April MCAC Meeting

April 24, 2024

Virtual Meeting

1115 Waiver Renewal: Aiming for Whole Person Care

Public Meeting

April 2024

DHCF Administers the District's Public Health Insurance Programs, Including Medicaid

- DC Medicaid provides health insurance coverage to 275,378 DC residents*
  - Children
  - Elderly
  - People with disabilities
- DC Medicaid provides a comprehensive benefit packages that is delivered through fee for service (FFS) or managed care. This includes coverage of:
  - Doctor's visits
  - Hospital visits
  - Prescription drugs
  - Behavioral health services
  - More

*DHCF Eligibility Monitoring Dashboard, Accessed 3/28/2024

Both the Federal and District Governments Have a Role in the District's Medicaid Program

- The Federal and District governments share the costs
- Federal approval from the Centers for Medicare & Medicaid Services (CMS) is required for changes to benefits, eligibility, payment methodologies
- There are mandatory benefits that all states must provide and optional benefits that each state chooses whether they are included
- States can submit a waiver to CMS when they want to make a change to their program that is not typically allowable and/or the state wants to try a new benefit, program, or spend money differently
  - The typical pathway is an 1115 Demonstration Waiver
- 1115 Waivers are time-limited (5 years, with renewal options) and have significant budget limitations and evaluation reporting requirements

DC's Current 1115 Waiver Supports the Continuum of Care for Behavioral Health Services

Beginning in January 2020, the Behavioral Health Transformation 1115 Waiver established new services to fill gaps in behavioral health care

For a 5-year period, the Behavioral Health Transformation 1115 Waiver:

- Allows Medicaid payment for services provided to non-elderly adults with SMI/SED/SUD in institutions for mental diseases (IMDs)
- Eliminates the co-pay for prescriptions associated with Medication Assisted Treatment (MAT)
- Initially allowed Medicaid payment for other community-based behavioral health services which have since been made permanent Medicaid benefits*

*Additional materials and information about the Behavioral Health Transformation Waiver can be found on DHCF's website here.

Current 1115 Waiver Goals

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

It's Time to Renew the 1115 Waiver: New Options Can Help Further District Priorities

- Recently, the federal government opened the door to states to expand services to include housing and nutrition supports; health related social needs (HRSN) case management, outreach and education; and additional supports for individuals returning to the community.

- DHCF proposes to extend the current demonstration *and* implement an updated program design that broadens the focus to address social determinants of health, in alignment with the framework of other state approved 1115 waivers.

- To reflect the broadened focus, DHCF proposes to rename the 1115 waiver: "**Whole-Person Care Transformation".**

Focus on Continuing Initial 1115 Waiver Services and Securing the Federal Authority to Do More

Proposed Whole Person Care Transformation Waiver

Behavioral Health Transformation (Continuing Authority)

Continue IMD services and removal of MAT co-pay beyond expiration of current 1115 waiver on December 31, 2024.

Health-Related Social Need (HRSN) Services (New Authority)

Implement new Medicaid housing, nutrition, and HRSN case management services, as well as infrastructure to support the delivery of HRSN services.

Justice-Involved Reentry Services (New Authority)

Provide a limited set of Medicaid services for up to 90-days prior to release from a carceral setting, as well as infrastructure to support the delivery of reentry services.

HRSN: District's Application Requests Authority for Entire CMS Scope of Approvable HRSN Services

Housing:

- Rent/temporary housing for up to 6 months and related utility assistance, specifically for:
  - Individuals transitioning out of institutional care or congregate settings
  - Individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter
  - Youth transitioning out of the child welfare system including foster care
- Short-term pre-procedure and/or post-hospitalization housing for up to 6 months
- Housing transition, navigation, pre-tenancy, and tenancy-sustaining services
- One-time transition and moving costs
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units
- Medically necessary home accessibility modifications and remediation services

Nutrition:

- Nutrition counseling and education
- Meals or pantry stocking, up to 3 meals a day, for up to 6 months
- Fresh produce prescriptions, protein boxes, and/or grocery provisions, up to 3 meals a day, for up to 6 months
- Cooking supplies

HRSN Case Management, Outreach, and Education:

Including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees

HRSN Infrastructure:

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

Justice-Involved Reentry: District's Application Takes Full Advantage of CMS Reentry Flexibilities

- **Eligibility to receive services:** DHCF is requesting authority to cover all Medicaid-eligible adults and youth to ensure all eligible individuals receive necessary supports.

- **Services:** In addition to the three mandatory services, DHCF is also requesting to cover four additional services to support transitions into the community:

Mandatory Services:	Additional Services:
▪ Medication Assisted Treatment (MAT)	▪ Behavioral health counseling/therapy
▪ 30 Day Rx Upon Release	▪ Peer support services
▪ Reentry Case Management	▪ Intensive, family-based services for youth
	▪ Physical and behavioral health screening

- **Carceral Facilities:** While CMS guidance limits demonstrations to state/local carceral facilities, DHCF is requesting authority for:
  - Local adult carceral operated by the Department of Corrections (DOC) - Central Detention Facility, Central Treatment Facility
  - Local youth secure detention facilities operated by the Department of Youth Rehabilitative Services (DYRS) - Youth Services Center, New Beginnings Youth Development Center
  - *Federal Bureau of Prisons facilities housing DC code offenders for a limited sub-set of waiver supports*

Waiver Renewal Focuses on Continuing Initial 1115 Waiver Services and Securing the Federal Authority to Do More to Support Whole Person Care

- ✓Behavioral Health Services
  - –IMD services
  - –Eliminate co-pay for MAT
- ✓Health-Related Social Need (HRSN) Services
  - –Housing and Nutrition supports and services
  - –HRSN case management, outreach, and education
- ✓Justice-Involved Reentry Services

Renewal Timeline: Like Other States, the District will Begin New Services Following Implementation Planning Period

CY 2024 *(Demonstration Year 5)*

- April 1 – April 30, 2024: Public Comment Period on draft 1115 renewal application
- On or about May 31, 2024: DHCF submits 1115 renewal application to CMS
  - DHCF negotiations with CMS to determine 1115 approval terms and conditions
  - Begin stakeholder engagement around implementation planning

CY 2025 *(Demonstration Year 6)*

- Continued stakeholder engagement, implementation planning, and infrastructure investment
  - Develop new HRSN and reentry services specifications
  - Ensure provider capacity and operational readiness to bill Medicaid for new services

CY 2026 *(Demonstration Year 7)*

- Begin new HRSN and reentry services

Resources and Public Comment

The draft 1115 waiver renewal application and other related materials are available on DHCF's website: https://dhcf.dc.gov/1115-waiver-initiative

How do I submit public comment? Public comment can be:

Discussed at public forums *(Please limit comments to 3 minutes)*

Emailed to dhcf.waiverinitiative@dc.gov

Mailed to DHCF at 441 4th Street NW, Suite 900S, Washington, DC 20001

Public comments will be accepted until **6:00 PM on April 30, 2024**

Medical Care Advisory Committee

PRESENTATION

FY25

#FairShot: Strategic Investments and Shared Sacrifice

April 23, 2024

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Presentation

- ☑ **District's Budget Challenge For Mayor Bowser's Proposed Financial Plan**
- ❑ The Development Of DHCF's FY2025 Budget Proposal
- ❑ DHCF Program Structure and Utilization Data
- ❑ The Concept Of Average Commercial Rate For Medicaid Reimbursement

This Year's Budget Reality Is Sobering And Was The Most Challenging In More Than A Decade – Why?

Significantly Increasing Costs

- **WMATA Fiscal Cliff** – $928 million
- **Labor Agreements** – $591 million
- **Retirement Costs** – $200 million
- **Schools Support** – $1.4 billion
- **Medicaid Matching** – $112 million
- **Utilities, Leasing, and Security** - $160 million

Expiring One-Time Federal Funds

More than $3.3 billion in American Rescue Plan Act (ARPA) funding expires at the end of FY 2024:

- **ARPA Recovery Funds** - $2.3 billion
- **ARPA Education Funds** - $618 million
- **ARPA Rental Assistance** - $418 million

Slowing Growth in Revenues

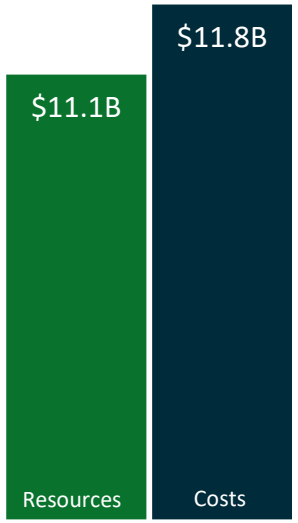
- **Revenue growth has been significant over the last decade**: Since 2010, revenues have grown 6% per year
- **Revenue growth is expected to slow over the next five years:** From FY 2024 through FY 2028, revenues are expected to grow by 2% per year

These factors combined resulted in a $4 billion gap between resources and expenditures through FY 2028

Steps Mayor Bowser Directed to Balance the Proposed FY25 Budget

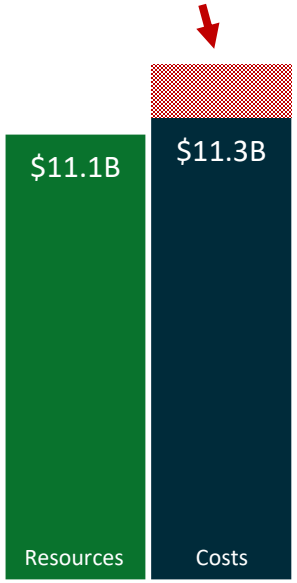
Starting Point Gap

$700 million



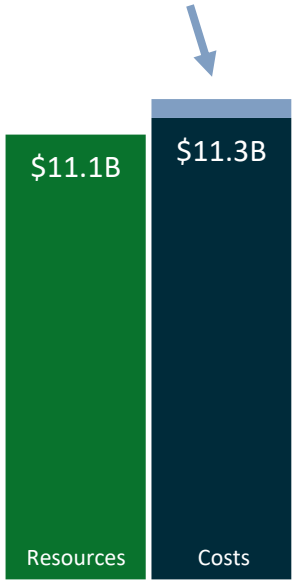
Efficiencies & Reductions

$493 million



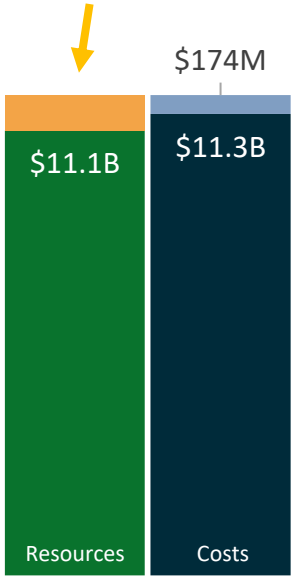
Catalytic Investments

$174 million



Strategic New Revenue

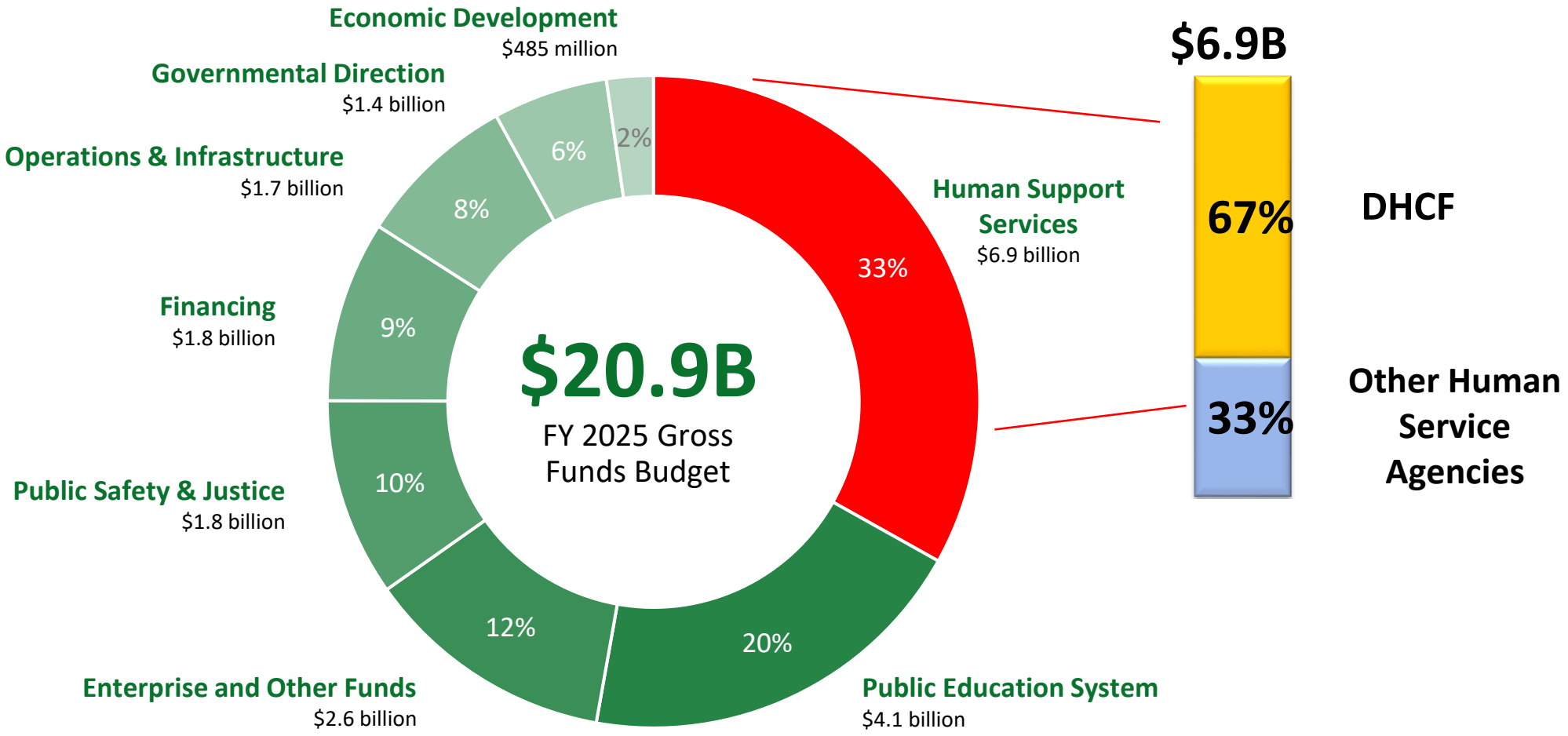
$328 million



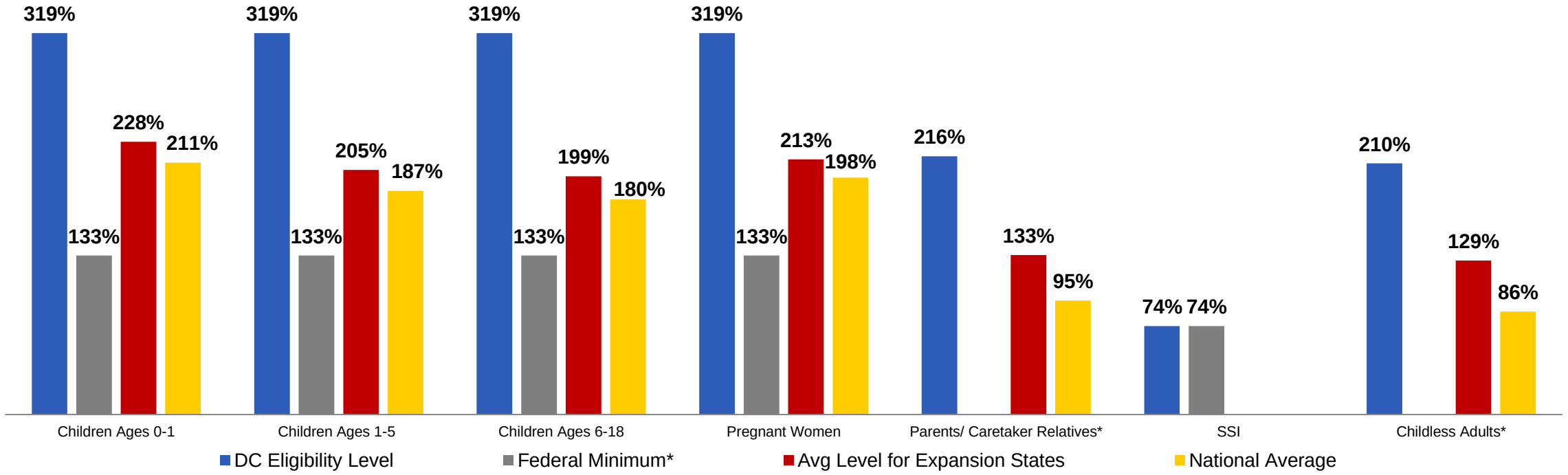
Economic and Budget Realities Shifted DHCF Budget Goals To Preservation of Health Insurance Safety Net

- Protect Eligibility Levels For Medicaid and Alliance Members
- Preserve Current Scope of Medicaid and Alliance Benefits
- Where possible, make targeted investments in provider rates, especially for industry groups facing surging costs
- Comply with CMS Requirements Notwithstanding Cost Impact

Human Services Programs Represent Largest Component In Mayor's Proposed FY 2025 Operating Budget And DHCF Accounts For Two-Thirds Of Planned Spending

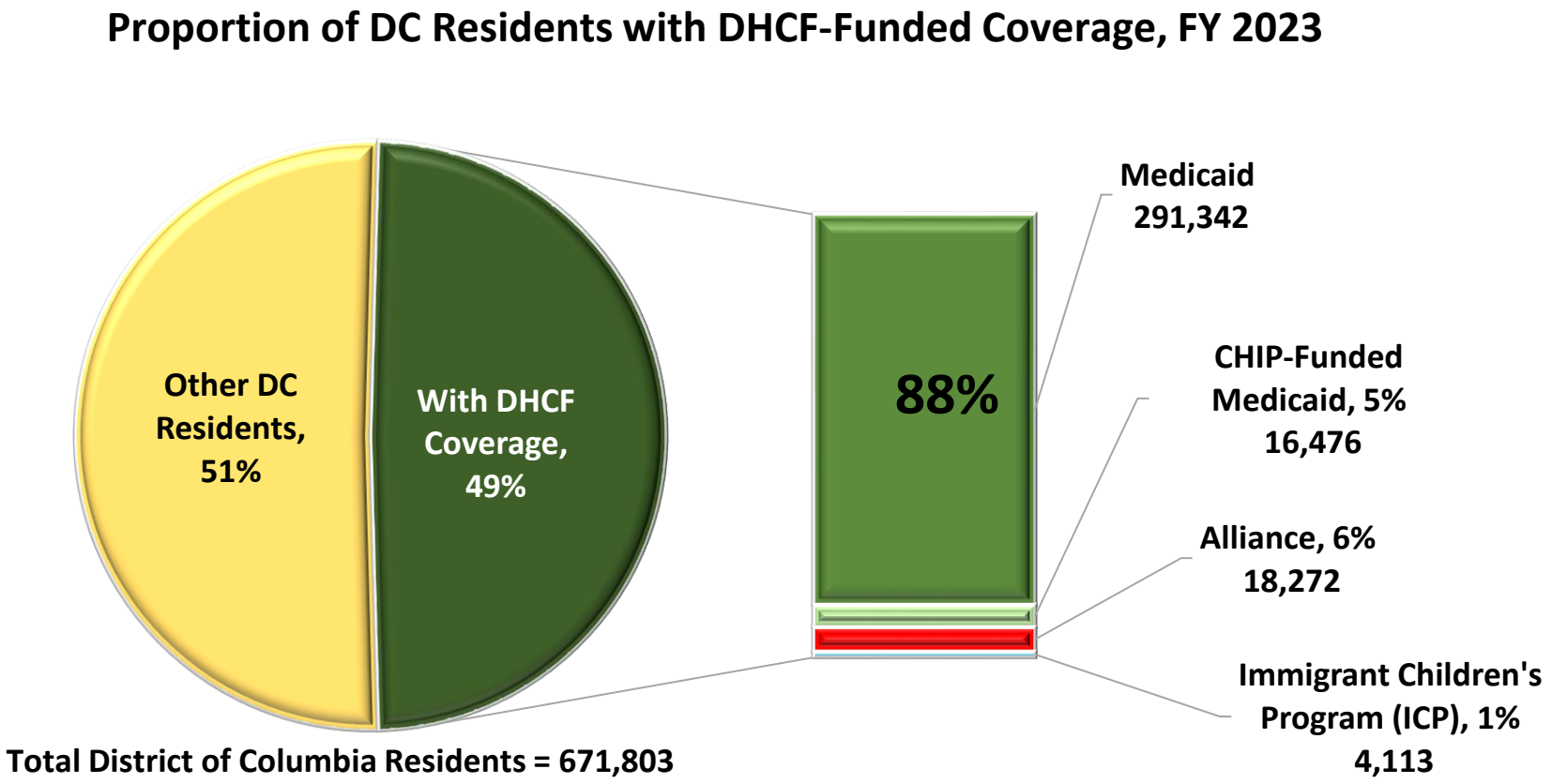


The District's Medicaid Eligibility Levels – Which Exceed Federal Requirements And Statewide Averages – Were Fully Preserved



Source: Centers for Medicare and Medicaid Services State Medicaid and CHIP Income Eligibility Standards, updated June 2016.

Nearly Half of District Residents Rely on DHCF-Funded Health Care Coverage – Most Are in Medicaid



Source: District population estimate reflects the U.S. Census Bureau's 2022 ACS 1-Year Data Tables. Medicaid, Alliance, and ICP data reflect FY 2023 average monthly enrollment as of 1/8/2024 from DHCF's Medicaid Management Information System.
Note: Sum of components may not equal total due to rounding.

Presentation

- ❑ District's Budget Challenge For Mayor Bowser's Proposed Financial Plan
- ☑ **The Development Of DHCF's FY2025 Budget Proposal**
- ❑ DHCF Program Structure and Utilization Data
- ❑ The Concept Of Average Commercial Rate For Medicaid Reimbursement

FY2025 Local Budget Increases To $1 Billion To Maintain Eligibility for Public Health Care Coverage

FY24 Recurring Budget	**$988,309,875**
Less FY24 One-Time Funding	(1,780,000)
5% Savings Reduction	(49,337,972)
Plus: Cost of Living Increase	229,567
FY2025 Baseline	**$937,421,470**
FY2025 Budget Need to Maintain FY24 Programs	1,128,479,607
Budget Adjustments:	
Adjustments Made During MARC Formulation	(191,058,137)
FY25 Adjusted Budget	**$ 937,421,470**
Additional Programmatic Savings	(40,696,708)
Restoration of Agency Budget Reductions to Meet MARC	140,345,015
Enhancement: 12-Mth Continuous Enrollment for Children	6,852,247
Mayor's Total Budget Adjustments	**$106,500,555**
FY2025 Proposed DHCF Local Budget	**$ 1,043,922,025**

Key Decision Points

- FY25 is the first year in three years without enhanced federal Medicaid Assistance Percentage (EFMAP)
- Maintains eligibility for all DC residents eligible for public health care
- Continues community-based grants to support programs that target better health outcomes
- Establishes the Average Commercial Rate for District hospitals
- Maintains services based on reasonable clinical determinations
- Ensures compliance with CMS regulations

The DHCF FY2025 Budget Included Adjustments to Ensure Health Care Coverage Remained Intact

- Maintain Eligibility For Alliance and Childless Adults $140.3M-
- **Enhancement**: CMS Requirement 12-Mth Continuous Enrollment for Children $6.9M
- Expiration of EFMAP $2.8M
- Utilization and Coverage Growth (3.7%) $34.6M

- ACR- Shift Hospital Cost to New ACR Admin. Revenue ($13.7)
- Shift Cost to Health DC Dedicated Tax ($9.8M)
- DSP Enhanced Wage Coverage Under ARPA ($7M)
- Cover Emergency Care for Immigrant Children Under Emergency Medicaid (600K)

- Phase Out of DSH due to Implementation of ACR ($18.9M)
- Maintain Behavioral Health Services in FFS (13.7M)
- Establish MCO Rates at Lower Bound ($6.1M)
- Align Personal Care Aide Service with Clinical Standard Instead of Maximum Allowed ($4.3M)
- Align Hospital Rates with CMS Upper Pymt Level Requirements ($1.9M)
- DME Efficiencies (Qty Control) ($1.5M)

- Practice Transformation and Outreach and Education ($1.2M)
- Digital Technical Assistance and CRISP Support ($1.2M)
- Permanent funding for Produce Rx, Diaper Bank and Home Visiting ($825k)

- Contract and Equipment Net Increase (Mainly DC Access) $3.1M
- Admin Savings in Non-Personal Services ($363K)

No Medicaid Services Were Eliminated As The District Continues With Significant Investments in Provider Services

Provider Payment Category	FY2023 Expenditures	FY2024 Approved Budget	FY2025 Proposed Budget	YoY Variance ($)	YoY Variance (%)	Variance Explanation
Hospital	207,901,088.12	237,426,785.36	169,148,361.66	(68,278,423.70)	-28.8%	With transition to ACR, DSH payments will not be paid in FY25.
ICF/IID	102,962,384.72	93,185,166.24	114,460,654.64	21,275,488.40	22.8%	
Skilled Nursing Facility	324,068,726.60	295,415,801.46	313,224,452.93	17,808,651.47	6.0%	Nursing Facility rate increase
Primary Care (Physicians, Clinics, & FQHC)	82,864,796.79	95,035,667.96	102,155,055.17	7,119,387.21	7.5%	Increase driven primarily by estimated increase in prescribed drugs.
Other (Medicare part A, B, etc)	140,666,202.85	153,502,467.91	168,786,191.17	15,283,723.26	10.0%	
DME	21,179,513.12	21,275,076.49	13,126,390.49	(8,148,686.00)	-38.3%	Savings initiative implemented to address unit limits on excessively billed items.
Behavioral Health (Inc. BH Waiver)	186,532,811.57	178,710,090.42	84,041,594.67	(94,668,495.75)	-53.0%	Complete Federal budget not included in this total. Federal budget will be added via budget adjustment.
Skilled Care	25,732,126.91	26,284,603.53	38,209,282.98	11,924,679.45	45.4%	Increase primarily in private duty nursing. Beneficiaries utilizing significantly more of this service than in past years.
LTCS (incl PCA and PACE)	97,682,872.18	137,954,642.52	121,063,028.04	(16,891,614.48)	-12.2%	PACE enrollment has growth has been lower than anticipated.
DSNP	228,524,460.85	216,382,667.25	305,065,954.86	88,683,287.61	41.0%	Increased capitation rates and enrollment
EPD Waiver	192,147,252.51	147,249,068.86	172,611,918.55	25,362,849.69	17.2%	Increased enrollment driven partially by increased ALF capacity.
DD Waiver	326,958,411.05	241,997,890.60	258,474,146.19	16,476,255.59	6.8%	As the PHE has ended more beneficiaries are beginning to utilizing services more.
IFS Waiver	405,347.71	5,619,813.66	1,568,755.62	(4,051,058.04)	-72.1%	We anticipated higher enrollment in 23 and 24. FY25 reflects observed enrollment.
Emergency Medicaid	31,476,885.17	35,829,676.70	31,511,188.34	(4,318,488.36)	-12.1%	
Medicaid MCO	2,004,949,303.96	1,902,271,177.74	2,426,706,552.99	524,435,375.25	27.6%	
Alliance MCO	111,194,269.82	118,327,853.31	132,493,842.66	14,165,989.35	12.0%	FY25 reflects increased enrollment.
Permanent Supportive Housing	17,254,710.39	57,863,452.64	49,431,530.93	(8,431,921.71)	-14.6%	
Total	**4,102,501,164.32**	**3,964,331,902.65**	**4,502,078,901.89**	**537,746,999.24**		

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From the PHE to Now, DHCF Focused on Responding to the Pandemic, Stabilizing the Health Care System and Promoting Resilience Across the Program

Response

- Maintained access to coverage and continuity of care for District residents
- Maintained agency operations - successful, quick, seamless transition to 100% telework
- Conducted Outreach to Beneficiaries Who May Have Underlying Health Conditions via mailers, text messaging, and phone calls
- Leveraged HITECH funding to provide laptops, data plans, and telehealth licenses to Medicaid providers

Stabilize

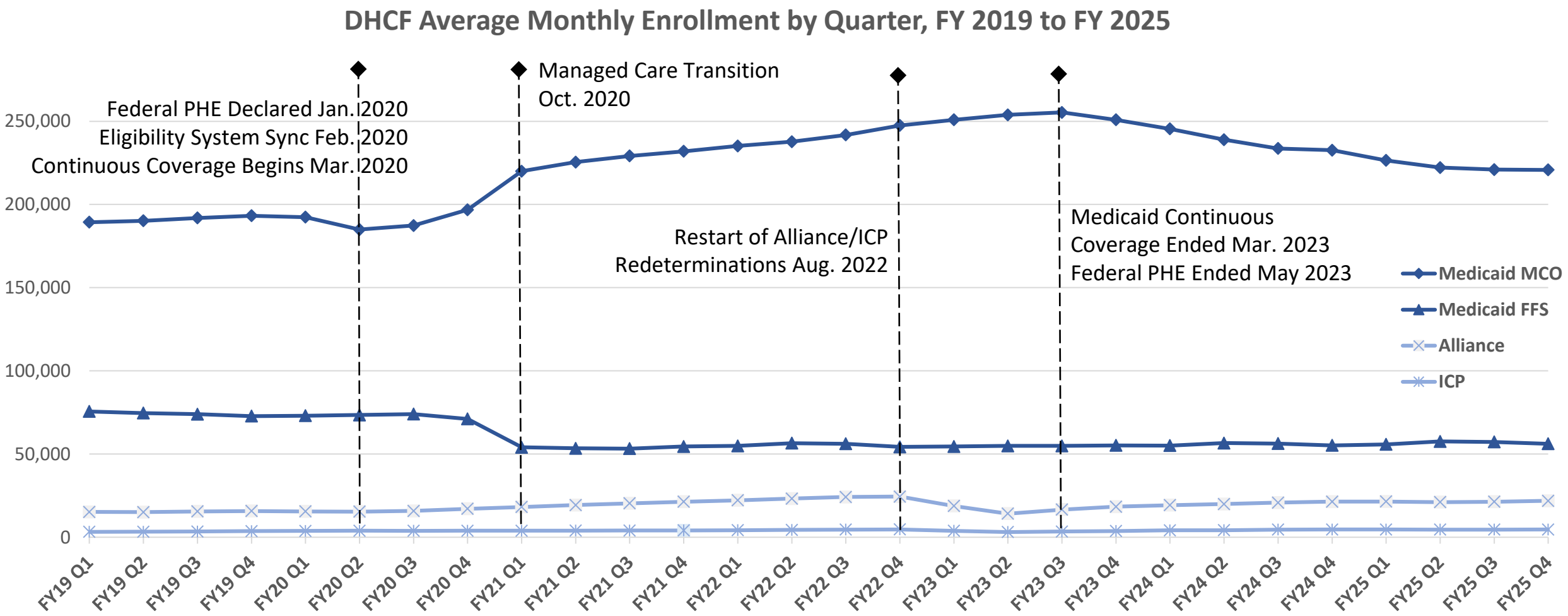
- Supported providers through enhanced rate to ensure continued access to care while preserving the health care delivery system in the long-term
- Developed and executed the Hospital Surge Grants program to support hospital capacity

Resilience

- Strengthened Medicaid behavioral health services through implementation of evidence-based services, setting rates that reflect costs of service, supporting providers in connecting to health information technology
- Integrated care for beneficiaries in both Medicaid and Medicare to include the Program for All Inclusive Care for the Elderly (PACE) and the Dual Choice Program
- Continued to offer technical assistance to an array of providers to achieve clinical and operational excellence
- Expanded 12-month continuous eligibility for children

FY2025: Preservation of the Agencies Work to Be Able to Respond to a Public Health Emergency, Stabilize it to Meet Workforce Shortages and Unmet Needs, and Promote a Resilient Health Care System all While Maintaining Beneficiary Coverage

FY 2025 Enrollment Levels Are Projected to Decline From Pandemic Highs

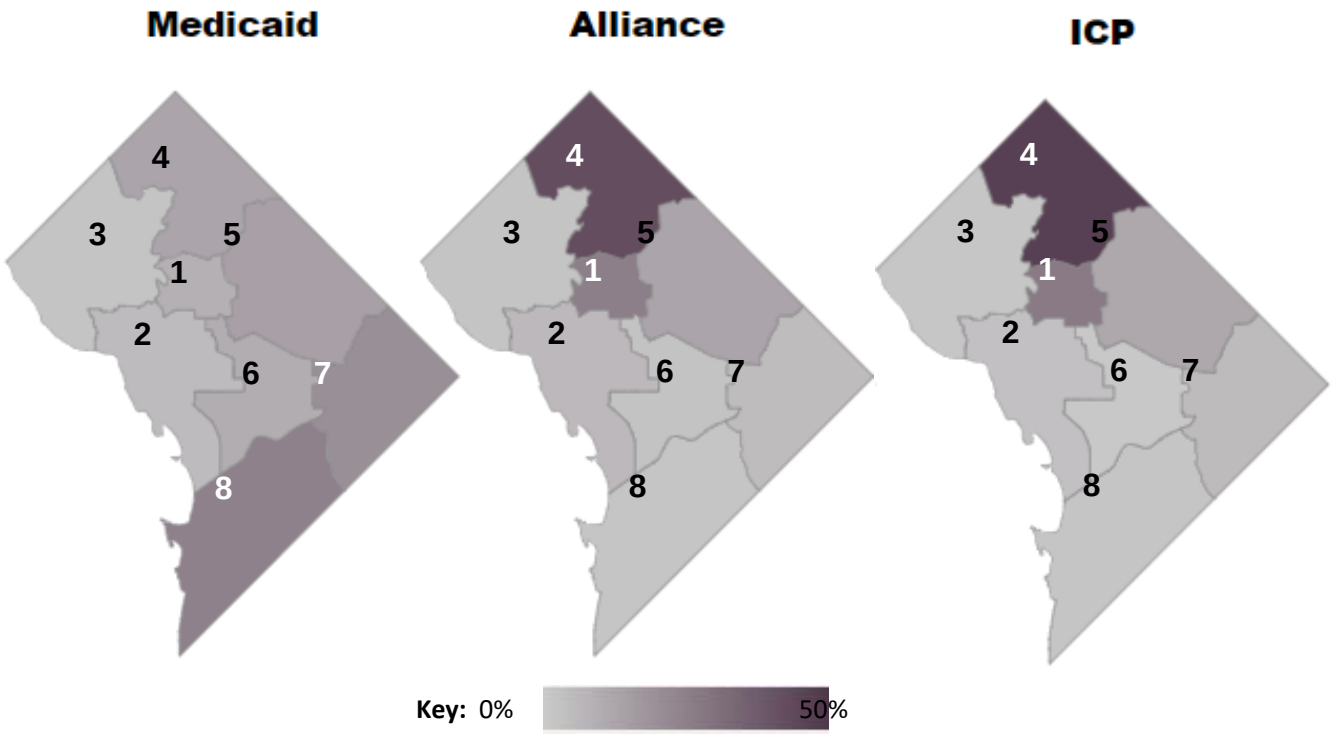


Source: DHCF budget projections as of February 2024.

Note: Managed care organization (MCO) figures on this chart exclude Medicare dual eligible special needs plan (D-SNP) coverage, which is grouped with fee-for-service (FFS).

Most Medicaid Beneficiaries Live in Wards 7 and 8, While Most Alliance and ICP Beneficiaries Live in Wards 1 and 4

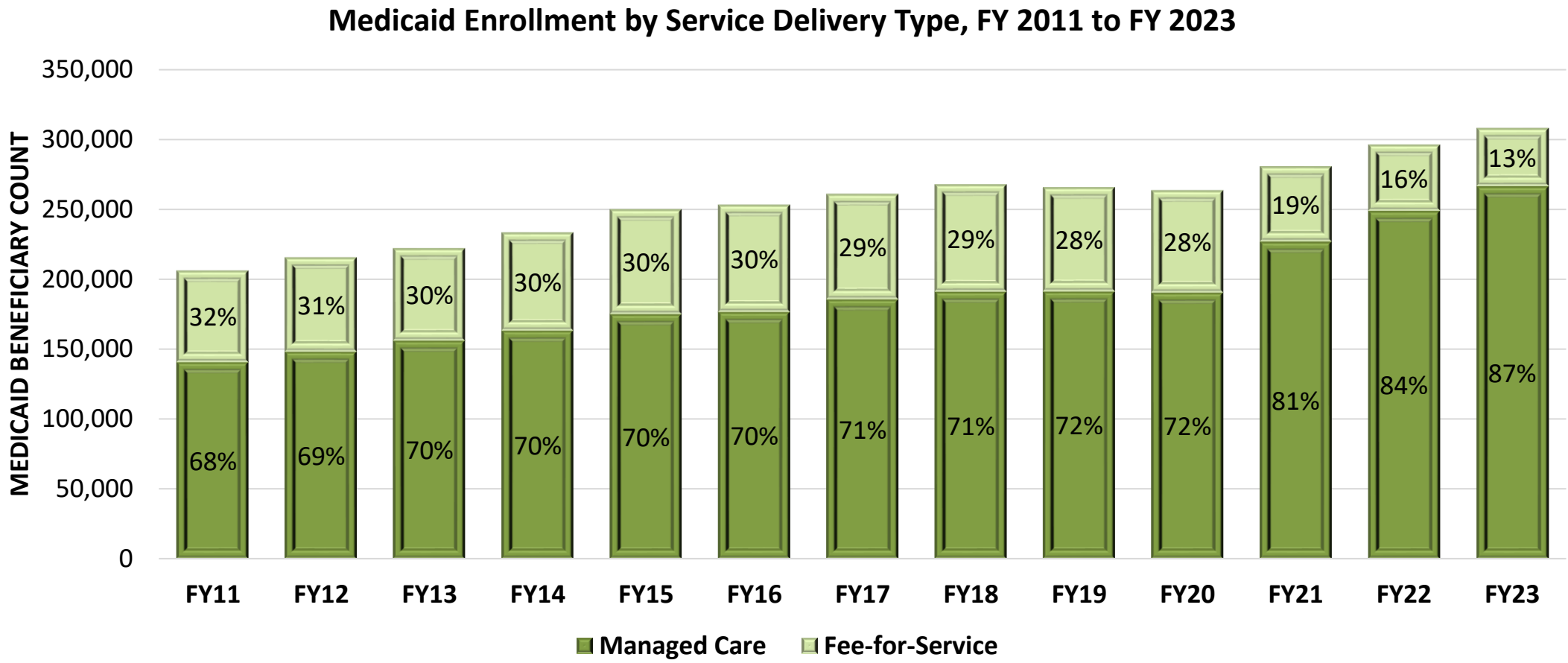
Ward Distribution by Program Type, FY 2023



Ward	Medicaid	Alliance	ICP
Ward 1	26,006 (8%)	4,303 (24%)	947 (23%)
Ward 2	11,933 (4%)	1,017 (6%)	124 (3%)
Ward 3	7,994 (3%)	554 (3%)	87 (2%)
Ward 4	37,295 (12%)	6,354 (35%)	1,397 (34%)
Ward 5	42,210 (14%)	3,114 (17%)	937 (23%)
Ward 6	29,043 (9%)	628 (3%)	105 (3%)
Ward 7	59,047 (19%)	938 (5%)	197 (5%)
Ward 8	70,496 (23%)	449 (2%)	102 (2%)
Other*	23,795 (8%)	916 (5%)	216 (5%)
Total	**307,819 (100%)**	**18,273 (100%)**	**4,112 (100%)**

Source: DHCF Medicaid Management Information System data extracted in January 2024.
Note: Based on average monthly enrollment. May 2023 represents the peak of Medicaid enrollment prior to a restart of redeterminations after the federal public health emergency ended; Alliance and the Immigrant Children's Program (ICP) peaked in August 2022 prior to a restart of their redeterminations. The population size in later months is lower as some individuals are no longer eligible or have not responded to a redetermination notice. Sum of components may not equal total due to rounding.
*Other includes cases where a mapping is not readily available (e.g., due to a non-standard address format).

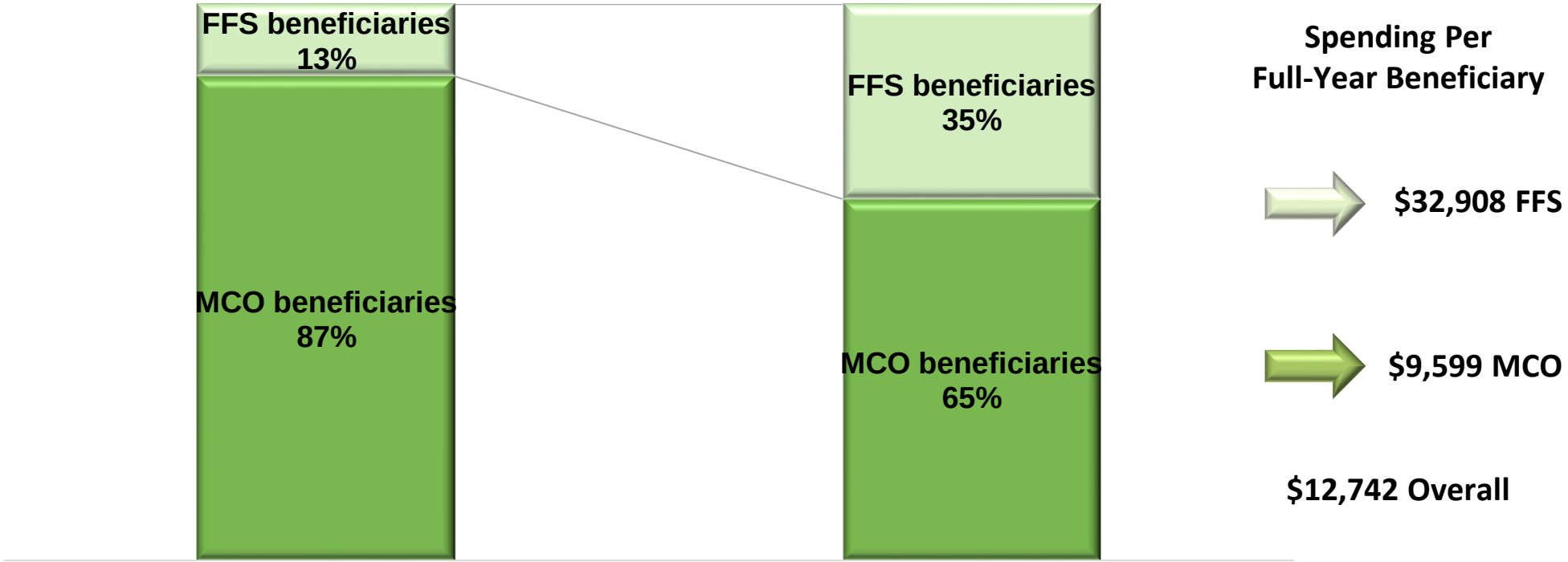
Nearly 90% of the District's Medicaid Enrollees Are in Managed Care



Source: DHCF Medicaid Management Information System data extracted in January 2024.
Note: Enrollment reflects average monthly.

Most Beneficiaries Are in Managed Care But Spending Is Substantial for Those Remaining Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2023



Source: DHCF Medicaid Management Information System (MMIS) data extracted in January 2024 for eligibility in FY 2023 and claims with dates of service in FY 2023.
Note: Enrollment is average monthly and spending per full-year beneficiary is the average cost over 12 months. Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

The District Has Utilized HCBS ARPA Funding To Support $50 Million In FY2023 Investment For Direct Support Professionals

DSP Wage Enhancement Payment Summary (Not Final)

	HHA Providers	DD Waiver
CY 2023 Payments Made	**$30,408,360.76**	**$19,481,422.00**
CY 2023 Actual Expense Reported*	($22,393,446.84)	($11,150,386.90)
Over payment/(underpayment for the year)	$5,885,332.01	$2,393,307.06
CY 2024 Calculated Payment Amount	**$48,047,008.71**	**$26,068,944.14**

In the CY2023 Annual Reporting There Were Inconsistencies In Reporting:

- 38 providers have not submitted the annual reports as required by the regulations set forth by DHCF
- Multiple providers have reported data that is between 7% and 35% above their initial report that we used to forecast payment (October thru June 2023)
- In the second half of the year(July through December 2-23) multiple providers reported between 26% and 118% above what they reported in their first six-month report
- DHCF will continue to review the information provided to ensure accuracy prior to implementation into the rate

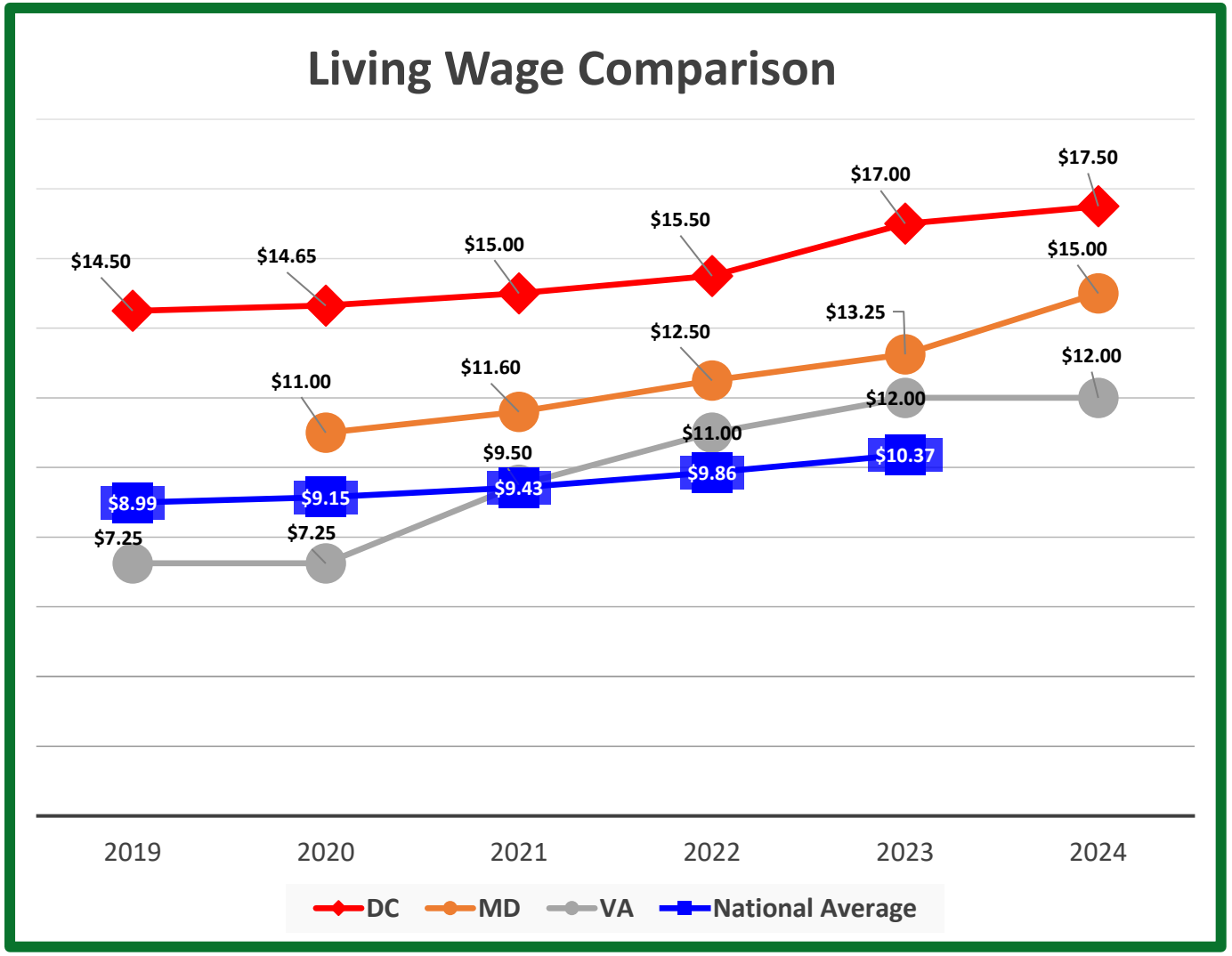
FY2025 DSP Wage Enhancement

The DHCF FY2025 budget proposes to maintain the DSP Wage enhancement as a separate payment and role out the inclusion into the rate methodology to FY2026.

The benefits include:

- The District will be able to cost shift over $15 million in local cost to HCBS ARPA funds
- This provides time for the Home Health Rate Study to be complete and the new rate factored into the proposed methodology simultaneously
- Ensure reporting data accurately reflects DSP wages across the provider industries
- Provide an additional year for Providers to establish an effective career ladder mechanism within their business model to provide competitive opportunities within and across HCBS services in the District

In FY2024, The District's Living Wage Is On Average 29% Higher Than The Surrounding States and The National Average



Key Factors

- **DC's living wage continues to be highest in the DMV area Including:**
  - Montgomery County ($17.15)
  - City of Alexandria ($15.00)
  - Fairfax County ($15.90)
- **DSP's in the District working in Home And Community Based services will have career ladder opportunities with a starting salary of $17.50 up to $23.66 per hour**
- **CNA's working as Certified Nursing Assistants average a salary of $18 to $23 per hour in Institutional setting**

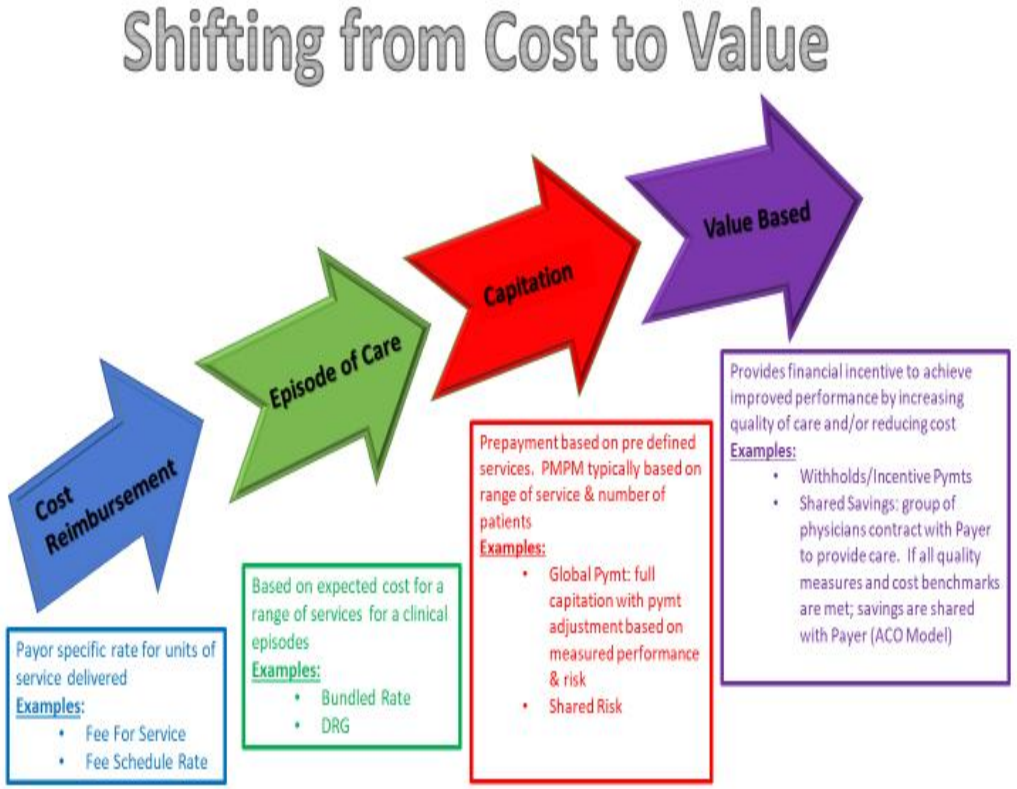
HOME HEALTH AGENCY RATE STUDY WILL PROVIDE GUIDANCE IN TRANSFORMING HCBS

Goal: The primary objective of the rate study is to ensure that District residents receiving home and community-based services (HCBS) get the right service at the right time and place. In short, the goal is to provide person-centered care within their homes with the full complement of services.

Process: To achieve this goal, the rate study will encompass the following processes:

- ✓ Conducting a comprehensive community engagement to identify the community's needs. The engagement process includes extensive interaction with beneficiaries, advocates, and HHA providers
- ✓ Assess whether existing services meet the community's needs or incorporate/design new services into the existing HHA program while ensuring they comply with applicable regulations and program structures.
- ✓ Identify the skillset, necessary personnel, and staffing ratios/levels required to provide the services in the HHA program.
- ✓ Developing quality measures incentivizing providers to hire and retain personnel with the requisite skills are assessed and incorporated.
- ✓ Develop a comprehensive value-based payment model incorporating services, personnel, structure, and quality incentives.

Timeline: The rate study was initiated in December 2023, with a target for implementation of a revised methodology in FY2026



Behavioral Health Cost Drivers: FY23 and FY24 Implementation of Comprehensive BH Rate Study Recommendations

DHCF and DBH collaborated to conduct a comprehensive review of the District's behavioral health services. Our goal was to ensure District residents received quality behavioral health services by making payment methodologies and rates align with the cost of care. Through this process we made adjustments to payment methodologies and rates and added new services to the continuum available.

FY23 Implementation (-$1.6M)

- Medically Managed Inpatient Withdrawal Management (MMIWM)
- Assertive Community Treatment (ACT)

FY24 Implementation ($1.8M)

- Diagnostic Assessments
- Medication Management
- Counseling and Therapy
- Clubhouse
- Methadone Clinic Services
- Rehabilitation Day Services
- Attachment and Biobehavioral Catchup (ABC)
- Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET-CBT)
- Collaborative Care Services (CoCM)
- Intensive Care Coordination (Modeled after the High-Fidelity Wraparound Model)
- Interprofessional Psychiatric Consultation
- Child Parent Psychotherapy (CPP)
- Developmental/Neuropsychological Testing
- MH and SUD Supported Employment
- TF-CBT
- Trauma Recovery and Empowerment Model (TREM)
- Adolescent Community Reinforcement Approach (ACRA)
- Clinical Care Coordination
- Crisis Emergency
- Community-Based Intervention (CBI)
- Screening/Brief Assessment Services
- Transition Planning

FY25 Anticipated Implementation ($6.5M)

- Dialectical Behavioral Therapy (DBT)
- Parent-Child Interaction Therapy (PCIT)
- Youth Crisis Beds
- Youth Mobile Outreach
- Transition to Independence
- Peer Support
- RSS
- Transition Management for Follow-up with a Clinician
- Maintained all FY23 and FY24 Rate Updates, Newly Implemented Services, and Consolidation of Rates across Provider Types (MHRS, ASURS, and FSMHC)

Presentation

- ❑ District's Budget Challenge For Mayor Bowser's Proposed Financial Plan
- ❑ The Development Of DHCF's FY2025 Budget Proposal
- ❑ DHCF Program Structure and Utilization Data
- ☑ **The Concept Of Average Commercial Rate For Medicaid Reimbursement**

What Is The Average Commercial Rate (ACR)?

- ACR is a uniform rate increase based on a survey of reimbursement levels for, in this case, hospital providers' top 5 commercial payers
- The payment is structured as a tiered percentage increase on top of current reimbursement levels for hospital inpatient and OP services
- DHCF, worked in collaboration with the DC Hospital Association (DCHA) to establish ACR
  - We will direct Managed Care Providers in FY2025 to pay inpatient and outpatient hospitals up to the ACR
  - Payment will be made through a supplemental payment.
  - Hospitals would still be reimbursed at Medicaid levels for services to Fee-for-Service (FFS) beneficiaries.

How Will DHCF Implement The ACR?

- ACR is calculated annually as a uniform rate increase based on a survey of reimbursement levels for providers' Top 5 commercial payers
- We will structured payment as tiered percentage increase on top of current reimbursement levels for IP and OP services
- ACR applies equally to all in provider class
- Separate payment term calculated retrospectively and paid to MCPs, who are directed to filter down payments to each hospital based on actual utilization

ACR Benefits DC Community

Allows reinvestment into community health care efforts

- DHCF will work with Hospitals and DCHA to identify a set of concrete investments designed to improve access to care

ACR Payments are tied to quality strategy and initiatives

- SDPs are important mechanism for DHCF to achieve policy goals and influence outcomes with respect to managed care quality

Ensures District beneficiaries continued access in all District Hospitals

- Shrinks reimbursement gap between commercial and Medicaid patients and promotes equitable treatment regardless of insurance

The End