337		546.1628238
FY2015	471	2,975	632	5	1	23	$ 1,759,053		591.2783361
FY2016	463	2,804	602	5	2	11	$ 1,714,101		611.3057275
FY2017	532	4,080	767	5	2	13	$ 2,633,482		645.4613775
FY2018	618	4,921	823	6	1	22	$ 3,192,761	1.33171521	648.8032514

Detox - MCO Encounter Claims with over 15 days of stay

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total MCO Encounter Spending
FY2014							
FY2015	1	23	1	23	23	23	$ 18,325
FY2016							
FY2017							
FY2018	1	22	1	22	22	22	$ 3,566

NOTE: Data were extracted from DC MMIS 02/27/19
Detox stays were captured using revenue codes 0116, 0126, 0136, 0156.
True IMD*

ST ELIZABETHS - PSYCH RESIDENTIAL TREATMENT

St. Elizabeths - Patients with Medicaid IDs with under 60 days stay

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total Spending
FY2014							
FY2015	67	1,797	77	23	1	58	$ 1,619,097
FY2016	36	781	37	21	1	55	$ 735,702
FY2017	27	606	27	22	1	58	$ 570,852
FY2018	22	552	22	25	1	58	$ 682,272

Episodes/Bene	Per Diem	Per Diem Growth	Person Month Factor	FFS Benes	FFS Expenditures	MCO Benes	MCO Expenditures	Growth Rate
1.15	901.00		2.00	53	1,280,778	14	338,319	24,165.63
1.03	942.00	4.6%	2.00	29	700,803	7	169,159	20,436.17
1.00	942.00	0.0%	2.00	21	507,478	6	144,994	21,142.67
1.00	1,236.00	31.2%	2.00	17	410,816	5	120,828	31,012.36
								6,846.74
								28.33%
								9.44%

NOTE: Data were retrieved from DBH Data 02/27/19
St. Elizabeth provided IMD stay for Medicaid beneficiaries

OTHER PSYCH STAYS (age 21 - 64)
DHCF (MMIS) Data Source

Other Psych stay - MCO Encounter Claims with over 15 days of stay (PIW)

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total MCO Encounter Spending
FY2014	7	174	8	22	16	35	$ 74,925
FY2015	31	792	34	23	16	74	$ 587,418
FY2016	22	554	25	22	16	43	$ 373,090
FY2017	15	530	19	28	16	58	$ 385,870
FY2018	20	485	21	23	16	40	$ 390,476

Episodes/Bene	Per Diem	Person Month Factor	Member Months	Expenditures	PMPM	Growth Rates
1.14	430.6034483	1	7	$ 74,925	$ 10,703.57	$10,703.57
1.10	741.6887626	2	62	$ 587,418	$ 9,474.48	$18,948.95
1.14	673.4476534	1	22	$ 373,090	$ 16,958.64	$16,958.64
1.27	728.0566038	2	30	$ 385,870	$ 12,862.33	$25,724.67
1.05	805.1043093	2	40	$ 390,476	$ 9,761.89	$19,523.78
						$8,820.21
						82.40%
						20.60%

Other Psych stay - FFS Claims (Non-PIW)

	Number of Medicaid Beneficiaries	Total Number of days	Total number of episodes of care	Average length of stay	min_length of stay	max_lenth of stay	Total Spending
FY2014	1,621	27,757	2,891	10	2	1,572	$ 18,909,027
FY2015	1,641	23,237	2,834	8	2	647	$ 19,357,473
FY2016	1,483	20,494	2,608	8	2	195	$ 20,506,279
FY2017	1,363	18,919	2,541	7	1	124	$ 19,928,164
FY2018	1,230	15,826	2,193	7	2	132	$ 16,778,585

Episodes/Bene	Per Diem	Person Month Factor	Member Months	Expenditures	PMPM	Growth Rates
1.78	681.2345311	1	2891	$ 18,909,027	$ 6,540.65	11,665.04
1.73	833.0452705	1	2834	$ 19,357,473	$ 6,830.44	11,796.14
1.76	1000.599175	1	2608	$ 20,506,279	$ 7,862.84	13,827.57
1.86	1053.341312	1	2541	$ 19,928,164	$ 7,842.65	14,620.81
1.78	1060.191146	1	2193	$ 16,778,585	$ 7,650.97	13,641.13
						1,976.09
						16.94%
						4.24%

Geographic Distribution	Beneficiaries									
	Adult			Under 21			Total			
Geographic designation	Number of Medicaid beneficiaries (Adult)	Number of Medicaid beneficiaries with SMI (Adult)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (Under 21)	Number of Medicaid beneficiaries with SED (Under 21)	Percent with SED (Under 21)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)	Beneficiary Category Notes
1. District of Columbia	166270	28653	17%	97811	3377	3%	264081	32030	12%	
2.			-			-	0	0	-	
3.			-			-	0	0	-	
4.			-			-	0	0	-	
5.			-			-	0	0	-	
6.			-			-	0	0	-	
7.			-			-	0	0	-	
8.			-			-	0	0	-	
9.			-			-	0	0	-	
10.			-			-	0	0	-	Data on beneficiaries was pulled from the District's MMIS
Total	**166270**	**28653**	**17%**	**97811**	**3377**	**3%**	**264081**	**32030**	**12%**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Providers							
	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe							
Geographic designation	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Total Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatrists or Other Prescribers	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes	Number of Other Types of Practitioners Authorized to Treat Mental Illness
1. District of Columbia	n//a	360	175	0.011239463	-	0.486111111	This includes Advanced Practice Registered Nurses in psychiatric practice and psychiatrists. Most mental health services are delivered under the Mental Health Rehabilitative Services (MHRS) benefit, which is targeted for individuals with SMI. Some services rendered by APRNs and psychiatrists through MHRS providers are allowable under the MHRS benefit, but the work of psychiatrists and APRNs in those MHRS settings will be reflected in "Other Practitioners Authorized to Treat Mental Illness". There are 315 psychiatrists and 45 APRNs with a psychiatric specialty. We used 'Medicaid-enrolled and who wrote a prescription for a Medicaid beneficiary in FY 18 and FY 19' as a proxy for accepting new Medicaid patients.	n/a
2.				-	-	-		
3.				-	-	-		
4.				-	-	-		
5.				-	-	-		
6.				-	-	-		
7.				-	-	-		
8.				-	-	-		
9.				-	-	-		
10.				-	-	-		
Total	**0**	**360**	**175**	**0.011239463**	**-**	**0.486111111**		**0**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Providers					
	Other Practitioners Authorized to Treat Mental Illness					
	Geographic designation	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness	Number of Medicaid-Enrolled Other Types of Practitioners Authorized to Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Medicaid Beneficiaries with SMI/ SED	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness to Total Practitioners Authorized to Treat Mental Illness	Ratio of Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness Accepting New Patients to Medicaid-Enrolled Practitioners Authorized to Treat Mental Illness	Other Practitioner Category Notes
1.	District of Columbia	48	48	0.001498595	-	1	This reflects how many providers were certified to deliver MHRS services as of May 2019. Though MHRS providers provide various levels of service and treat varying numbers of Medicaid patients, MHRS providers are responsible for many Medicaid beneficiaries' mental health needs. We feel that this category will imply an undercount the number of providers, as each MHRS provider will have multiple individual clinicians and other practitioners treating mental illness. However, it does provide an accurate count of the clinics available through the DBH-certified MHRS provider network to individuals with SMI.
2.				-	-	-	
3.				-	-	-	
4.				-	-	-	
5.				-	-	-	
6.				-	-	-	
7.				-	-	-	
8.				-	-	-	
9.				-	-	-	
10.				-	-	-	
	Total	**48**	**48**	**0.001498595**	**-**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Community Mental Health Centers

	Geographic designation	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled CMHCs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled CMHCs to Total CMHCs	Ratio of Medicaid-Enrolled CMHCs Accepting New Patients to Medicaid-Enrolled CMHCs	CMHC Category Notes
1.	District of Columbia	61	61	n/a	0.001904465	1	-	We defined Community Mental Health Centers as being either Core Service Agencies (CSAs) or Freestanding Mental Health Clinics (FSMHCs). CSAs are certified as points of entry for MHRS services and as quality service providers. FSMHCs are a specific provider type and provide a subset of outpatient mental health services to DHCF beneficiaries. There are 28 FSMHCs and 53 CSAs, with 18 facilities overlapping. There is significant overlap between this category and the "Medicaid-Enrolled Providers Authorized to Treat Mental Illness" section because many CSAs are MHRS
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**61**	**61**	**0**	**0.001904465**	**1**	**0**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Intensive Outpatient or Partial Hospitalization Providers						
	Geographic designation	Number of Intensive Outpatient/Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers to Total Partial Hospitalization/Day Treatment Providers	Ratio of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients to Medicaid-Enrolled Partial Hospitalization/Day Treatment Providers	Intensive Outpatient/Partial Hospitalization Category Notes
1.	District of Columbia	n/a	10	10	0.000312207	-	1	This is a subset of providers covered in Providers Authorized to Treat Mental Illness. Intensive Outpatient was defined as day rehabilitation services in MHRS and there are 10 providers. Partial hospitalization was defined as intensive day services in MHRS and is covered under MHRS, but no providers are currently delivering this service.
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	
	Total	**0**	**10**	**10**	**0.000312207**	**-**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution

Residential Mental Health Treatment Facilities

Residential Mental Health Treatment Facilities (Adult)

	Geographic designation	Number of Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) to Total Residential Treatment Facilities (Adult)	Ratio of Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) Accepting New Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult)
1.	District of Columbia	2	1	1	3.12207E-05	0.5	1
2.					-	-	-
3.					-	-	-
4.					-	-	-
5.					-	-	-
6.					-	-	-
7.					-	-	-
8.					-	-	-
9.					-	-	-
10.					-	-	-
	Total	**2**	**1**	**1**	**3.12207E-05**	**0.5**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Residential Mental Health Treatment Facilities					
	Residential Mental Health Treatment Facilities (Adult)					
Geographic designation	Total Number of Residential Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds (Adult)	Total Number of Medicaid-Enrolled Residential Treatment Beds Accepting New Adult Medicaid Patients	Number of Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients
1. District of Columbia	313	313	313	2	2	2
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total	**313**	**313**	**313**	**2**	**2**	**2**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Residential Mental Health Treatment Facilities						
	Residential Mental Health Treatment Facilities (Adult)						
Geographic designation	Ratio of Medicaid-Enrolled Residential Treatment Beds to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Beds to Total Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Beds Accepting New Medicaid Patients to Medicaid-Enrolled Residential Treatment Beds	Ratio of Medicaid-Enrolled Residential Treatment Facilities that Qualify as IMDs to Medicaid Beneficiaries with SMI (Adult)	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs to Total Residential Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients to Medicaid-Enrolled Residential Treatment Facilities (Adult) that Qualify as IMDs	Residential Treatment Facility Category Notes (Adult)
1. District of Columbia	0.010923813	1	1	6.98007E-05	1	1	The Psychiatric Institute of Washington provides psychiatric treatment at its hospital, with 58 beds dedicated to mental health patients and 15 beds available on a "flex" basis. St. Elizabeths is the public psychiatric hospital, with 240 beds. While most of those beds are used for long-term stays or court-ordered supervision, some are available to patients with more acute mental health needs. There are no PRTFs in
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**0.010923813**	**1**	**1**	**6.98007E-05**	**1**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Residential Mental Health Treatment Facilities					
	Psychiatric Residential Treatment Facilities					
Geographic designation	Number of Psychiatric Residential Treatment Facilities (PRTF) (Under 21)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PTRFs to Medicaid Beneficiaries with SED (Under 21)	Ratio of Medicaid-Enrolled PRTFs to Total PTRFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs
1. District of Columbia	0	22	22	0.006514658	-	1
2.				-	-	-
3.				-	-	-
4.				-	-	-
5.				-	-	-
6.				-	-	-
7.				-	-	-
8.				-	-	-
9.				-	-	-
10.				-	-	-
Total	**0**	**22**	**22**	**0.006514658**	**-**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Residential Mental Health Treatment Facilities						
	Psychiatric Residential Treatment Facilities						
	Geographic designation	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid Beneficiaries with SED	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Total Number of PRTFs	Ratio of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients to Number of Medicaid-Enrolled PRTFs	Psychiatric Residential Treatment Facility (Under 21) Category Notes
1.	District of Columbia	n/a	n/a	n/a	-	-	-	
2.					-	-	-	
3.					-	-	-	
4.					-	-	-	
5.					-	-	-	
6.					-	-	-	
7.					-	-	-	
8.					-	-	-	
9.					-	-	-	
10.					-	-	-	The District does not have any PRTFs. PRTF services are delivered on a case by case basis with providers outside of the District.
	Total	**0**	**0**	**0**	**0**	**-**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Inpatient					
	Psychiatric Hospitals					
Geographic designation	Number of Public Psychiatric Hospitals	Number of Private Psychiatric Hospitals	Number of Medicaid-Enrolled Public Psychiatric Hospitals	Number of Medicaid-Enrolled Private Psychiatric Hospitals	Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients	Medicaid Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients
1. District of Columbia	1	1	0	1	0	1
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
Total	**1**	**1**	**0**	**1**	**0**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Inpatient						
	Psychiatric Hospitals						
Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals to Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals to Private Psychiatric Hospitals	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals	Psychiatric Hospital Category Notes
1. District of Columbia	0	3.12207E-05	0	1	0	1	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	The District has one private psychiatric hospital, the Psychiatric Institute of Washington. It has one public psychiatric institution, St. Elizabeths.
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	
Total	**0**	**3.12207E-05**	**0**	**1**	**-**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

	Geographic Distribution	Inpatient					
		Psychiatric Hospitals That Qualify As IMDs					
	Geographic designation	Number of Public Psychiatric Hospitals that qualify as IMDs	Number of Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Number of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients	Number of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients
1.	District of Columbia	1	1	0	1	0	1
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
	Total	**1**	**1**	**0**	**1**	**0**	**1**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Inpatient						
	Psychiatric Hospitals That Qualify As IMDs						
Geographic designation	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs to Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs to Private Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Public Psychiatric Hospitals that qualify as IMDs	Ratio of Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs Accepting New Medicaid Patients to Medicaid-Enrolled Private Psychiatric Hospitals that qualify as IMDs	Psychiatric Hospitals That Qualify As IMDs Category Notes
1. District of Columbia	0	3.12207E-05	0	1	0	1	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	Both PIW and St. Elizabeths qualify as IMDs. St. Elizabeths is not currently working with Medicaid.
Total	**0**	**3.12207E-05**	**0**	**1**	**-**	**1**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

	Geographic Distribution	Inpatient					
		Psychiatric Units					
	Geographic designation	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients
1.	District of Columbia	7	0	7	0	7	0
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
	Total	**7**	**0**	**7**	**0**	**7**	**0**

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Inpatient						
	Psychiatric Units						
Geographic designation	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Psychiatric Units in Critical Access Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients to Medicaid-Enrolled Psychiatric Units in Critical Access Hospitals	Psychiatric Unit Category Notes
1. District of Columbia	0.000218545	0	1	-	1	-	
2.	-	-	-	-	-	-	
3.	-	-	-	-	-	-	
4.	-	-	-	-	-	-	
5.	-	-	-	-	-	-	
6.	-	-	-	-	-	-	
7.	-	-	-	-	-	-	
8.	-	-	-	-	-	-	
9.	-	-	-	-	-	-	
10.	-	-	-	-	-	-	The Washington Hospital Center and United Medical Center are hospitals that have psychiatric units. They are not psychiatric hospitals
Total	**0.000218545**	**0**	**1**	**-**	**1**	**-**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Inpatient						
	Psychiatric Beds						
Geographic designation	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Medicaid Beneficiaries with SMI/SED	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds	Ratio of Medicaid-Enrolled Licensed Psychiatric Hospital Beds Accepting New Medicaid Patients to Medicaid-Enrolled Licensed Psychiatric Hospital Beds	Psychiatric Beds Category Notes
1. District of Columbia	576	284	235	-	0.493055556	0.82746479	
2.				-	-	-	
3.				-	-	-	
4.				-	-	-	
5.				-	-	-	
6.				-	-	-	
7.				-	-	-	
8.				-	-	-	
9.				-	-	-	
10.				-	-	-	This combines United Medical Center, Howard University Hospital, Sibley Memorial Hospital, Childrens Hospital, Metro Washington Hospital Center, Georgetown University Hospital (226 beds combined) along with PIW (58 beds for mental health patients) and St. Elizabeths (292). We do not include St. Elizabeth's as currently serving Medicaid patients and excluded 49 licensed beds from hospitals as accepting patients because they are not in service.
Total	**576**	**284**	**235**	**-**	**0.493055556**	**0.82746479**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

	Geographic Distribution	Crisis Stabilization Services								
	Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Coordinated Community Crisis Response Teams	Ratio of Crisis Call Centers to Medicaid Beneficiaries with SMI/SED	Ratio of Mobile Crisis Units to Medicaid Beneficiaries with SMI/SED	Ratio of Crisis Observation/ Assessment Centers to Medicaid Beneficiaries with SMI/SED	Ratio of Coordinated Community Crisis Response Teams to Medicaid Beneficiaries with SMI/SED	Crisis Stabilization Services Category Notes
1.	District of Columbia	1	2	3	2	3.12207E-05	6.24415E-05	9.36622E-05	6.24415E-05	
2.						-	-	-	-	
3.						-	-	-	-	
4.						-	-	-	-	
5.						-	-	-	-	
6.						-	-	-	-	
7.						-	-	-	-	
8.						-	-	-	-	
9.						-	-	-	-	
10.						-	-	-	-	The District's Department of Behavioral Health operates, as well as oversees crisis stabilization services. The District is planning to increase the number of mobile crisis units as a part of its new, Integrated Community Response Team (ICRT) over the next year.
	Total	**1**	**2**	**3**	**2**	**3.12207E-05**	**6.24415E-05**	**9.36622E-05**	**6.24415E-05**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Geographic Distribution	Federally Qualified Health Centers		
Geographic designation	Number FQHCs that Offer Behavioral Health Services	Ratio of FQHCs that Offer Behavioral Health Services to Medicaid Beneficiaries with SMI/SED	FQHC Category Notes
1. District of Columbia	41	0.00128005	All FQHCs serve Medicaid patients and most offer mental health services. These services are available for patients of all non-inpatient levels of acuity. We found 8 FQHC providers with 41 locations registered at DHCF with a behavioral health ID in May 2019.
2.		-	
3.		-	
4.		-	
5.		-	
6.		-	
7.		-	
8.		-	
9.		-	
10.		-	
Total	**41**	**0.00128005**	

Note: This tab illustrates the data points states will be asked to report as part of initial and annual assessments of the availability of mental health services. In the future this tab will contain additional pop-up instructions.

Section 1115 Behavioral Health Transformation Demonstration Application Summary

Section I: Overview

The District of Columbia Department of Health Care Finance (DHCF) is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration that will combine, under a single demonstration authority, the ability to reimburse for inpatient, residential, and other services provided to Medicaid-eligible beneficiaries in institutions for mental diseases (IMDs) to individuals diagnosed with substance use disorder (SUD) or serious mental illness (SMI)/serious emotional disturbance (SED). The demonstration will also allow the District to expand Medicaid's continuum of behavioral health services, including through improved access to community-based behavioral health services, provide important new resources to help the District fight the epidemic of deaths associated with opioid use disorder and related SUDs, and aid the District's efforts to transform Medicaid's behavioral health service delivery system.

Section II: Background and Purpose

This demonstration program was conceived, in large part, as a response to the crisis unfolding in the District relating to opioid use and abuse. From 2014 to 2017, the District of Columbia experienced a nearly 240 percent increase in opioid-related fatal overdoses and now ranks fourth among all states and first among urban counties with the highest percentage of opioid-related fatalities per capita. In December 2018, the Mayor released *Live.Long.DC.,* an opioid strategic plan with the goal of decreasing rates of opioid use, misuse, and opioid-related deaths by 2020.

The District is planning to use the 1115 demonstration to strengthen the continuum of care and move the District's Medicaid program toward a more integrated model of behavioral health care delivery by expanding treatment options for SMI/SED and SUD, delivering better quality care, identifying and treating behavioral health issues at earlier stages, and supporting improved data collection and reporting in the District's behavioral health system. The demonstration will also assist the District in advancing key goals within its Opioid Strategic Plan. Specifically, the demonstration will expand access to SUD treatment and providers, improve the quality of behavioral health treatment, improve the beneficiary experience after discharge through follow up, and prevent emergent and acute hospitalizations by scaling up crisis treatment programs

In fiscal year (FY) 18, nearly one-third (31 percent) of all Medicaid beneficiaries had a behavioral health diagnosis and an estimated 20 percent (55,919) of all Medicaid beneficiaries had an SMI/SED or SUD diagnosis. Sixty percent of Medicaid beneficiaries with an SMI/SED are receiving behavioral health treatment. In FY18, 2,933 adult Medicaid beneficiaries and those likely eligible for Medicaid had SUD or mental health-related IMD stays, resulting in $16.5 million in total District spending, $11.2 million of which was locally funded. The restrictions on Medicaid reimbursement for the treatment provided in IMDs has resulted in access gaps for Medicaid beneficiaries.

Roughly one-third (34 percent) of adult District residents being treated for SMI in the public health system also have a co-occurring SUD. Persons with a mental illness are at greater risk of developing a substance use disorder than the general population. Addressing the SUD crisis also requires treatment for the SMI/SED that is likely a contributing factor.

Oversight of Medicaid behavioral health services is divided, with overlapping authority, primarily among DHCF, Medicaid managed care organizations (MCOs), and the District's Department of Behavioral

Health (DBH), although other sister agencies also provide ancillary behavioral health services and supports. DHCF has authority over Medicaid's reimbursement of clinic services (free-standing mental health clinics (FSMHCs) and federally qualified health centers (FQHCs)), hospitals, and outpatient services. MCOs serving District Medicaid beneficiaries contract with a behavioral health provider network providing low-acuity, primary, behavioral health services, including assessment, counseling, and medication/somatic treatment. However, more intensive services and supports for SMI/SED/SUD treatment are carved out of MCO contracts and delivered by providers operating under the oversight and certification of DBH.

Because of overlapping oversight of separate delivery systems and provider networks by DHCF, MCOs and DBH, providers and beneficiaries are sometimes not well informed about available benefits and coverage. Through this demonstration, the District is beginning a process that aims to further improve coordination of coverage and services, beginning with a focus on strengthening transitions of care among participating providers.

The District conducted an assessment of its mental health system to provide a baseline understanding of current rates of utilization, provider participation, and system funding against which to measure as the demonstration is implemented. The assessment, which follows a federally-provided template, includes information on the number of District providers of mental health services and a brief overview of the District's population with SMI. For more information on the District behavioral health system, interested stakeholders are able to review the *District of Columbia Uniform Application FY 2018/2019 - State Behavioral Health Assessment and Plan Substance Abuse Prevention and Treatment Block Grant*. Other District government materials that analyze the behavioral health system include the District Medicaid Program's *2016 Access Monitoring Review Plan* and the District Department of Health's *2014 Community Health Needs Assessment* which are also available for reference. Federal resources include the Mental Health National Outcome Measures reporting from the HHS/Substance Abuse and Mental Health Services Administration.

<u>Section III</u>: Demonstration Goals and Objectives

The District has three overarching goals for this demonstration:

Increasing Medicaid's service array to improve coverage of a broader continuum of behavioral health treatment for individuals with SMI/SED/SUD;

Advancing the District's goals for reducing opioid use, misuse, and deaths outlined in the District's Opioid Strategic Plan, *Live.Long.DC.*; and

- Supporting the District Medicaid program's movement toward a more integrated health care experience that facilitates coordinated treatment of behavioral and physical health needs.

The District's goals support the broader objectives of the Medicaid program to ensure equitable access to medically necessary services for Medicaid-eligible beneficiaries. These goals also support the specific goals for the SUD and SMI/SED demonstrations outlined by the Centers for Medicare and Medicaid Services in SMD 17-003 and 18-011, which include reducing preventable admissions to emergency, inpatient and residential settings, promoting access to community-based treatment, strengthening transitions to care in the community and ensuring timely follow-up after hospitalization or a residential stay, and ensuring care is consistent with medical guidelines for SMI and SUD, as appropriate.

<u>Section IV</u>: Eligibility, Benefits, Cost Sharing, and Delivery System

Eligibility

This demonstration will impact all children and adults eligible to receive Medicaid benefits under the District of Columbia Medicaid State Plan who are diagnosed with an SMI/SED or a SUD, or self-identified with an SUD.

Medicaid beneficiaries will qualify for services outlined in this demonstration based upon their medical need for services. Medicaid beneficiary eligibility requirements will not differ from the approved Medicaid State Plan and DHCF is not proposing changes to Medicaid eligibility standards in this demonstration application.

Specifically, the District is seeking authorization to reimburse for clinically appropriate care delivered in residential and inpatient treatment settings that qualify as IMDs will increase the scope of services and treatment options available to District Medicaid adults 21-64 diagnosed with an SMI/SED or a SUD, who have traditionally had limited access to these services as a result of the IMD exclusion.

The District also plans add new and augment existing Medicaid services that would otherwise be authorized under the State Plan. These additional services will ensure greater access to outpatient and community-based services for all Medicaid-eligible children and adults diagnosed with an SMI/SED or a SUD, or self-identified with an SUD, with the goal of improving health outcomes for these individuals.

Benefits

In addition to reimbursement for clinically appropriate, short term stays for acute care delivered to individuals with SMI/SED or SUD in IMD inpatient or residential settings, the demonstration program seeks approval to incorporate the following services and service changes for individuals participating under the demonstration:

- Crisis Stabilization Services, including an expansion of the current Crisis Psychiatric Emergency Program (CPEP), Mobile Crisis Support services, and Psychiatric Residential Crisis Stabilization Services
- Recovery Support Services
- Clubhouse
- Trauma-Informed Services
- Supported Employment Services
- Psychologist and Other Licensed Behavioral Health Provider Services; and
- Transition Planning Services.

Cost Sharing

This demonstration will not impose any additional beneficiary cost-sharing requirements beyond those identified in the Medicaid State Plan. However, the demonstration will seek authority to remove beneficiary cost-sharing requirements for prescriptions associated with medication-assisted treatment for individuals receiving services under the demonstration.

Delivery System

No changes to the current FFS and managed care delivery systems are being proposed in this demonstration application. There will be no differences in the delivery system used to provide benefits to demonstration participants than those provided under the State Plan.

Section V: Hypothesis and Evaluation

The demonstration will test whether the expenditure authority granted under this demonstration, in addition to other concurrent behavioral health delivery system enhancements and re-design efforts, results in increased access to health care services and improved health outcomes for individuals with SUD and SMI/SED.

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

Among other goals, the District will evaluate whether the demonstration:

- Increases enrollee identification of, access to, and utilization of appropriate SUD and/or SMI/SED treatment services;
- Reduce emergency department (ED) and hospital visits among enrollees with SUD and/or SMI/SED for SUD and/or SMI/SED treatment;
- Diagnose and treat co-morbid physical health conditions among enrollees with SUD and/or SMI/SED in an IMD setting;
- Increase timely initiation of follow up after discharge from ED, residential, or inpatient treatment for SMI or SUD and timely transition to community-based behavioral health services; and

- Improves the availability of crisis stabilization services including through call centers and mobile crisis units and through intensive outpatient and residential or inpatient settings.

Section VI: Waiver and Expenditure Authorities

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

- Comparability requirements described in section 1902(a)(17): this demonstration program includes benefits and cost-sharing specific to eligibility criteria as described in Section IV.A that may not be comparable to benefits and cost-sharing provided under the State Plan.
- Amount, Duration, and Scope requirements described in section 1902(a)(10)(B): to enable the District to offer a different benefit package to demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.
- Any Willing Provider requirements described in section 1902(a)(23) and 42 CFR 431.51(b)(1): to enable the District to limit provider participation in the Medicaid program with respect to services offered as Supported Employment as described in Section IV.B

DHCF requests Expenditure Authority for otherwise covered services furnished to State Plan eligible adults (21-64) who are primarily receiving treatment and withdrawal management services for substance use disorder or primarily receiving treatment for serious mental illness/serious emotional disturbance, who are short-term residents/inpatients in facilities that meet the definition of an IMD.

Section VII: Impact on Expenditures and Enrollment

This demonstration is not expected to increase or decrease annual Medicaid enrollment. Those who are Medicaid enrolled and diagnosed with SMI/SED or SUD, are largely, the target of this demonstration program (over 56,000 individuals in FY18). Demonstration expenditures are estimated through 2024 in the table below:

Table 1: **Projected IMD Member Months/Caseloads and Enrollment**

		DEMONSTRATION YEARS (DY)					
	Trend Rate	2020	2021	2022	2023	2024	Estimated Enrollment
SUD IMD Services MCO	4.5%	902	942	984	1,029	1,075	451
SUD IMD Services FFS	3.1%	1,298	1,339	1,381	1,425	1,469	718
SMI IMD Services MCO	4.5%	54	57	59	62	65	27
SMI IMD Services FFS	3.1%	2,369	2,443	2,520	2,599	2,681	1,329
Non-IMD Services CNOM Limit MEG	4.2%	60,913	63,459	66,111	68,873	71,751	16,809

Table 2: Demonstration Expenditures Across Five Years

Supplemental Test #1: IMD Services Cost Limit						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD Services MCO	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644
With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
SUD IMD Services MCO	$1,524,289	$1,640,461	$1,765,485	$1,900,041	$2,044,848	$8,875,125
SUD IMD Services FFS	$3,188,045	$3,386,680	$3,597,691	$3,821,841	$4,059,964	$18,054,221
SMI IMD	$585,113	$629,707	$677,700	$729,351	$784,939	$3,406,811

Services MCO						
SMI IMD Services FFS	$19,256,547	$20,456,311	$21,730,837	$23,084,759	$24,523,034	$109,051,488
TOTAL	$24,553,993	$26,113,159	$27,771,714	$29,535,993	$31,412,786	$139,387,644
Net Overspend	$0	$0	$0	$0	$0	$0
Supplemental Test #2: Non-IMD Services CNOM Limit						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2020	2021	2022	2023	2024	
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
Non-IMD Services CNOM Limit MEG	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
TOTAL	$13,045,207	$13,997,752	$15,020,349	$16,117,743	$17,294,974	$75,476,025
Net Overspend	$0	$0	$0	$0	$0	$0

MEGs	Trend Rate	2020	2021	2022	2023	2024
SUD IMD Services MCO	3.0%	$1,690	$1,741	$1,793	$1,847	$1,903
SUD IMD Services FFS	3.0%	$2,455	$2,529	$2,605	$2,683	$2,763
SMI IMD Services MCO	3.0%	$10,769	$11,092	$11,425	$11,768	$12,121
SMI IMD Services FFS	3.0%	$8,128	$8,372	$8,623	$8,882	$9,149
Non-IMD Services CNOM Limit MEG	3.0%	$214	$221	$227	$234	$241

Section VIII: Public Notice

The District took the following actions to support public notice and awareness of this demonstration before the draft waiver application was released on April 12, 2019:
DHCF discussed the draft demonstration application with the following interest groups during the development of the waiver:

- District of Columbia Medical Care Advisory Committee (MCAC) on February 26, 2019
- DC MCAC Health System Redesign Subcommittee on March 27, 2019
- DC Behavioral Health Waiver Stakeholder Meeting on March 28, 2019
- DC Behavioral Health Planning Council on March 29, 2019
- Medicaid MCO Medical Directors on April 8, 2019
- DC MCAC Access Subcommittee on April 9, 2019
- DC Behavioral Health Provider Meeting on April 10, 2019

DHCF provided an open comment period from April 12, 2019 to May 13, 2019 on the draft demonstration application.

DHCF published an abbreviated notice of public comment in the April 12, 2019 issue of the District of Columbia Register (DCR) at 65 DCR 004860. The abbreviated notice can be found online at https://www.dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N0081563.

On April 12, 2019, DHCF published full notice on the DHCF website at http://dhcf.dc.gov/1115-waiver-initiative. The draft demonstration application, an executive summary, and information on how interested stakeholders could give feedback on the proposed demonstration were available on the DHCF website at or before 6:00PM EST. DHCF also emailed the draft application, the executive summary, and a link to the DHCF website to a listserv of approximately two-hundred and fifty (250) interested members of the public.

Public Hearings were scheduled during the public comment period as identified below:

Public Hearing #1
Date: Thursday April 18, 2019
Time: 4:00 to 5:30PM
Location: Room 284/285 at 64 New York Avenue NE, Washington, DC 20002

Public Hearing #2
Date: Thursday April 25, 2019
Time: 5:30 to 7:00PM
Location: Room 2023 at 2235 Shannon Place SE, Washington, DC 20020

Public Hearing #3 (Virtual)
Date: Tuesday April 30, 2019
Time: 1:30 to 3:00PM
Location: Web conference and Teleconference only

DC MCAC Meeting
DHCF also presented information and heard feedback on the proposed demonstration during the April 26, 2019 meeting of the DC MCAC. The DC MCAC is a forum for key participants and stakeholders in the Medicaid program, including consumers, advocates, providers, and District officials to review the program's operations and offer advice for improvements directly to DHCF. Information on the April 2019 meeting of the DC MCAC is available on the DHCF website at https://dhcf.dc.gov/node/1401616.

DHCF and DBH received 20 written as well as additional oral comments, during the comment period during the comment period. The overwhelming majority of stakeholders indicated their satisfaction that

the District is pursuing the demonstration to address the behavioral health needs of Medicaid beneficiaries. Common themes focused on:

- Demonstration Eligibility/Impacted Population
- Medicaid Enrollment of Psychologists/LICSW and Other Stand-Alone Providers
- Services Provided by Peer Support Specialists
- Need for Workforce Development/Specialty Training
- Transition Services/Discharge Planning and Follow-Up After Discharge from Institutional Care
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Service Definition
- Scope of IMD Services under the Demonstration; and
- Role of Manage Care in Coordinating Behavioral Health Services.

Key changes were made to Crisis Stabilization Service Definitions; Supported Employment Service Definition; and Psychologist and LICSW Service Definitions in response to public comment.

Transition Planning Services were added to the demonstration.

SUD Residential Services for Children and Youth and the SBIRT Pilot were removed from the proposed demonstration.

Section IX: **Demonstration Administration**

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