

**District of Columbia Section 1115 Medicaid
Behavioral Health Transformation Demonstration Program**

[DATE]

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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 disorders (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 SUD and SMI) (SED) 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 and related 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. The District is making this draft application available to the public for comment in advance of submitting the Demonstration application to CMS.

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

A. Background

The District of Columbia offers a broad array of behavioral health services, ranging from lower acuity 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 impacted the District’s capacity to manage behavioral health services in a holistic way that is better 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 protective services, and justice system, among others. This division of spheres of oversight has sometimes resulted in service gaps, confusion about points of entry, and a disconnect between beneficiaries’ physical and behavioral health care. There is also a disparity in coverage of services provided in institutions for mental disease (IMD) under current policy, which provides disparate treatment among Medicaid beneficiaries and unfairly disadvantages fee-for-service 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 resident’s needs. This demonstration seeks to strengthen the District’s Medicaid behavioral health system through the addition of a broader array of services and

providers, including coverage for short-term residential and inpatient services provided by IMDs for individuals with SMI/SED and SUD and complementary community-based services designed to improve access to and transitions of care.

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 primarily affects 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 older adults between the ages of 40 and 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 over 40 years.³ While individuals who have used 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%) 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.
- **MME Limits:** In 2018, the District's Medicaid program [imposed new limits on morphine milligram equivalents \(MMEs\)](#) in Medicaid prescriptions designed to reduce the

¹ *Live.Long.DC: Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths*, Department of Behavioral Health, December 24, 2018, 4.

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 *Id.*

availability and utilization of high MME prescriptions and to thereby lessen the risk of substance use disorder and diversion among Medicaid beneficiaries.

- **Removing Prior Authorization for MAT:** 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)⁴. The goal of these changes is to improve the accessibility of opioid use disorder treatment services, consistent with the 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 IAP technical assistance program. Through this program, the District's Medicaid agency has been creating and refining a data dashboard that will present annual metrics on opioid use disorder (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, in March of 2019, the District Medicaid program [required all prescribers of MAT-related buprenorphine or naltrexone for extended-release injectable suspension to check the PDMP](#) and record findings in the patient's medical record to improve monitoring and deterring misuse or diversion.
- **Emergency Room MAT Induction Pilot:** Beginning in April, 2019, the District is implementing a hospital emergency room MAT induction pilot that will screen emergency room patients in four District hospitals for potential SUD risk using a screening, brief intervention and referral to treatment model (SBIRT) and connect any interested patients who are identified as at-risk 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. Building on this foundation, the demonstration will test the impact of ongoing support for individuals to sustain MAT and their recovery.

The District has faced challenges in its efforts to combat this 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 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. Advocates and providers also report that the closure of a major hospital providing psychiatric inpatient services and emergency room care and several longstanding community behavioral health service providers in the District may also be

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

impacting access, increasing the volume of psychiatric emergency and inpatient hospitalizations at certain facilities.

Although Medicaid provides coverage for inpatient hospital psychiatric stays at non-IMD facilities and community behavioral health services, advocates and community providers report individuals being discharged from emergency and hospital stays need more support or follow up to ensure a smooth transition to community care following discharge. In addition, stabilization and crisis services for Medicaid-covered individuals with serious behavioral health needs frequently occurs in the emergency or inpatient hospital setting rather than utilizing resources in the community or in IMD inpatient or residential settings. Over-reliance on these hospital settings may lead to poorer outcomes for patients with behavioral health needs and others. 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 this population. 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 for federally qualified health centers, MCOs, and nursing facilities. In addition, the District has two 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. This demonstration will enable the District 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 services at the lowest burden entry point.

Link Between Serious Mental Illness and Substance Use Disorder:

There is a strong co-occurrence of SUD and SMI in the District. 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, more than half of fee-for-service (FFS) non-elderly adult Medicaid beneficiaries (53 percent) had a behavioral health diagnosis. Among these non-elderly adult FFS beneficiaries with behavioral health needs, 62 percent had an SMI diagnosis, 43 percent had an SUD diagnosis and 26 percent had both.

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.⁵

Substance use is the most common adverse behavior of District residents with SMI. Research suggests that people with mental illness may use drugs or alcohol as a form of self-medication.⁶ For individuals with mental illness, brain changes may enhance the rewarding effects of

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4663043/>

⁶ <http://www.mentalhealth.gov/what-to-look-for/mental-health-substance-use-disorders>

substances, making an individual more likely to continue using the substance.⁷ 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

Roughly three-quarters (72%) of Medicaid/CHIP beneficiaries in the District were enrolled in MCOs and just over one-quarter (28%) received services through the FFS program in FY18. 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 generally prohibited from receiving Medicaid-covered IMD services. Beneficiaries that meet medical necessity criteria and undergo an assessment are also eligible to receive State Plan mental health (MH) and SUD rehabilitative benefits, which include a range of intensive diagnostic and therapeutic services.

Oversight of Medicaid behavioral health services is divided, with overlapping authority, primarily among DHCF, Medicaid MCOs, and DBH, although sister agencies also provide ancillary behavioral health services and supports.⁸ 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.⁹ 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 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. Table 1, below, summarizes the full spectrum of Medicaid behavioral health services.

Medicaid beneficiaries with lower-acuity behavioral health needs can access diagnostic/assessment, counseling, prescriptions, medication somatic treatment, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) covered services for children through a variety of community-based providers covered under the Medicaid State Plan. For FFS beneficiaries, DHCF oversees Medicaid reimbursement of these providers and services directly.

Medicaid MCOs manage their own network of behavioral health service providers offering a comparable panoply of services. Providers that MCOs typically contract with include primary, lower level, non-rehabilitative behavioral health services, including those provided by stand-alone psychiatrists, psychologists, free-standing mental health clinics, FQHCs, and other providers. MCOs also provide inpatient, emergency, pharmacy, and psychiatric residential

⁷ Santucci K. Psychiatric disease and drug abuse. *Current Opinion Pediatrics* 2012;24(2):233-237. doi:10.1097/MOP.0b013e3283504fbf

⁸ 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.

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 MHRS) provides an array of mental health services and supports through MHRS. This benefit includes: (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. In addition, the District offers a health home program for individuals with SMI/SED that provides care coordination and wrap-around services and supports. A variety of 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 forensic services.¹⁰ DBH contracts with 35 core service agencies (CSAs) and 11 sub- and specialty providers to provide the majority of mental health services. DBH also operates adult and child clinics that provide urgent care and crisis emergency services. Homeless outreach and treatment services are also provided.¹¹

In 2011, Medicaid-covered SUD services administered by DBH expanded with the implementation of the ASARS program, providing MHRS-like services for individuals with SUD, 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. The District Medicaid program is now facing challenges with insufficient utilization of SUD services including MAT. Advocates have reported shortfalls in Medicaid-enrolled providers, SUD and SMI/SED training, culturally competent and bi-lingual providers for individuals with limited English proficiency, and consistent discharge planning and follow up care as possible factors contributing to low treatment utilization for individuals with SUD.

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 requirements for Medicaid, contrasted with locally funded behavioral health services. DHCF is planning to transition all claiming for Medicaid covered behavioral health services to its oversight in FY20, which will greatly improve transparency and opportunities for coordination among providers. This demonstration seeks to begin a process that will, over time, further improve coordination of coverage and services, beginning with a focus on strengthening transitions of care among participating providers.

¹⁰ DBH 2019 MHEASURES Report

¹¹ Ibid.

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

Emergency	Inpatient/Residential MH and SUD	Outpatient
<ul style="list-style-type: none"> • MH: Crisis Emergency • SUD: Crisis Intervention 	<ul style="list-style-type: none"> • 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 days¹² 	<p><i>Clinic and Physician (Medicaid/MCO Managed)</i></p>
		<ul style="list-style-type: none"> • Diagnostic/Assessment/Treatment Planning • MH: Medication/Somatic Treatment • MH/SUD: Counseling/Medication Management • EPSDT services for children, including screenings and treatment for SUD and other behavioral health needs
		<p><i>Mental Health Rehabilitative Services (DBH Managed)</i></p>
		<ul style="list-style-type: none"> • 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 Services • Intensive Day Treatment • Community-Based Intervention • Assertive Community Treatment • Child-Parent Psychotherapy for Family Violence • Trauma-Focused Cognitive Behavioral Therapy
		<p><i>Adult Substance Abuse Rehabilitative Services (DBH Managed)</i></p>
<ul style="list-style-type: none"> • 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 “in lieu of services” payments by MCOs

Current Behavioral Health Diagnoses and Utilization, Including IMD Stays

Under current policy, Medicaid MCOs are able to cover and claim reimbursement for up to 15 days per month for non-elderly adult MCO enrollee IMD inpatient and residential services through an “in lieu of services” payment to the IMD. Under current policy, Medicaid MCOs are able to cover and claim reimbursement for up to 15 days per month for non-elderly adult MCO enrollee IMD inpatient and residential services through an “in lieu of services” payment to the IMD. 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 14 percent (36,000) of Medicaid beneficiaries had an SMI/SED diagnosis. Sixty percent of Medicaid beneficiaries with an SMI are receiving behavioral health treatment. In 2017, six percent of beneficiaries with an SUD had a non-tobacco SUD, including OUD, alcohol, cannabis, or other substances. 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).

The District was one of 12 states that participated in the Medicaid Emergency Psychiatric Demonstration program (MEPD) 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 in the wake of the demonstration.

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 shortfalls in consistent and adequate Medicaid reimbursement for Medicaid eligible beneficiaries have resulted in access gaps for beneficiaries. Medicaid reimbursement of these stays provides a critical part of the District’s behavioral health safety net.

Behavioral Health System Assessment

The District is conducting an assessment of its behavioral health system for inclusion in the final version of this demonstration application. 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*.¹³ Other District government materials that analyze the behavioral health

¹³ <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/FY%202018-2019%20Substance%20Abuse%20Block%20Grant%20%28draft%29.pdf>

system include the District Medicaid Program's *2016 Access Monitoring Review Plan*,¹⁴ and the District Department of Health's *2014 Community Health Needs Assessment*.¹⁵ The District offers these resources as a preliminary statement of the District's current behavioral health assessment in this draft.

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

The District will 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 preventing behavioral health issues at earlier stages, and supporting improved data collection and reporting in the behavioral health system in the District. 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 BH 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 will strive 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 most substantial opportunity to increase the number of beneficiaries served, provides for a more comprehensive approach to improving access to IMD services, and will allow DHCF 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 SUD-targeted 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/SED or SUD in residential and inpatient IMD settings. This also includes the addition of residential IMD services for children and youth with SUDs. To complement new residential and inpatient IMD services, the District plans to bolster the availability of community-based interventions, including:

- Crisis stabilization and mobile crisis & outreach services in the community;
- Comprehensive recovery support services including

¹⁴

<https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/District%20of%20Columbia%202016%20Access%20Monitoring%20Review%20Plan%20first%20few%20pages%20....pdf>

¹⁵

https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DC%20DOH%20CHNA%20%28v5%200%29%2005%2007%202014%20-%20FINAL%20%282%29.pdf

- peer support services for individuals with SUD, and
- offering a new peer-partnered Clubhouse model providing day rehabilitative treatment for individuals with SMI and/or co-occurring SMI/SUD.
- Vocational supported employment services for individuals with SMI and 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;
- Psychologist and licensed clinical social worker providers operating independently outside of a clinic or facility, which is designed to increase access to Medicaid-enrolled providers for treatment;
- Elimination of the current \$1 copayment requirement for prescriptions associated with MAT to ensure this treatment is broadly accessible without any barrier; and
- SBIRT pilot providing reimbursement for emergency hospital providers participating in SOR-funded MAT induction pilot and primary care providers trained in SBIRT at 8 community sites.

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 also complement ongoing work to transition provider claims administration for behavioral health services from DBH to DHCF, restructure 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 a newly designated District-wide Health Information Exchange, which is expected to launch in 2019. The District's overall goal is to build a system of care that provides a greater continuum of behavioral health services, reduces illicit substance use, misuse, and overdose fatalities, and moves Medicaid toward a more holistic, integrated approach to health care treatment.

Relationship to 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 FY 19 and FY 20. 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 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 to provide outreach throughout the continuum of care, and foster engagement and service connection. The DCOR program will also use training, technical assistance, and Extension for Community Healthcare Outcomes (ECHO) consultation using HRSA's opioid use treatment curriculum with health care professionals to increase their ability to address the needs of more challenging clients.

In addition, DBH is undergoing an effort to decentralize its substance use disorder assessment and referral center (ARC) services and allow multiple community-based SUD providers to provide intake, assessment, and referrals, such that individuals in need of SUD services will have multiple points of entry into DC's system of care. The demonstration's proposed expansion of services and focus on transitions and community-based services and 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 these funded interventions and determine their applicability to Medicaid. In this way, the District is hoping to use the waiver to leverage these federal investments to promote sustainability of proven interventions.

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. 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, 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.

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 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, 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 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 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 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 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 primarily be medically appropriate, short-term, acute or stabilization stays. Reimbursement for long-term, custodial stays is not being proposed under this demonstration. The District will continue to work with stakeholders and federal regulators to determine and clarify the scope of available IMD coverage.

The District also seeks to add new and augment existing Medicaid services that would be otherwise authorized under the State Plan, including:

- *Residential SUD Services for Children/Youth:* The demonstration proposes 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.
- *Crisis Stabilization Services:* The demonstration proposes an expansion of the comprehensive psychiatric emergency program (CPEP) to allow for treatment of individuals with SUD, as well a change the reimbursement methodology for CPEP. It

also seeks to increase the hours and reimbursement for the mobile crisis and outreach service for those with SMI and SUD.

- *Recovery Support Services*: The demonstration proposes to add this benefit for individuals who are either diagnosed or self-identified with SUD, providing peer support services, housing supports, education and life supports, and other services designed to support and maintain recovery.
- *Clubhouse*: The demonstration proposes to fund services offered in a peer-partnered facility targeting support services for adults with SMI to assist them with social networking, independent living, budgeting, self-care and other skills to enable community living.
- *Trauma-Informed Services*: The demonstration proposes to reclassify two trauma-informed services and change the reimbursement methodology to more equitably reimburse providers for certain currently covered trauma-informed services for children and family members.
- *Supported Employment Services*: The demonstration proposes to add vocational services to currently provided supported therapeutic employment services for individuals with SMI. The demonstration also proposes to make individuals with SUD eligible for these services. These additional services will connect individuals with training and skills to promote and maintain employment.
- *Psychologist and Licensed Clinical Social Worker Services*: The demonstration proposes to add stand-alone psychologist and licensed clinical social worker services for children and adults to the already covered services that are provided when offered through an institution, including a free-standing mental health clinic, hospital or federally qualified health center (FQHC).
- *SBIRT*: The demonstration proposes to pilot allowing for reimbursement of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in emergency departments of hospitals that participate in a SOR-funded MAT induction pilot and 8 trained primary care provider sites as a means of helping individuals before they need more extensive or specialized treatment. The aforementioned providers will have received training and technical assistance through DC's SOR grant that supports integrating a comprehensive SBIRT process into the provider clinical practice and electronic health records to better identify persons with substance use disorder.

C) Cost Sharing

The District is not planning to impose any cost-sharing under this 1115 demonstration. The District is also seeking not to apply existing cost-sharing requirements to some individuals enrolled under the 1115 demonstration, specifically to change cost-sharing requirements for individuals who are using prescription medication assisted treatment (MAT)

- *Remove Cost-Sharing Requirement for Prescriptions Associated with Medication-Assisted Treatment (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 the DHCF's FFS system under this demonstration, DHCF expects to follow the state plan with respect to SUD and SMI/SED payment rates. For the services being added where there is no established rate, DHCF intends to develop and propose a rate for CMS approval. DHCF also expects that MCO capitation rates may need to be adjusted in light of the addition of residential SUD services for children and youth and changes regarding the administration and coverage of IMD services. SUD services must have been determined necessary for a beneficiary's placement and treatment based on the ASAM criteria, except for proposed recovery support services which may also be provided to individuals with a self-identified SUD. SMI/SED services must have been determined necessary for a beneficiary's placement and treatment based on nationally recognized criteria.

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.

Goals:

The District will evaluate whether the demonstration:

- Increases enrollee identification of, access to, and utilization of appropriate SUD treatment services based on the ASAM Criteria, with a focus on community settings;
- Increases enrollee access to and utilization of appropriate SMI/SED treatment services based on nationally recognized criteria, with a focus on community settings;
- Increases adherence to and retention in SUD treatment;
- Decreases use of medically inappropriate and avoidable, high-cost emergency department and hospital services by enrollees with SUD and/or SMI/SED;
- Increases timely initiation of follow up after discharge from emergency department or residential or inpatient treatment for SMI or SUD, and timely transition to community based behavioral health services;
- Reduces readmission rates for inpatient SUD and/or SMI/SED treatment;
- Ensures that beneficiaries being treated in an IMD setting are also being assessed for and accessing treatment for their physical health conditions; 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.

Changes:

Resulting changes expected through the demonstration are:

- Improved access to, availability, and utilization of Medicaid IMD residential and inpatient services, regardless of delivery system;
- Increased availability of data related to behavioral health service utilization and payment; and
- Implementation of additional quality monitoring and oversight to ensure behavioral health providers are meeting prescribed milestones for the demonstration.

Plan for Testing:

Upon approval of the demonstration, the District will contract with an external evaluator to develop a Medicaid 1115 demonstration evaluation design plan that will include (for example):

- Analysis of claims, encounters, and public health data to measure changes in:
 - Rates of Medicaid beneficiary overdose episodes or deaths
 - Access to SUD services (including MAT) and SMI/SED services
 - Rates of adherence to and retention in SUD treatment
 - Rates of emergency room utilization for individuals with SMI/SED or SUD
 - Timeframes for follow-up between discharge from emergency room, inpatient, or residential treatment and treatment in the community
 - Hospital inpatient, emergency room, and IMD residential readmission rates for individuals with SMI/SED and SUD
 - Utilization rates for physical diagnostic and treatment services in IMD settings
 - Utilization rates for crisis stabilization services
- Development and use of protocols for assessing and reporting on provider/service capacity in order to:
 - Identify high need treatment areas and service gaps
 - Identify any barriers to participation for SUD or SMI/SED providers
 - Identify barriers to accessing services for individuals with SUD or SMI/SED
 - Understand best practices for connecting individuals to care in the community
- Capacity to collect and analyze data from FFS, MCO, and local expenditures to assess performance and identify trends and challenges, using the measures outlined below per CMS guidance:

Per SMD #17-003 (November 1, 2017), the District will report the initial performance measures identified in Table 3 and will work with CMS to identify additional optional measures of particular relevance to the District’s SUD experience.

Table 2. Demonstration Performance Measures – SUD

Demonstration/SUD Goals	Performance Measures
Increased Rates of Identification, Initiation and Engagement in Treatment	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (National Committee for Quality Assurance; NQF #0004)

Improved Adherence to Treatment	Follow-up after Discharge from Emergency Department for Mental Health or Alcohol or Other Drug Dependence (National Committee for Quality Assurance; NQF #2605)
Reduction in Overdose Deaths Particularly Those Due to Opioids	Use of Opioids at High Dosage in Persons Without Cancer (Pharmacy Quality Alliance; NQF #2940)
Reduced Utilization of Emergency Department and Inpatient Hospital Settings	Low-Acuity Non-Emergent Emergency Department Visits (DHCF)
Fewer Readmissions to the Same or Higher Level of Care	Plan All-Cause Readmissions (National Committee for Quality Assurance; NQF #1768)
Improved Access to Care for Co-morbid Physical Health Conditions among Beneficiaries	Adults' Access to Preventive/Ambulatory Health Services (National Committee for Quality Assurance)

Per SMD #18-011 (November 13, 2018), the District will report the initial performance measures identified in Table 3, pending further guidance from CMS. The District may also work with CMS to identify additional optional measures of particular relevance to the District's SMI experience.

Table 3. Demonstration Performance Measures – SMI

Demonstration/SMI Goals	Performance Measures
Reduced Utilization and Length of Stay in Emergency Department	Follow-Up After Emergency Department Visit for Mental Illness (National Committee for Quality Assurance; NQF #2605)
Reduced Preventable Readmissions to Acute Care Hospitals and Residential Settings	1. Plan All-Cause Readmissions (National Committee for Quality Assurance; NQF #1768) 2. Thirty-Day All-Cause Unplanned Readmission following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (Centers for Medicare and Medicaid Services; NQF #2860)
Improved Availability of Crisis Stabilization Services	<i>Under Development</i>
Improved Access to Community-Based Services through Increased Integration of Primary and Behavioral Health Care	Adults' Access to Preventive/Ambulatory Health Services (National Committee for Quality Assurance)
Improved Care Coordination	Follow-up after Hospitalization for Mental Illness (National Committee for Quality Assurance; NQF #0576)

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 only requesting waiver of the comparability requirements described in section 1902(a)(10)(B) of the Social Security Act in order to allow a subset of Medicaid beneficiaries who are receiving MAT to be exempt from the \$1 co-payment otherwise associated with outpatient prescription medications.

DHCF requests the following Expenditure Authority: Expenditures for otherwise covered services furnished to otherwise eligible individuals 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 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 85,967 were diagnosed with behavioral health disorders. Of those with diagnosed with behavioral health disorders, approximately 56,041 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 decreased 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 reflects 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 4: Projected IMD Member Months/Caseloads and Enrollment

	Trend Rate	DEMONSTRATION YEARS (DY)					Estimated Enrollment
		2020	2021	2022	2023	2024	
SUD IMD Services MCO	4.5%	900	940	982	1,026	1,072	451
SUD IMD Services FFS	3.1%	1,265	1,304	1,345	1,387	1,431	767
SMI IMD Services MCO	4.5%	56	59	62	64	67	28
SMI IMD Services FFS	3.1%	1,487	1,534	1,582	1,632	1,683	1,469
Non-IMD Services CNOM Limit MEG	4.2%	242,097	252,214	262,754	273,734	285,173	29,336

Table 5: Demonstration 5 Years Expenditures

	DEMONSTRATION YEARS (DY)						TOTAL
	2020	2021	2022	2023	2024		
SUD IMD Services MCO	\$1,487,352	\$1,600,710	\$1,722,710	\$1,854,005	\$1,995,308	\$8,660,084	
SUD IMD Services FFS	\$3,683,901	\$3,913,422	\$4,157,241	\$4,416,250	\$4,691,409	\$20,862,222	
SMI IMD Services MCO	\$594,295	\$639,590	\$688,336	\$740,798	\$797,258	\$3,460,277	
SMI IMD Services FFS	\$20,831,862	\$22,129,788	\$23,508,570	\$24,973,265	\$26,529,211	\$117,972,696	
TOTAL	\$26,597,409	\$28,283,509	\$30,076,857	\$31,984,318	\$34,013,186	\$150,955,279	
With-Waiver Total Expenditures							
	2020	2021	2022	2023	2024	TOTAL	
SUD IMD Services MCO	\$1,487,352	\$1,600,710	\$1,722,710	\$1,854,005	\$1,995,308	\$8,660,084	
SUD IMD Services FFS	\$3,683,901	\$3,913,422	\$4,157,241	\$4,416,250	\$4,691,409	\$20,862,222	
SMI IMD Services MCO	\$594,295	\$639,590	\$688,336	\$740,798	\$797,258	\$3,460,277	
SMI IMD Services FFS	\$20,831,862	\$22,129,788	\$23,508,570	\$24,973,265	\$26,529,211	\$117,972,696	
TOTAL	\$26,597,409	\$28,283,509	\$30,076,857	\$31,984,318	\$34,013,186	\$150,955,279	
Net Overspend	\$0	\$0	\$0	\$0	\$0	\$0	
Without-Waiver Total Expenditures							
	DEMONSTRATION YEARS (DY)						TOTAL
	2020	2021	2022	2023	2024		
Non-IMD Services CNOM Limit MEG	\$12,688,318	\$13,614,519	\$14,609,110	\$15,676,738	\$16,822,341	\$73,411,026	

TOTAL	\$12,688,318	\$13,614,519	\$14,609,110	\$15,676,738	\$16,822,341	\$73,411,026
With-Waiver Total Expenditures						
	2020	2021	2022	2023	2024	TOTAL
Non-IMD Services CNOM Limit MEG	\$12,688,318	\$13,614,519	\$14,609,110	\$15,676,738	\$16,822,341	\$73,411,026
TOTAL	\$12,688,318	\$13,614,519	\$14,609,110	\$15,676,738	\$16,822,341	\$73,411,026
Net Overspend	\$0	\$0	\$0	\$0	\$0	\$0

Section VIII – Public Notice

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

DHCF provided an open comment period from April 12, 2019 to May 13, 2019 on the draft demonstration application. Written comments were accepted by mail, email, and in person.

DHCF published a Notice of Public Comment in the District of Columbia Register on April 12, 2019. The publication in the District of Columbia Register can be found at:

<https://dhcf.dc.gov/1115-Waiver-Initiative>

DHCF presented on the draft demonstration application to the following interest groups during the development of the waiver:

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

This section will be updated to reflect the completion of the public comment period, the feedback received, and how that feedback was addressed upon final submission to CMS.

Section IX – Demonstration Administration

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