Mental Health and Substance Use Report on Expenditures and Services

District of Columbia Department of Behavioral Health
Barbara J. Bazron, Ph.D., Director

Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)

Mid-Year Report, FY20 Q1 and Q2 (Oct 1, 2019-March 31, 2020)

Overview

The mission of the DBH is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services. DBH serves children and youth with a diagnosis of severe emotional disturbance (SED) and adults with severe mental illness (SMI), as well as youth and adults with substance use disorders (SUD). District residents who meet the enrollment criteria are eligible to receive the full range of behavioral health services and supports. Integrated services are available for individuals who have co-occurring disorders.

Due to the coronavirus pandemic, on March 11, 2020, the Mayor declared a public health emergency and on March 30, 2020 issued a stay at home order. These actions impact how behavioral health services are accessed and delivered. Because they occurred during the last month of the reporting period, more data and analysis related to services used during the pandemic will be included in the year-end report.

Mental Health

DBH provides an array of mental health services and supports through the Health Homes and Mental Health Rehabilitation Services (MHRS) program. Health Homes provide care coordination services to ensure that consumers with multiple chronic conditions are connected to appropriate care. Consumers enrolled in MHRS have access to the following services: (1) Diagnostic and Assessment, (2) Medication/Somatic Treatment, (3) Counseling, (4) Community Support, (5) Crisis/Emergency, (6) Rehabilitation/Day Services, (7) Intensive Day Treatment, (8) Community Based Intervention, (9) Assertive Community Treatment, and (10) Transition Support Services. In addition, a variety of evidence-based programs and promising practices are offered to those enrolled in the system of care. These include wraparound support, trauma-informed care, school-based mental health services, early childhood services, suicide prevention, forensic services, peer support, and supported employment.

DBH contracts with 50 core service agencies and eight sub-and specialty providers to deliver mental health services. In addition, DBH operates adult and child clinics that provide urgent care, crisis emergency services and specialty services that are not available within the community provider network such as services for individuals dually diagnosed with mental health and developmental disabilities and those with co-occurring mental health and hearing impairment. Direct outreach in the form of prevention, treatment services and crisis stabilization is also available through the Community Response Team (CRT).

Substance Use

The Department supports four Prevention Centers that conduct community education and engagement activities related to substance use prevention across all eight wards. This includes training young people to support the Prevention Centers' capacity-building efforts focused on youth leadership and outreach to the youth population. DBH has developed the Prevention Policy Consortium made up of more than 15 District agencies and national leaders to bolster the substance use prevention infrastructure and system.

DBH also contracts with 29 treatment and recovery services and supports providers that deliver services for adolescents and adults with substance use disorders (SUD), some of which are paid for through Medicaid's Adult Substance Abuse Rehabilitation Services (ASARS) program. Individuals seeking services may go through the Access and Referral Center (ARC) or the eight community intake sites operated by existing treatment providers. During the intake process, clients receive a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance care. A comprehensive continuum of substance abuse treatment services, including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy is available within the system of care. Clients may also receive recovery support services, either independently or concurrently with treatment. Recovery services include care coordination services, recovery coaching/mentoring, and education support services.

SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Three certified substance use disorder treatment providers offer these specialized services. Screening, assessment, out-patient and in-patient treatment, and recovery services and supports are provided.

Contents

The Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) provides a summary of key agency measures related to service cost, utilization and access to the public behavioral health system. It contains information regarding MHRS, Health Homes, and ASARS services paid for by Medicaid and local dollars. Specifically, the following information is contained within this document:

- Individuals receiving services from both mental health and substance use providers is shown in *Figure 1;*
- Gender and race distribution for individuals receiving services from both mental health and substance use providers is shown in *Figures 2 and 3;*
- Mental health enrollment data are presented in *Figures 4, 5, and 6*;
- Mental health funding sources are shown in *Figures 7 and 8*;
- Mental health cost and utilization data based upon claims expenditures is presented in *Figures 9-16;*
- Substance use clients served by treatment and recovery services and supports programs are shown in *Figure 17;*
- Substance use services by Level of Care are shown in *Figure 18;*
- Medication Assisted Treatment client counts are shown in *Figure 19*;
- Substance use expenditure breakouts are presented in *Figures 20 and 21; and*
- Primary drug of choice is presented in *Figure 22.*

Limitations of the Report

1. **Mental health findings are based solely on the public mental health system's MHRS fee-for-service and Health Homes claims data**. Individuals receiving behavioral health care receive a wider array of services than what is reflected through DBH claims data. Many of these services are delivered through other arrangements. For example, approximately seventy percent of all Medicaid beneficiaries are enrolled in a managed care organization (MCO), through which they may receive behavioral health services paid for by the MCO. Other behavioral health services may be delivered through non-MHRS providers such as free-

standing mental health clinics, Federally Qualified Health Centers (FQHCs) or independent psychiatrists. These services also are not captured in the DBH MHRS claims data. Additionally, the MHRS claims data do not include:

- Inpatient psychiatric stays;
- Hospital Emergency Department psychiatric visits; and
- Contracted services supported with local dollars such as prevention and intervention services (e.g., school based mental health, early childhood services, forensic services, housing, transition-age youth services, and suicide prevention services).

2. Substance use findings are based solely on the public substance use system's ASARS claims data. As with mental health, individuals receive substance use services outside of the ASARS benefit. There are providers certified by DBH that do not have a contract with DBH and therefore do not use the DBH electronic health record, WITS, which is the source of data for this report. The count of individuals receiving medication assisted treatment (MAT) in the form of Buprenorphine or Naltrexone, which are not billable as ASARS services, is only shown in Figure 19. Methadone, which is provided in DBH's Opioid Treatment Programs (OTPs), is the only MAT shown in all other charts.

3. Matching of substance use drug of choice and level of care data is incomplete. FY20 mid-year data was pulled from a combination of Medicaid claims from the Department of Health Care Finance and from DBH's electronic health record, WITS. A new process for documenting claims as paid in WITS resulted in less than complete reporting. Declines in any data related to drugs of choice or levels of care will be re-examined in the annual report.

4. Youth treatment is predominantly covered by Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and/or funded by grants. Youth under age 21 enrolled in DC Medicaid are entitled to the EPSDT benefit. Most youth in DC Medicaid are enrolled in managed care plans. Since DBH does not collect claims data for services provided by managed care plans and/or grants, information on the number of youth served and expenditures likely understate SUD and MH services for youth.

Summary of Findings

The Department of Behavioral Health provides a robust array of services to meet the mental health and substance use service needs of District residents. Findings based upon the current analysis of data show:

Consumers Served Mid-Year FY20 (October 2019 through March 2020)

- DBH served a total of 22,923 mental health consumers in the first six months of FY20. This is about 91% of the total served in FY19.
- DBH served 3,035 clients with substance use disorders in the first six months of FY20. This is about 59% of the total served in FY19.
- Of the individuals receiving mental health or substance use services in the first six months of FY20, 1,262 received both types of services in that timeframe. This represents 5% of the mental health consumers and 42% of the substance use clients.

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District Expenditures on Behavioral Health Services

- District Medicaid and local funds paid $79.4 million for mental health services claims in the first six months of FY20. Community support represented the largest share (60%) of expenditures.

- The highest cost driver per consumer within the mental health system was intensive community-based services (Assertive Community Treatment, Community Based Intervention, Multi-systemic Therapy and Functional Family Therapy). This is consistent with previous years, as these are services for the highest acuity population.

- District Medicaid and local funds paid $10.3 million for substance use services claims in the first six months of FY20. Residential (inpatient) treatment represented the largest share (44%) of expenditures. OTP (Methadone) was the level of care with the second-highest expenditures.

Types of Services Provided

- About 13 percent (2,479) of adult mental health consumers received an intensive community-based service and seven percent (1,396) of adults obtained a crisis and emergency service in the first six months of FY20. Among youth aged 17 and younger, about 15 percent (355) received an intensive community-based service and 10 percent (247) obtained a crisis and emergency service in the first six months of FY20.

- About 46 percent (1,390) of substance use clients received OTP (Methadone) treatment in the first six months of FY20. The second-most frequently used service in the first six months of FY20 was residential services with 32 percent (967) of clients having a residential admission.

The data presented here is through mid-year FY 2020 and is based on mental health claims submitted and substance use data entered for dates of service between October 1, 2019 and March 31, 2020. Some data trends are also provided which date back to FY2018.

MH Data Source: *iCAMS, DHCF claims data (Run Date: 6/25/2020)*

SUD Data Source: *WITS, DHCF claims data (Run Date: 8/13/2020)*

Report prepared by the DBH Data and Performance Management Division

Figure 1. Individuals Who Received Mental Health and Substance Use Services by Mid-Year FY20

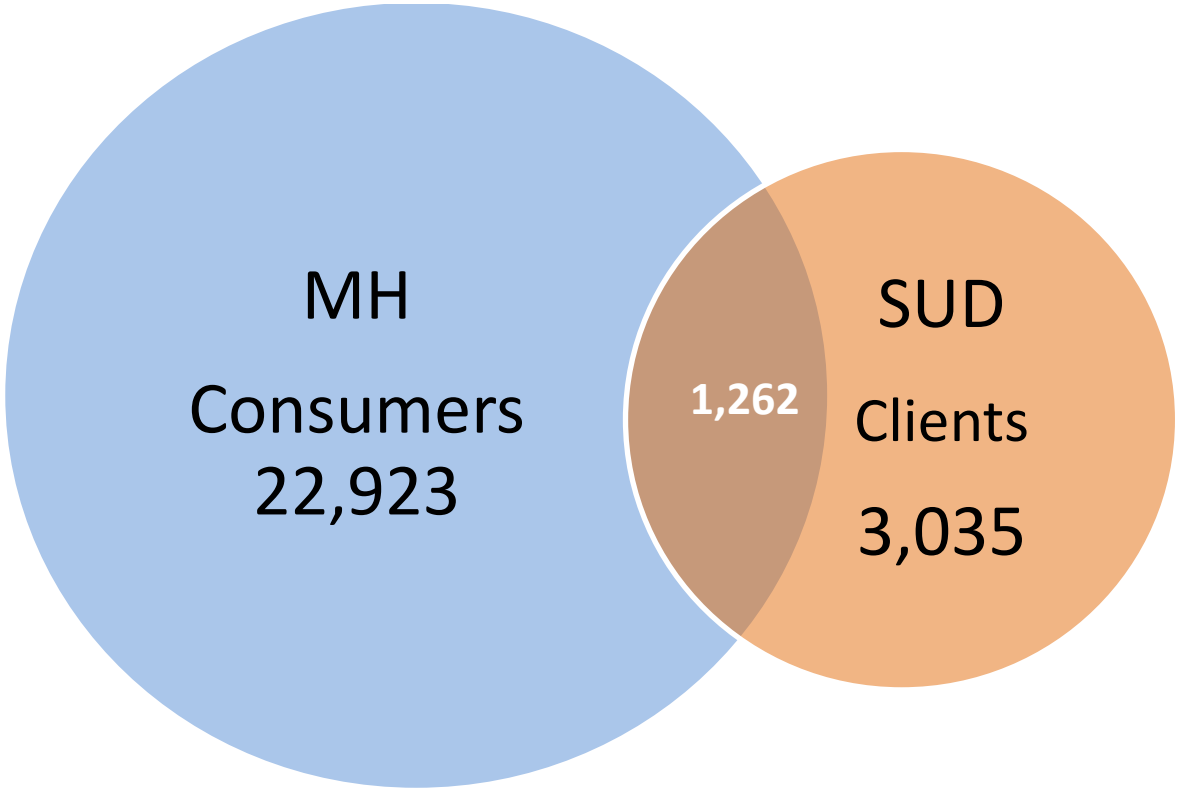


Figure 1 shows the number of persons receiving mental health services, substance use disorder services, and those receiving both mental health and substance use disorder services. There were 1,262 people who received services from both a mental health and substance use provider during the first six months of FY20.

Figure 2. Gender of Consumers Receiving Services by Mid-Year FY20

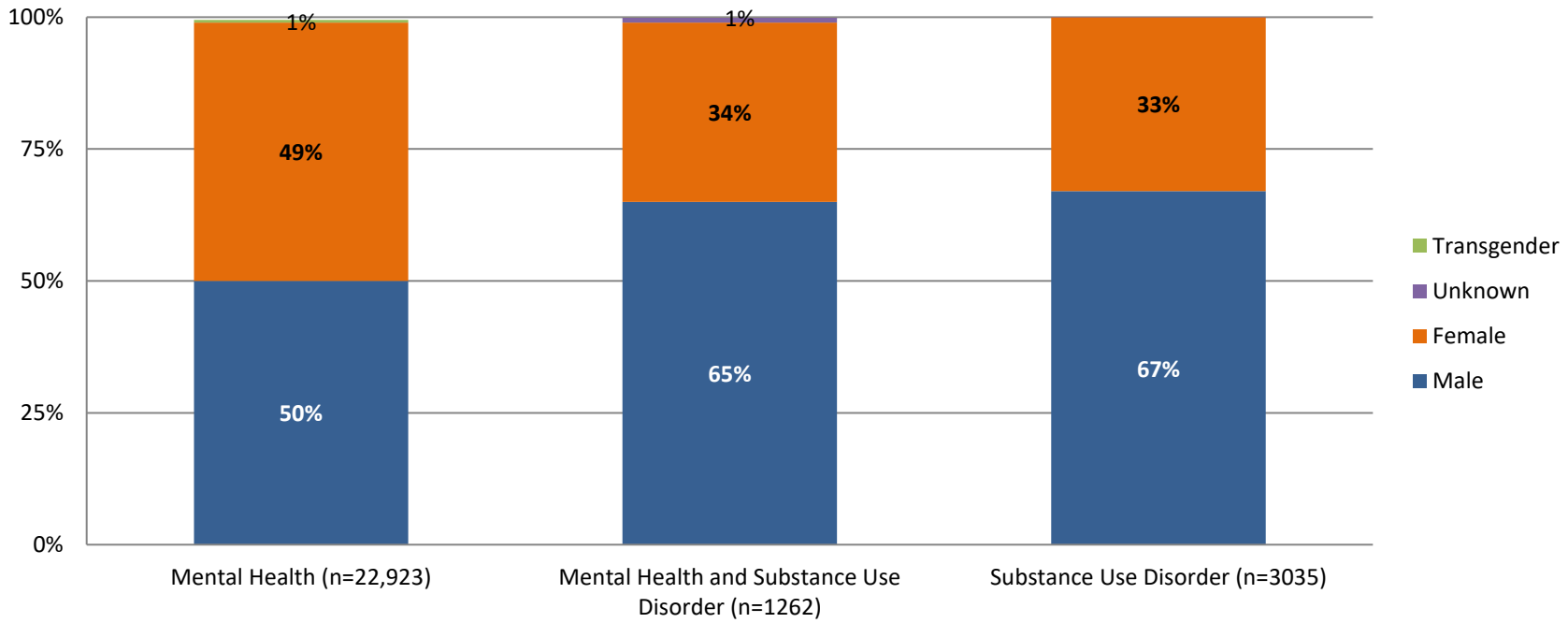


Figure 2 shows that a similar proportion of males and females are receiving mental health services; however, males are a larger share (two-thirds) of consumers receiving substance use disorder services, and/or both mental health and substance use disorder services. Individuals identifying as transgender are about 1% of consumers served.

Figure 3. Race of Consumers Receiving Services by Mid-Year FY20

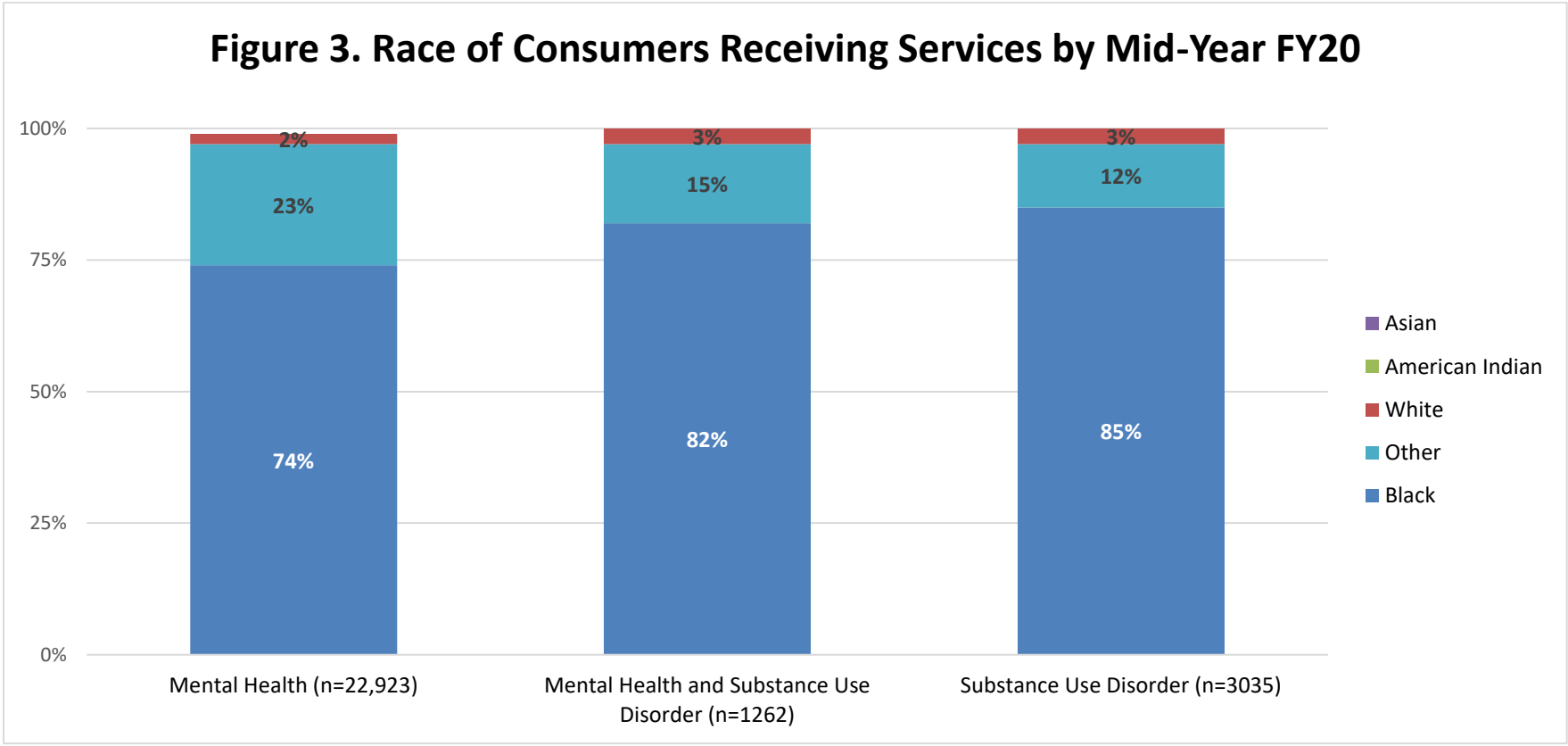
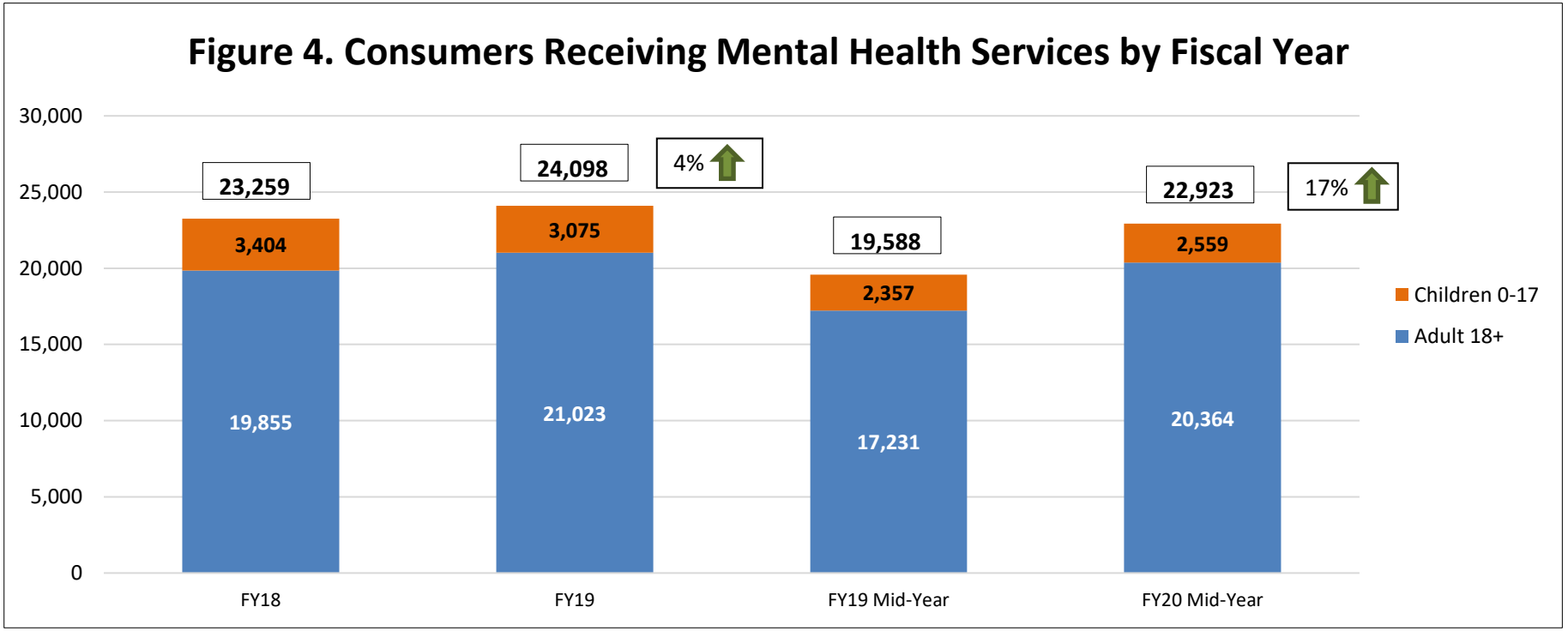


Figure 3 shows that Blacks are at least three-fourths of persons receiving mental health services, substance use disorder services, and those receiving both mental health and substance use disorder services. The next largest racial group receiving services is "Other," which include individuals of Latino/Hispanic origin.

Figure 4. Consumers Receiving Mental Health Services by Fiscal Year



	Children (0-17)	Adults	Children & Adults Total
2018 to 2019:	6% Decrease	10% Increase	4% Increase
19MY to 20MY:	9% Increase	18% Increase	17% Increase

Figure 4 shows that the number of consumers who received at least one mental health service by FY20 Mid-Year was 17% higher than FY19 Mid-Year (9% increase for children and 18% increase for adults).

Figure 5. Child (0-17) Mental Health Consumers Enrolled & Served

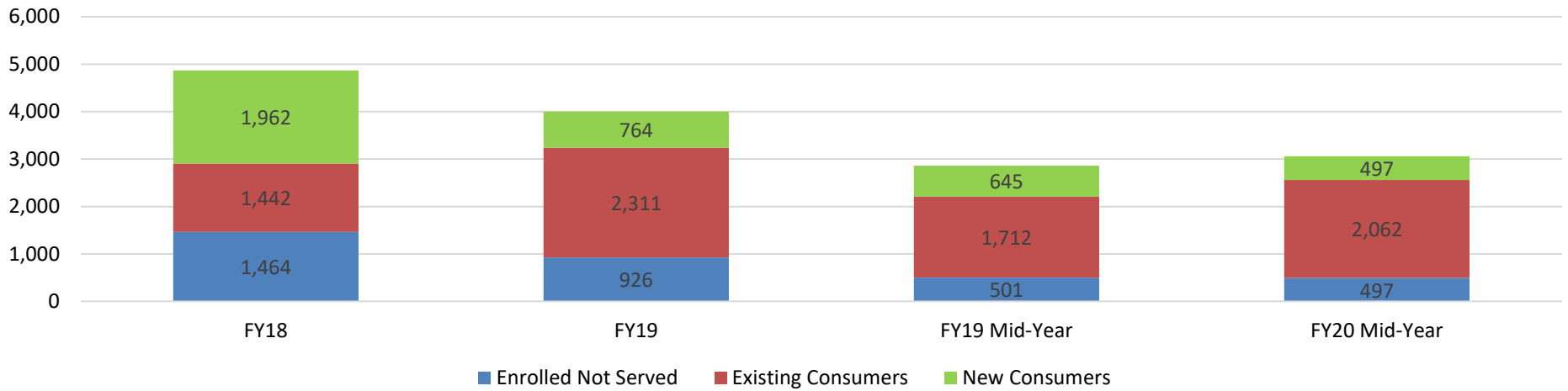


Figure 6. Adult (18+) Mental Health Consumers Enrolled & Served

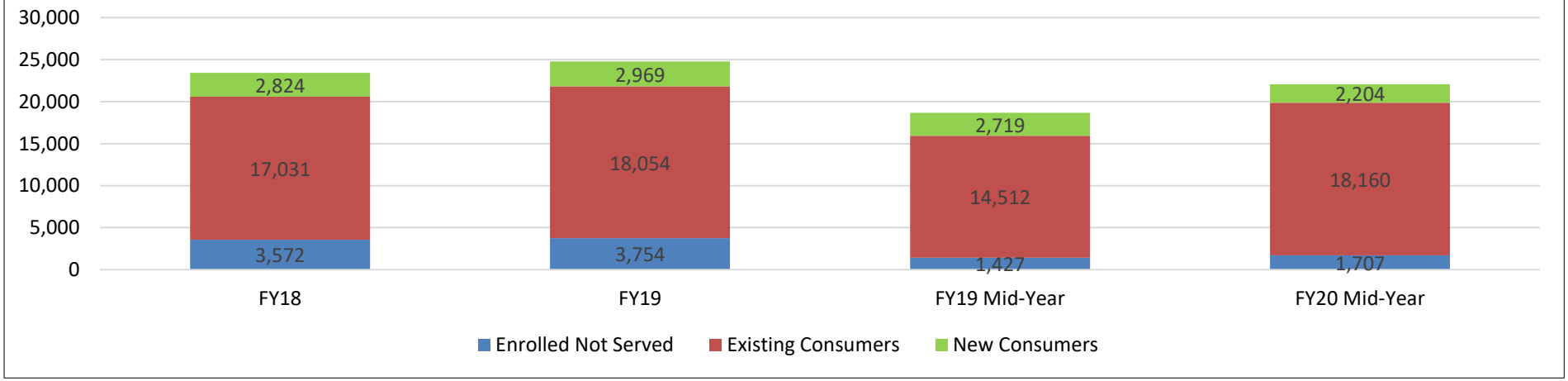


Figure 5 shows that the number of children (existing and new consumers) with a paid MHRS service is similar in FY20 mid-year and FY19. There was also little difference in the number of children enrolled but not receiving a paid MHRS claim during this timeframe. The number of adults (existing and new consumers) with a paid MHRS service is 18% higher in FY20 mid-year than FY19 mid-year. The number of adults enrolled but not receiving a service by FY20 mid-year (N=1,701) was slightly higher than in FY19 mid-year (n=1,427). For the purposes of this report, enrollment is defined as linkage to a Core Service Agency (CSA) in the public mental health system.

Figure 7. Child (0-17) Mental Health Consumers Insurance Type

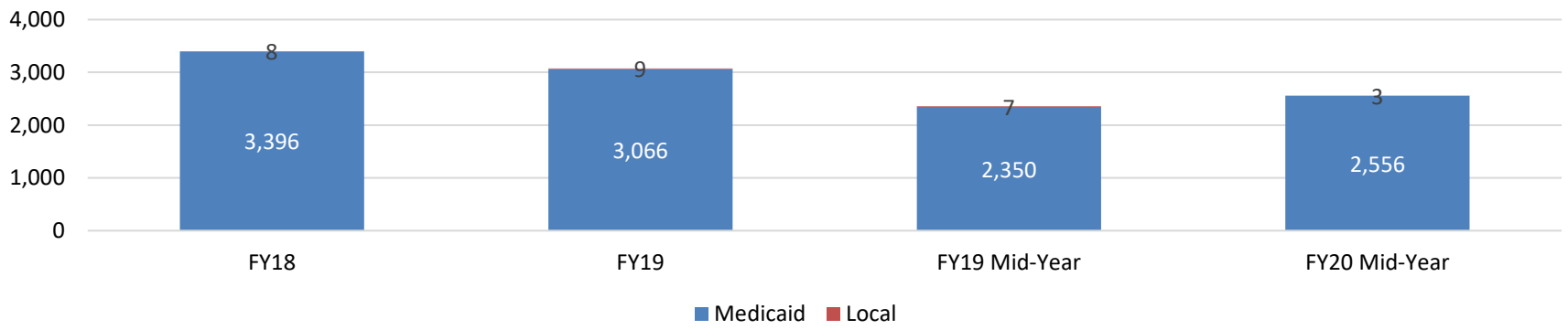
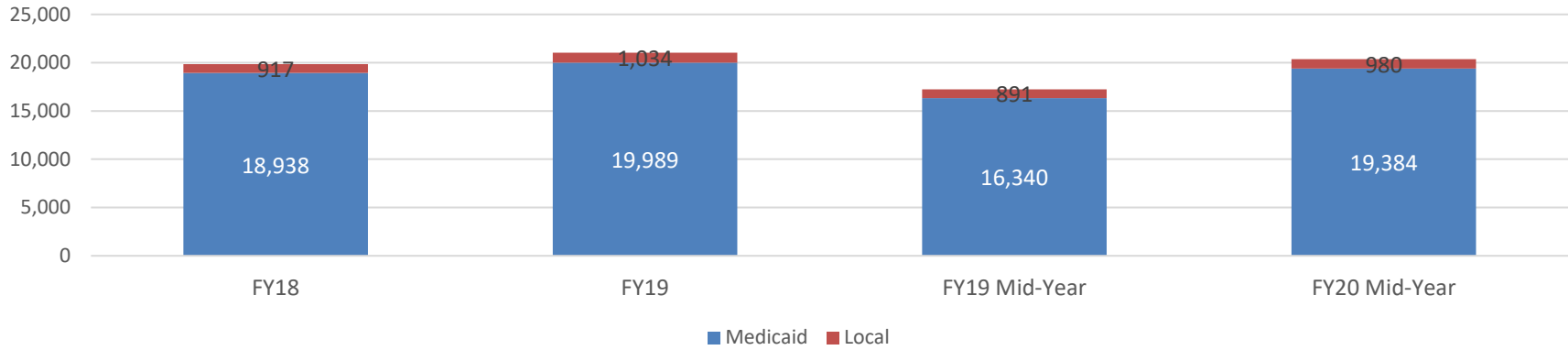


Figure 8. Adult (18+) Mental Health Consumers Insurance Type



Figures 7 and 8 show that mental health services of children and adults were paid for largely by Medicaid. However, the small fraction of consumers with mental health services paid with local dollars was 10% higher in FY20 mid-year than FY19 mid-year. Consumers with Medicaid coverage may have also had some services paid with local dollars.

Figure 9. FY20 Mid-Year Utilization and Expenditure Details – MHRS Paid Claims						
Service Group	**Child Total**	**Adult Total**	**Child & Adult Total**	**Avg Units**	**Avg Cost Per Consumer**	**Paid Amount**
ACT	**3**[1]	**2,467**	**2,470**	**157**	**$5,697**	**$17,184,771**
CBI	**357**	**19**	**376**	**153**	**$7,972**	**$2,555,424**
Level I - MST	33	1	34	72	$3,773	$117,689
Level II & III - 90/180 Day Auth	331	19	350	153	$7,950	$2,435,501
Level IV - FFT[2]	3	0	3	14	$745	$2,234
Community Support	**2,038**	**16,968**	**19,006**	**85**	**$2,037**	**$47,988,475**
Counseling	**465**	**2,822**	**3,287**	**22**	**$606**	**$1,589,853**
CPP-FV	17	0	17	35	$989	$16,807
TF-CBT	72	4	76	24	$895	$41,596
Crisis Services[3]	**246**	**1,415**	**1,661**	**12**	**$714**	**$1,142,291**
Crisis Bed	0	42	42	11	$4,016	$168,685
CPEP	3	1,113	1,116	11	$510	$634,070
Emergency – Community MH Facility	79	1	80	7	$456	$39,710
Community Response Team (CRT)	2	516	518	6	$297	$156,122
ChAMPS	198	1	199	7	$400	$143,704
Day Services	**0**	**882**	**882**	**46**	**$5,296**	**$4,671,488**
D&A	**338**	**3,368**	**3,706**	**1**	**$150**	**$488,748**
Brief	181	2,725	2,906	1	$88	$259,481

[1] Consumers' ages are calculated as of the beginning of the fiscal year. An individual who turns 18 during the fiscal year and begins receiving the adult service of ACT will be classified as a child/youth for that fiscal year.

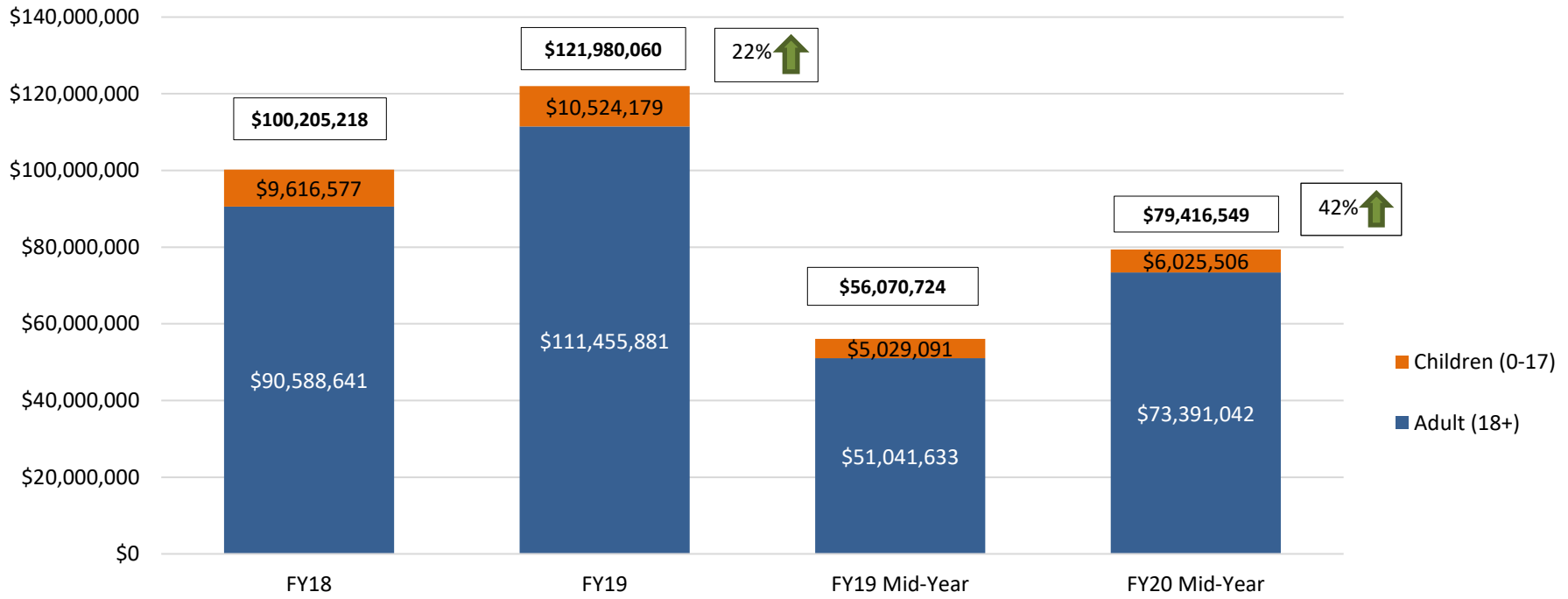
[2] In addition to those served by DBH-certified providers, 76 children received FFT from the Department of Human Services' PASS program.

[3] As a result of the District's Medicaid 1115 behavioral health waiver, new crisis services became Medicaid reimbursable effective June 1, 2020. Future MHEASURES will provide information on the use of crisis services with expanded coverage due to the waiver.

Figure 9. FY20 Mid-Year Utilization and Expenditure Details – MHRS Paid Claims						
Service Group	**Child Total**	**Adult Total**	**Child & Adult Total**	**Avg Units**	**Avg Cost Per Consumer**	**Paid Amount**
Community Based	0	0	0	0	$0	$0
Comprehensive	158	694	852	1	$269	$229,267
Medication Somatic	**516**	**8,383**	**8,899**	**5**	**$265**	**$2,704,817**
Supported Employment	**0**	**314**	**314**	**28**	**$532**	**$167,018**
Therapeutic	0	55	55	5	$136	$7,475
Vocational	0	286	286	30	$558	$159,543
Transition Support Services	**26**	**369**	**395**	**27**	**$857**	**$234,289**
Inpatient Discharge Planning	4	95	99	14	$308	$31,988
Continuity of Care Tx Planning	6	96	100	13	$307	$32,120
Cont. of Care Tx Planning (Non-ACT/CBI)	17	136	142	11	$247	$44,359
Community Psych Supportive Tx Program	0	185	202	33	$1,174	$157,810
Health Homes	**0**	**1,206**	**1,206**	**4**	**$571**	**$688,984**
Team Meeting	**2**	**4**	**6**	**5**	**$62**	**$390**
Total	**2,559**	**20,364**	**22,923**	**99**	**$2,979**	**$79,416,549**

The consumer counts for each category may include consumers who received services in each of the sub-categories and are therefore not a sum of the numbers in the sub-categories.

Figure 10. Mental Health Claims Expenditures by Age Group



	Children (0-17)	Adults	Children & Adults Total
2018 to 2019:	9% Increase	23% Increase	22% Increase
19MY to 20MY:	20% Increase	44% Increase	42% Increase

Figure 10 displays the total amount paid for mental health claims for children and adults. There were increases in total expenditures in 2019 and in FY20 Mid-Year compared to the previous year.

Figure 11. Mental Health Claims Expenditures by Payer Type

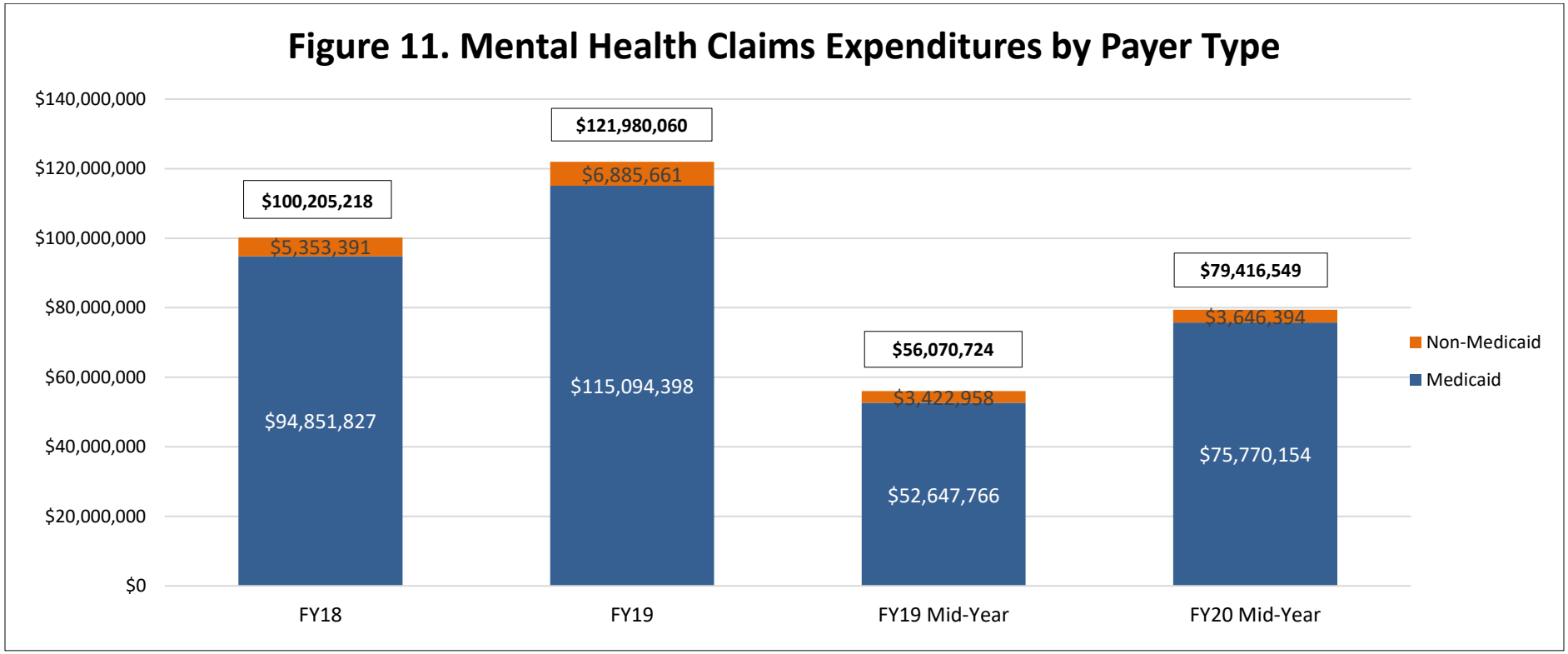


Figure 11 displays the total amount paid for Medicaid and Non-Medicaid (Locally Funded) claims for services. Local expenditures remained steady, between 5% and 6% of the total.

Figure 12. Average Cost Per Consumer By Fiscal Year

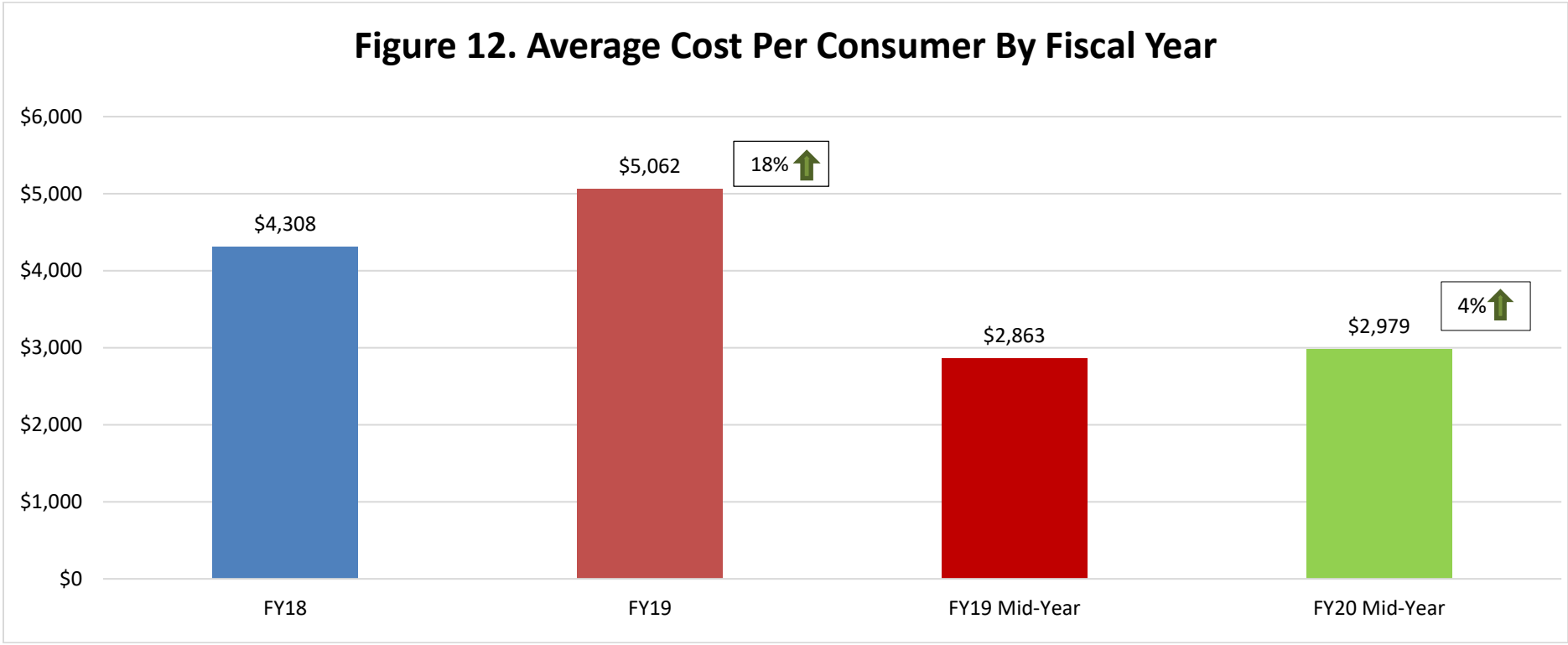
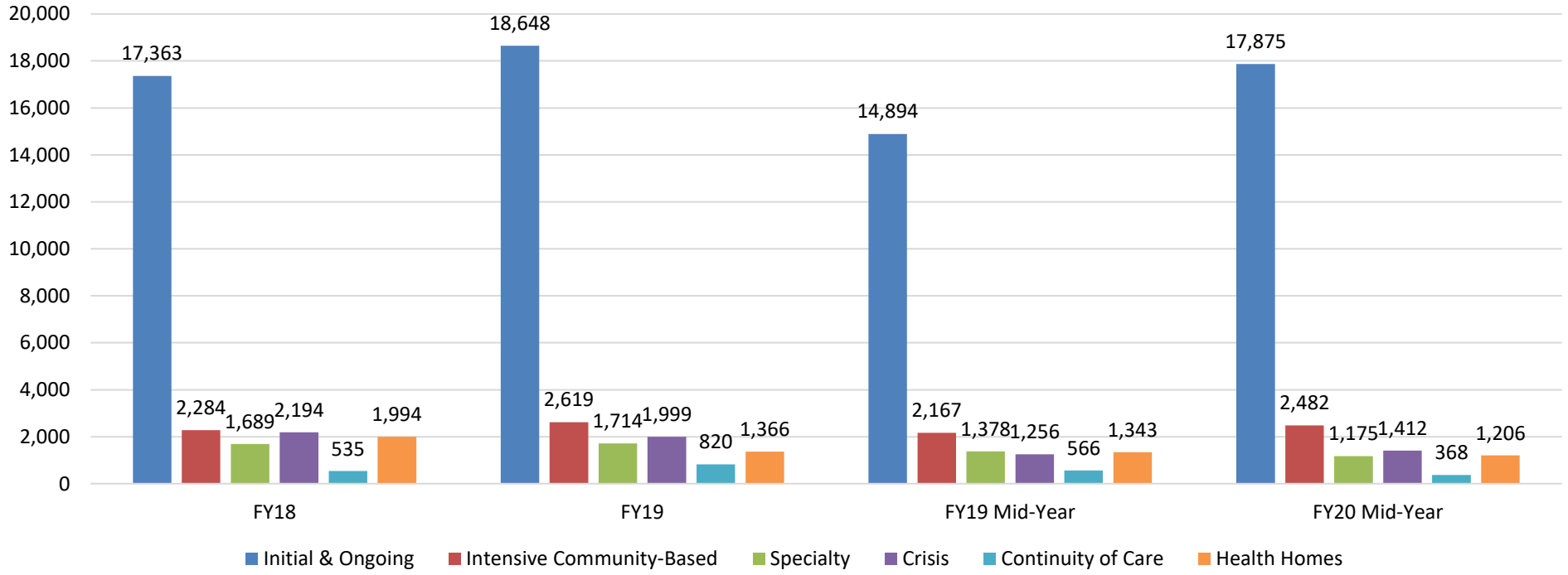


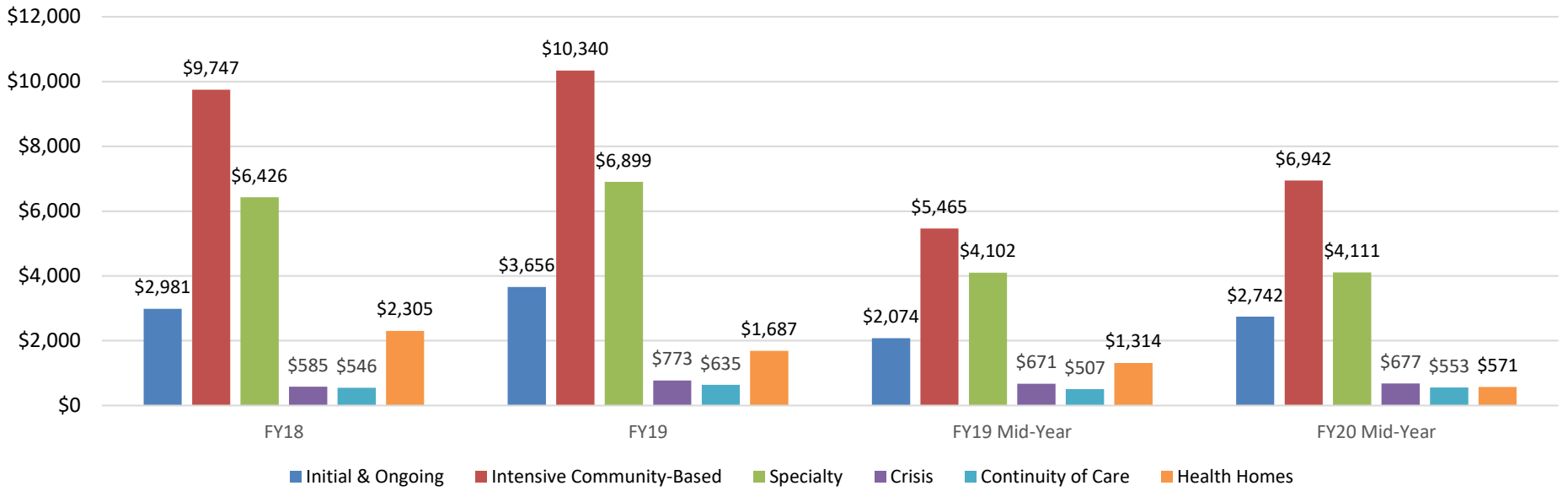
Figure 12 shows the average cost of claims paid per consumer was 18% higher in FY19 compared to FY18; and 4% higher in FY20 mid-year compared to the previous mid-year.

Figure 13. Adult (18+) Mental Health Consumer Counts by Service Group



Initial and Ongoing Services include Counseling, Community Support, Diagnostic Assessment and Medication Somatic
Intensive Community Based Services include Assertive Community Treatment, Community Based Interventions, Multi-Systemic Therapy & Family Functional Therapy
Specialty Services include Day, Integrated Care Community Project, Supported Employment, Team Meeting and Jail Diversion
Crisis Services include Crisis Beds, Psych Beds and Emergency Services
Continuity of Care Services include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program
Health Homes includes Health Homes services (adults only)

Figure 14. Average Annual Cost Per Adult (18+) Consumer by Service Group



	Initial & Ongoing	Intensive Community	Specialty	Crisis & Emergency	Continuity of Care	Health Homes
2018 to 2019:	23% Increase	6% Increase	7% Increase	32% Increase	16% Increase	26% Decrease
19MY to 20MY:	32% Increase	27% Increase	0% Change	0% Change	9% Increase	57% Decrease

Initial and Ongoing Services include Counseling, Community Support, Diagnostic Assessment and Medication Somatic
Intensive Community Based Services include Assertive Community Treatment, Community Based Intervention, Multi-Systemic Therapy & Family Functional Therapy
Specialty Services include Day, Integrated Care Community Project, Supported Employment, Team Meeting and Jail Diversion
Crisis Services include Crisis Beds, Psych Beds and Emergency Services
Continuity of Care Services include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program
Health Homes includes Health Homes services (adults only)

Figure 15. Child (0-17) Mental Health Consumer Counts by Service Group

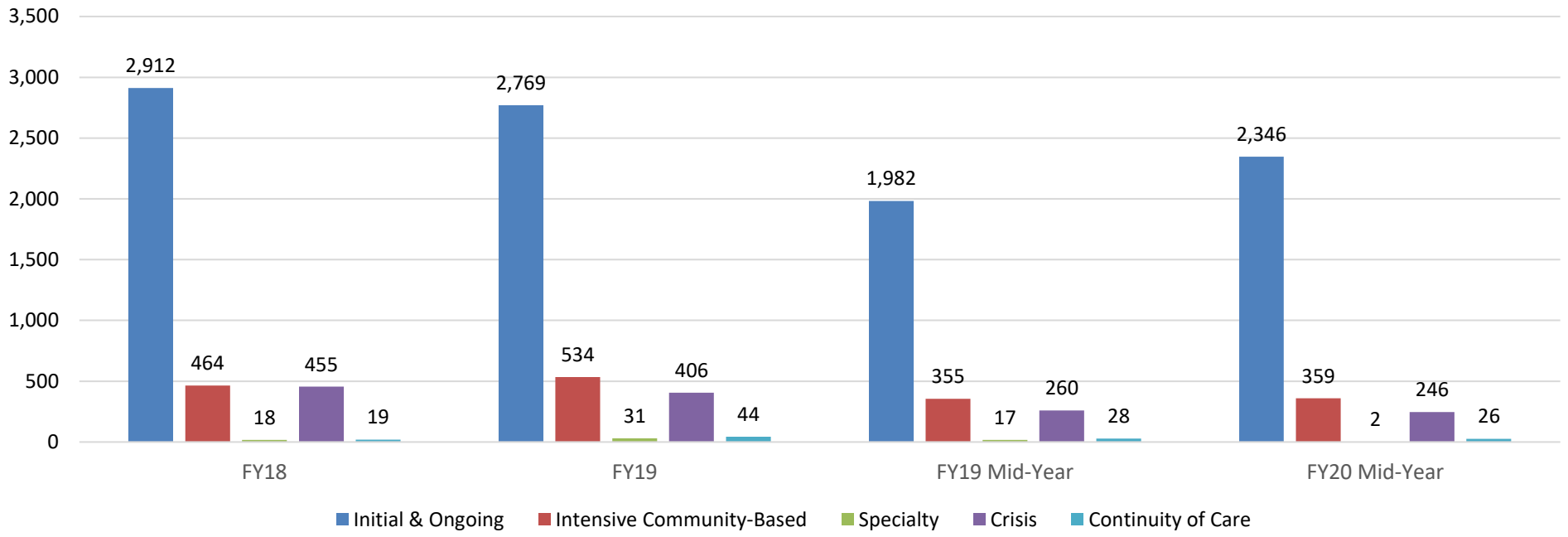
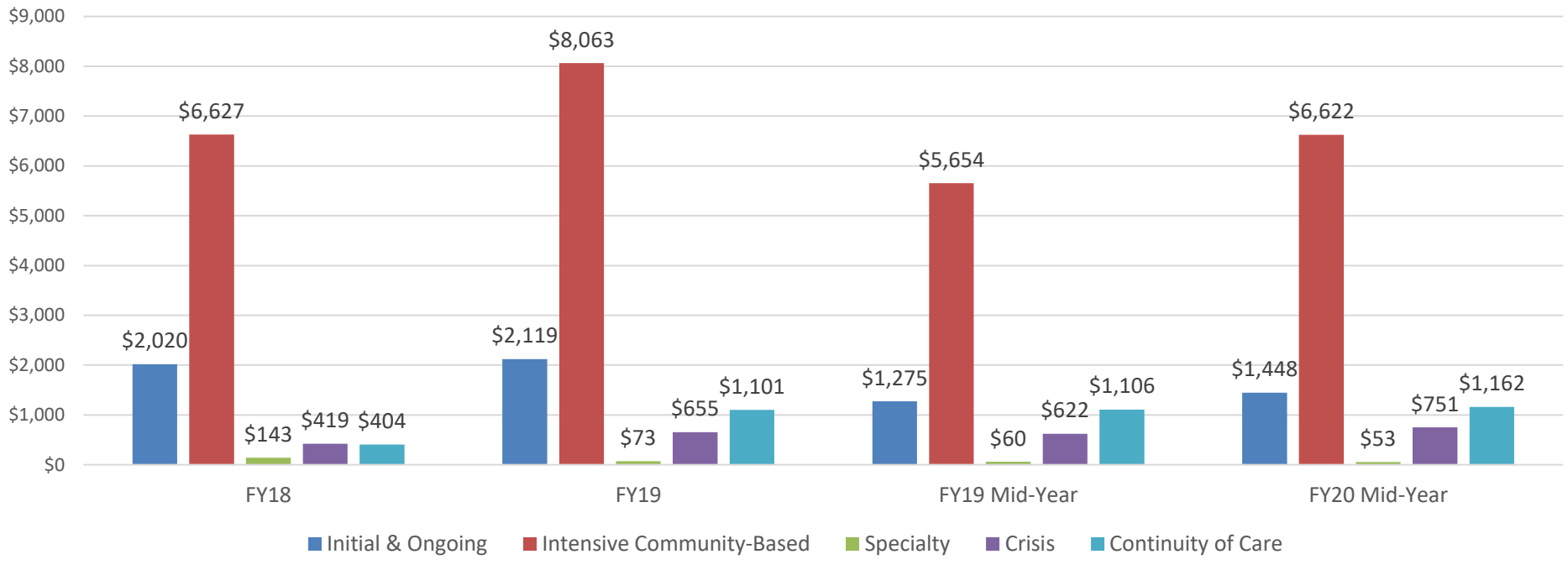


Figure 15 shows that the number of children receiving initial and ongoing services is 18% higher in FY20 mid-year than the prior mid-year. The next two largest categories of services (i.e., intensive community-based, crisis services) provided services to a similar number of children during the first six months of FY20 as in mid-year FY19. Services designed to ensure continuity of care were received by a similar number of children during the first six months of FY20 as in FY19.

Initial and Ongoing Services include Counseling, Community Support, Diagnostic Assessment and Medication Somatic
Intensive Community Based Services include Assertive Community Treatment, Community Based Intervention, Multi-Systemic Therapy & Family Functional Therapy
Specialty Services include Day, Integrated Care Community Project, Supported Employment, Team Meeting and Jail Diversion
Crisis Services include Non-Authorized Crisis Beds, Psych Beds and Emergency Services
Continuity of Care Services include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program

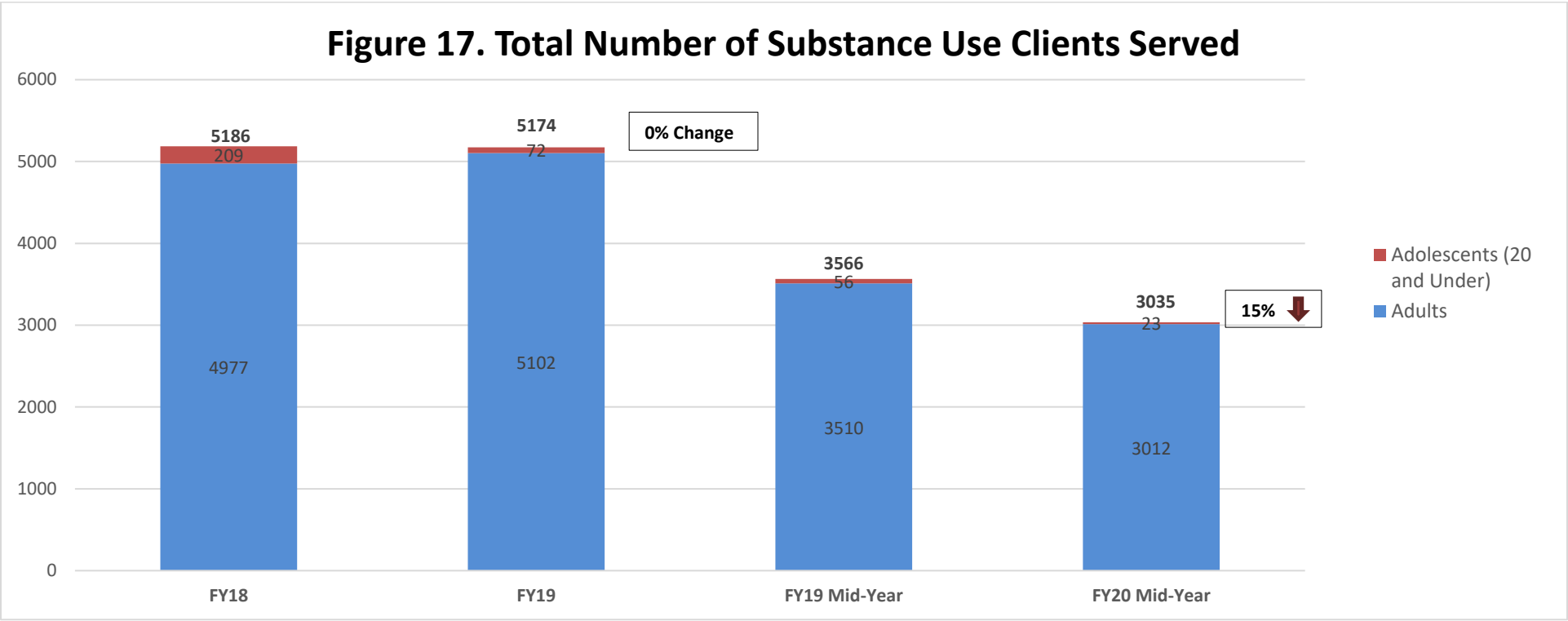
Figure 16. Average Annual Cost Per Child (0-17) Consumer by Service Group



	Initial & Ongoing	Intensive Community Based	Specialty	Crisis & Emergency	Continuity of Care
2018 to 2019:	5% Increase	22% Increase	49% Decrease	56% Increase	173% Increase
19MY to 20MY:	14% Increase	17% Increase	12% Decrease	21% Increase	5% Increase

Initial and Ongoing Services include Counseling, Community Support, Diagnostic Assessment and Medication Somatic
Intensive Community Based Services include Assertive Community Treatment, Community Based Intervention, Multi-Systemic Therapy & Family Functional Therapy
Specialty Services include Day, Integrated Care Community Project, Supported Employment, Team Meeting and Jail Diversion
Crisis Services include Non-Authorized Crisis Beds, Psych Beds and Emergency Services
Continuity of Care Services include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program.

Figure 17. Total Number of Substance Use Clients Served



	Adolescents (0-20)	Adults	Adolescents & Adults Total
2018 to 2019:	66% Decrease	3% Increase	0% Change
19MY to 20MY:	59% Decrease	14% Decrease	15% Decrease

Figure 17 shows that the number of adult substance use clients served decreased by 15% between mid-year FY20 and mid-year FY19. There was also a decrease in youth served in FY20 mid-year compared to the FY19 mid-year.

Figure 18. Substance Use Clients by Level of Care

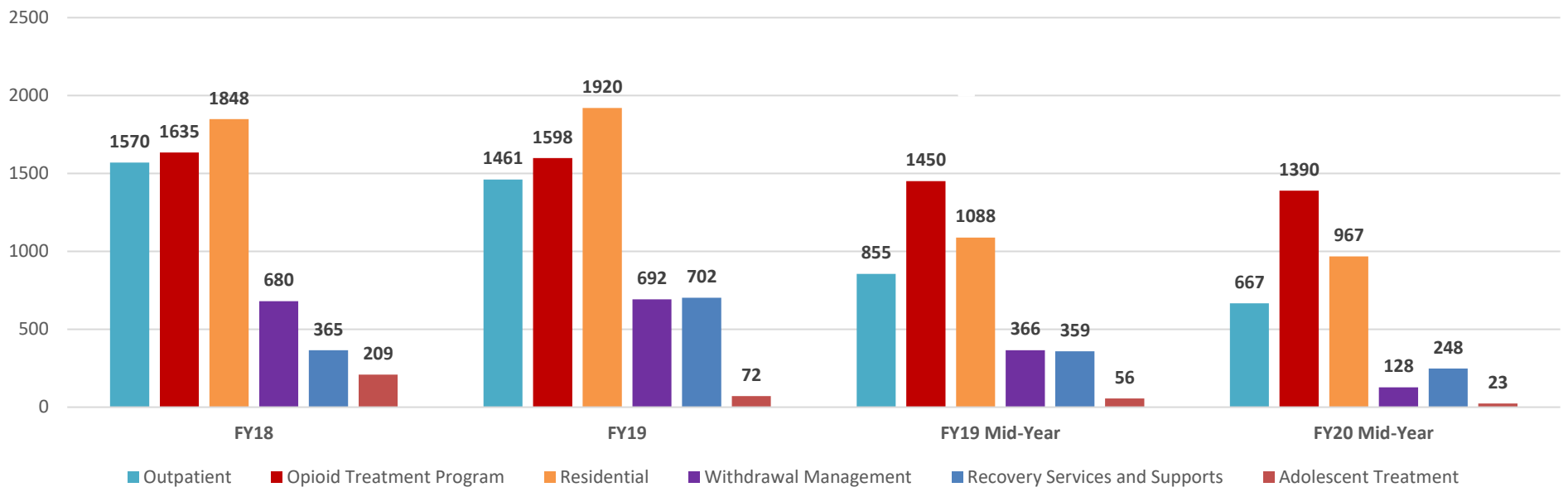


Figure 18 shows a decrease in admissions to all levels of care between mid-year FY19 and mid-year FY20. This figure includes individuals who, during the fiscal year, moved from one level of care to another, had a new assessment and referral, remained at the same level of care, and/or received recovery services. Individuals may appear in the counts for multiple levels of care if they had more than one admission during the year. Due to the data quality issues discussed in the limitation section, these findings will be reexamined when more complete data are available.

NOTE: **Withdrawal Management** (detoxification) is for clients with sufficiently severe signs and symptoms of withdrawal from psychoactive substances who require medical monitoring and nursing care, but for whom hospitalization is not indicated. **Residential Treatment** (inpatient) programs focus on helping individuals change their behaviors in a highly structured setting. **Outpatient** services provide counseling and monitoring several times a week in a supportive group setting. **Opioid Treatment Programs (OTP)** involve the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

Figure 19. Medication Assisted Treatment

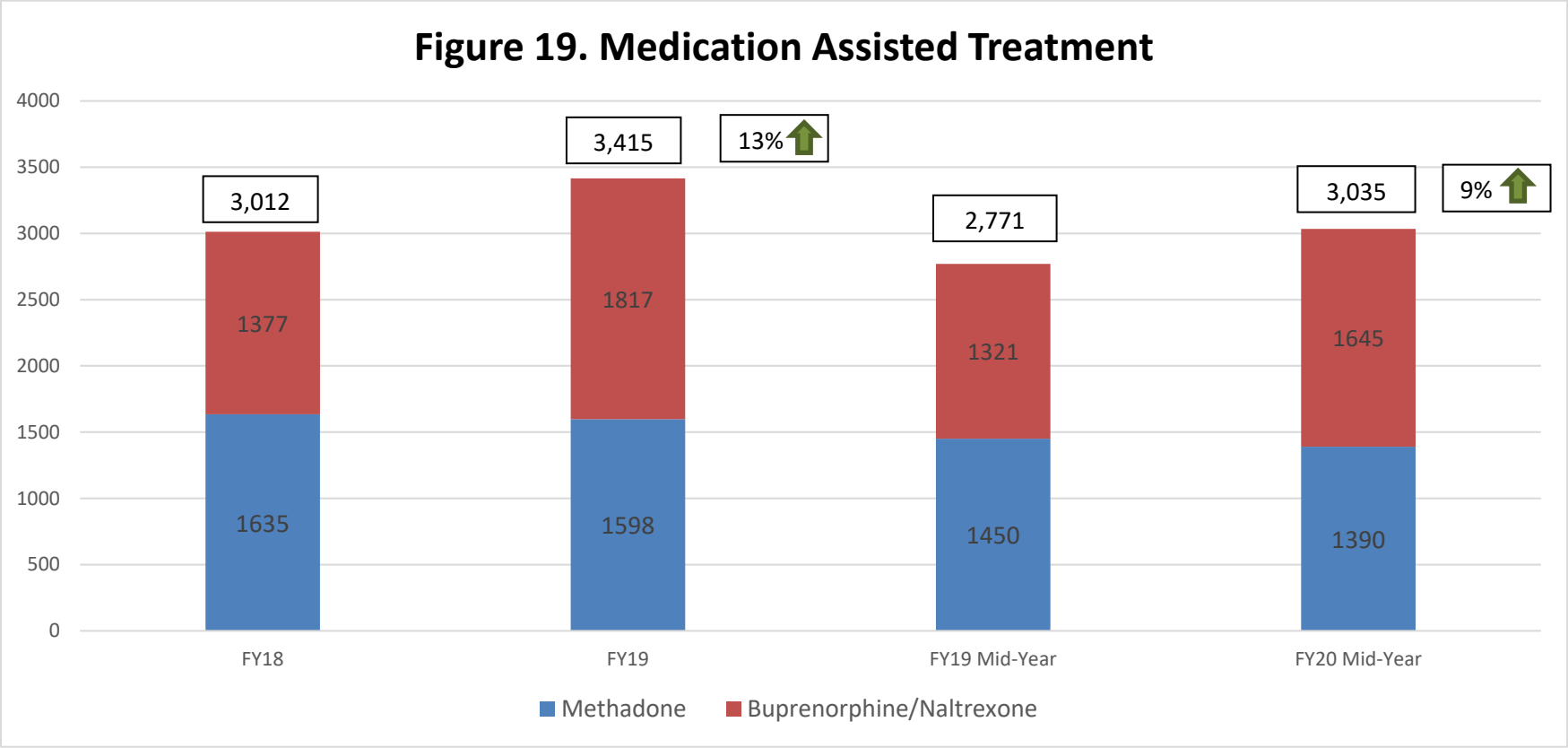


Figure 19 shows the number of clients receiving two forms of Medication-Assisted Treatment (MAT) for opioid use disorder. Methadone is administered in Opioid Treatment Programs (OTPs), while Buprenorphine and Naltrexone are prescribed in primary care settings. DBH certifies the OTP providers, and the Department of Health Care Finance monitors prescribers of Buprenorphine and Naltrexone. While the use of Methadone decreased in the timeframe shown above, the use of Buprenorphine and Naltrexone increased. The overall use of both types of MAT increased by 13% between FY18 and FY19 and by 9% between FY19 mid-year and FY20 mid-year.

Figure 20. Expenditures by Level of Care

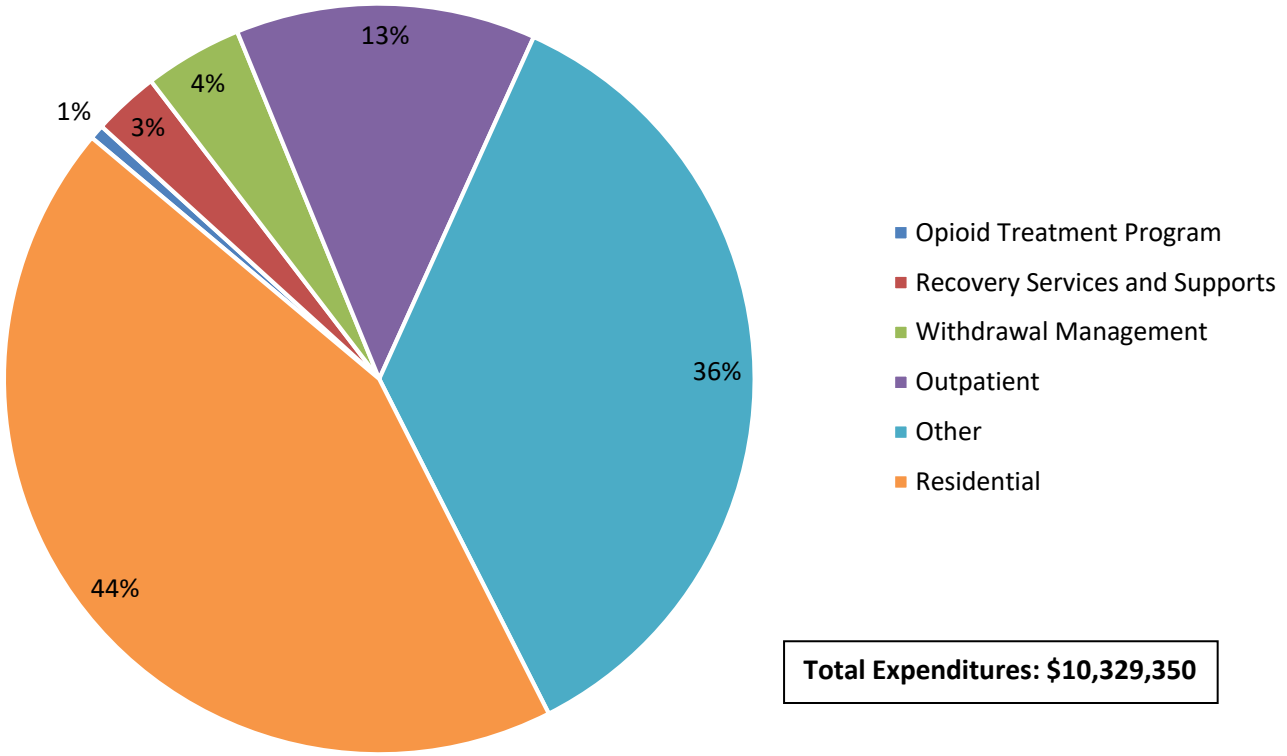
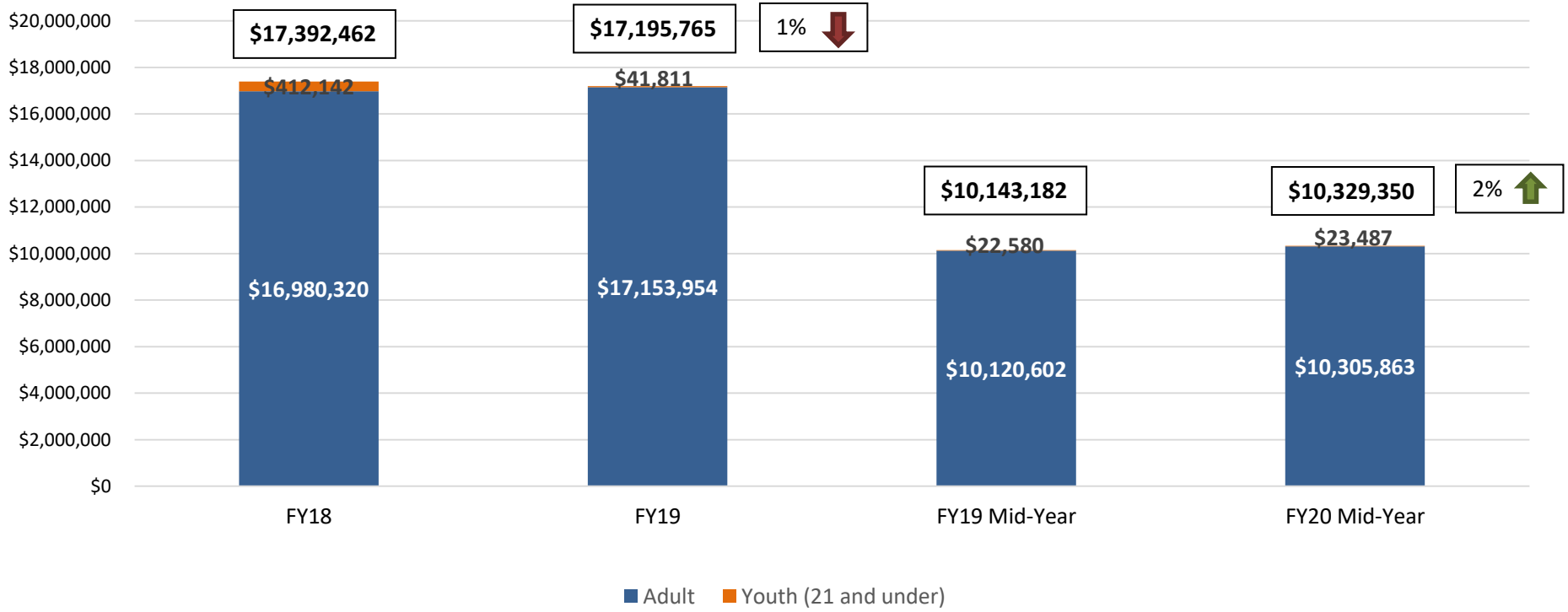


Figure 20 shows that 44% of Substance Use Disorder (SUD) expenditures were for residential services. The next largest category of expenditures (24%) was OTP (Methadone). "Other" includes SUD services for veterans (including housing cost) and SUD services for individuals with HIV (including education and medical costs). Due to the data quality issues mentioned in the limitations section, OTP expenditures only include Methadone dosing. Expenditure for additional services provided by OTPs, such as counseling and drug testing, are counted in the Outpatient level of care.

Figure 21. Substance Use Expenditures



	Adolescents (0-20)	Adults	Adolescents & Adults Total
2018 to 2019:	90% Decrease	3% Increase	1% Decrease
19MY to 20MY:	4% Increase	1% Increase	2% Increase

Figure 21 shows that expenditures (Medicaid and Locally Funded) for substance use services for youth and adults in FY20 mid-year are roughly similar to those in FY19 mid-year. The decline in expenditures for adolescents between FY18 and FY19 mirrors the decline in the number of people served.

Figure 22. Primary Drug of Choice

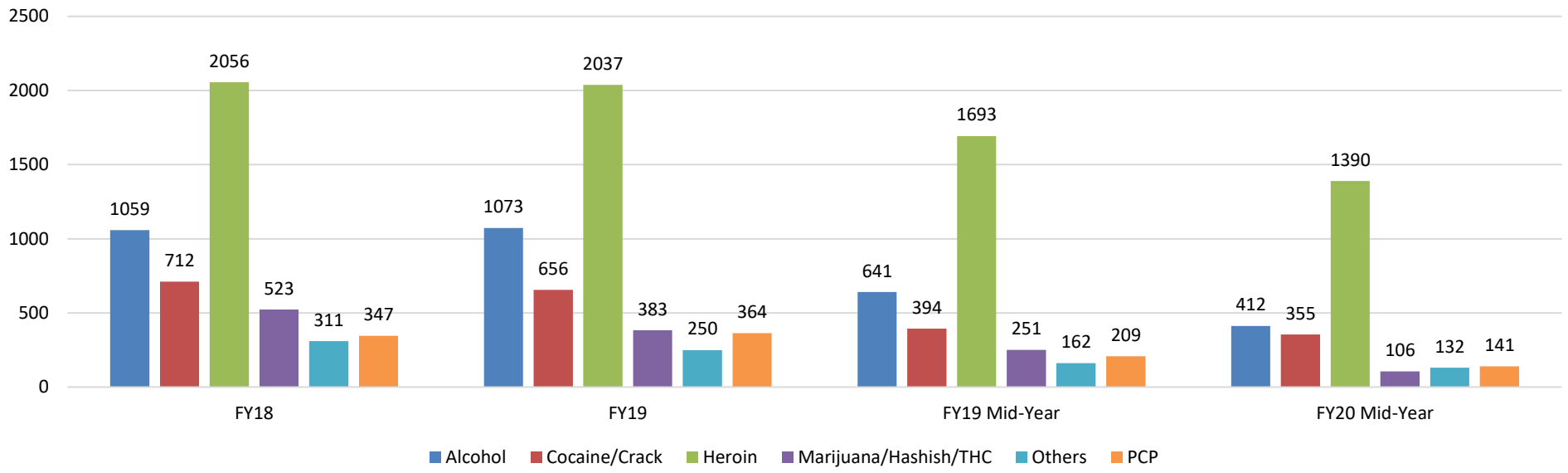


Figure 22 shows that clients with heroin as their primary drug of choice dropped in FY20 as compared with FY19 mid-year. The number of clients with alcohol as their primary drug of choice also was lower in the first six months of FY20 than in FY19. Because of the data quality issues mentioned in the limitations section, these trends will be re-examined in the full year report, as drug of choice data was not available for some clients served in FY20.

NOTE: The counts for each substance in Figure 22 come from the most recent admission for each client. Not included are the primary substances for clients who only received recovery services and supports, nor youth. Clients who had more than one admission are only counted once.