501 3rd Street, NW · 8th Floor
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony Before the District of Columbia Council
February 16, 2023 & February 17, 2023

Public Performance Oversight Hearing:
Department of Health Care Finance

Amber Rieke
Project Lead, *A Path Forward*
Children's Law Center

My name is Amber Rieke. I am the Project Lead for *A Path Forward* at Children's Law Center. [1] Children's Law Center believes every child should grow up with a strong foundation of family, health, and education and live in a world free from poverty, trauma, racism, and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners, and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today about important issues under the purview of the DC Department of Health Care Finance (DHCF). At Children's Law Center, nearly all of our clients are Medicaid beneficiaries. We know the importance of having a public health insurance system that can meet the diverse health needs of District residents. Children represent over one-third of DC's Medicaid enrollment; children's health needs are unique, and their interests and concerns require special attention. Today I will describe how the major changes underway in DC's Medicaid structures could potentially improve access to behavioral health services, especially for children. However, DHCF will need to be especially attentive to and intentional about

various technical aspects of the transition to Managed Care Organizations (MCOs) over the next year to achieve improvements rather than worsen gaps.

In my testimony, I will detail the areas that require attention and oversight to provide youth with behavioral health services that are timely, high quality, and culturally appropriate. I will then spotlight recommendations for DHCF to undertake with agency and Council partners:

1. Guarantee an adequate network of child-serving behavioral health providers to deliver appropriate services to Medicaid beneficiaries, including multilingual providers, through reasonable credentialing processes and reimbursement rates adjusted annually for inflation in order to sustain and broaden the provider network.
2. Prioritize collection and sharing of data that improves quality and performance, while minimizing the burden on providers.
3. Address current gaps for DC youth in foster care related to Medicaid enrollment and continuity of care, while also preparing to successfully transition this population to MCOs.
4. Maintain investment in the HealthySteps program to support growing families by providing pathways to long-term, sustainable funding.
5. Remedy recent changes to the Respite Benefit that make the benefit almost impossible to use.

The recommendations detailed here draw liberally from last year's report, *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, which Children's Law Center co-authored with community partners.[2] The report drew on evidence and consultation with stakeholders to identify gaps in the current landscape and detailed 94 unique recommendations to better meet the behavioral health needs of DC children and families. We envision a working *system* – in the truest sense of the word – that not only meets the service demand, but embodies the values of family-centered care, cultural humility, racial equity, and trauma-informed care.

Background: Transitions to Medicaid create opportunities for evolution and equity

Over the past few years, DHCF has initiated several major changes to the District's behavioral health system. These changes include the 2019 announcement to move toward a fully-managed Medicaid program by 2024.[3] Beginning October 1, 2023, behavioral health services will be integrated into the District's managed care contracts.[4] Additionally, at the beginning of 2020, the DC Section 1115 Medicaid Behavioral Health Transformation Demonstration became effective, which allows the District's Medicaid program to cover more behavioral health services.[5] Finally, a new behavioral health service rate study is under review. These changes provide a real opportunity to transform the behavioral health system in the District. If not properly planned and

implemented, however, these changes could result in further breakdowns and failures in the District's behavioral health system.

At Children's Law Center, the children we work with – including those in the foster care system, receiving special education services, or dealing with unhealthy housing conditions – often have significant behavioral health needs compounded by trauma, loss, or instability. In a review of over 400 clients between June 2021 through May 2022, approximately three-fifths of our clients had documented behavioral health needs, but one-quarter of those were not receiving some of the most basic services our system should be able to provide them – initial intake appointments, individual and family therapy, counseling, autism evaluations, and medication management appointments. Delays are due to many factors including provider shortages (particularly in certain specializations like psychiatry and grief counseling, for example), difficulty finding therapists that can communicate in languages other than English, poor coordination across agencies or providers, and/or limited transportation.

Far and away though, the biggest obstacle to critical services is the lack of behavioral health care professionals practicing in the District. Our clients consistently report being unable to find providers offering the services they need – or if they manage to find a provider, the wait for an appointment is prohibitively long.

Five DC departments, including DHCF, have some governance role in children's behavioral health, which causes extensive system fragmentation and leads to

inefficiencies in the system. When DC transitions to a fully managed Medicaid program, the responsibility for behavioral health services managed by DBH will move to the MCOs. DBH and DHCF need to carefully coordinate this shift in responsibility with consumers in mind and ensure there is clarity and transparency regarding new roles.

1. **DHCF must ensure "network adequacy" in MCOs, including services in non-English languages, to prepare for major systemic transitions.**

As DHCF begins the integration of behavioral health services into MCOs this year, one of the most essential jobs will be ensuring there are enough providers in MCO networks to meet the broad and diverse needs of beneficiaries. Networks must establish relationships with enough professionals across specialties to serve clients across the lifespan, including those who speak languages other than English. DHCF should ensure that credentialing requirements are not too burdensome or exclusive and that pay rates incentivize participation and are adjusted annually for inflation.

Network adequacy – what is it?

Federal Medicaid regulations require that participating states maintain an adequate network of providers "to achieve greater equity in health care and enhance consumer access to quality, affordable care."[6] Under current MCO contracts, the behavioral health services network must include: child psychiatrists, specialists in developmental/behavioral health medicine, child psychologists, social workers

(including those specializing in treatment of mental health and substance use disorder), inpatient psychiatric units for children, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers. Additionally, the MCO network must include certified early intervention providers for health-related Individuals with Disabilities Education Act (IDEA) services, as well as providers qualified to perform evaluations for IDEA eligibility. MCOs must accord with network adequacy standards, "availability of services standards," as well as the Mental Health Parity and Addiction Equity Act of 2008 and the District of Columbia Behavioral Health Parity Act of 2018.[7]

Networks are functionally inadequate, with people waiting too long for evaluations and appointments and clients frequently losing therapists to turn-over. Waitlists become so long that providers close them indefinitely. Currently, there is an insufficient number of child-serving behavioral health providers, including child psychiatrists, specialists, child psychologists, social workers (including those specializing in treatment of mental health and substance use disorder), especially for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays. We also need more providers with training in specific evidence-based treatments (e.g., applied behavior analysis therapy, parent-child interaction therapy, child-parent psychotherapy, dialectical behavior therapy, etc.). Lastly, networks should include

inpatient psychiatric units for children, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers. With the current systems shortages, it is going to be quite challenging for the MCOs to ensure network adequacy without strong oversight and enforcement.

Enforcing network adequacy standards can increase access and equity.

It is critical for DHCF to not only routinely monitor but also enforce network adequacy. Meaningful measures should go beyond the federally mandated standards (which include travel time and distance standards)[8] and should have strong correlations with access to and quality of care.[9] The development of new and/or updated local network adequacy standards should involve stakeholder consultation (inclusive of providers and beneficiaries) and consider specific settings, community needs, and resource constraints. All network adequacy standards should be tied to accountability mechanisms that are regularly and transparently enforced.

According to the new MCO contracts, "The Contractor's failure to comply with the Provider Network and Access requirements in this section will result in DHCF requiring the Contractor to develop and implement a corrective action plan (CAP) to remedy the failure. In addition, DHCF may impose sanctions on the Contractor in response to Provider network and access violations."[10] However, we are not aware of any enforcement measures being levied to date, despite recent external reviews

documenting inadequacies. Additionally, MCO contracts lack sufficient clarity and direction to effectively incentivize payers to improve behavioral health care access.

The only place in the MCO contract with timeliness requirements for behavioral health service is for "the assessment and stabilization of psychiatric crises" (within 15 minutes for phone-based, and 90 minutes for in-person, on a 24-7 basis).[11] The contracts do not dictate the time to less acute behavioral health services, though they do set limits for waits for initial primary care appointments for adults (30-45 days),[12] appointments for diagnosis and treatment of non-urgent health conditions (30 days),[13] routine and well-health assessments of adults (30 days),[14] and non-urgent referral appointments with specialists (30 days).[15]

MCO contracts specify distance standards as within five miles of an enrollee's residence or no more than thirty minutes travel time.[16] Specifically, MCOs "shall ensure that the [t]ravel [t]ime to general acute care hospitals or mental health providers shall not exceed thirty (30) minutes [t]ravel [t]ime by public transportation."[17] However, without complementary focus on time waiting for intake or therapy, payors can say they have adequate networks even when services remain severely inaccessible.

Similarly, in the new contracts, MCOs are only required to "ensure that its non-English speaking enrollees have access to free interpreters, if needed."[18] That requirement is not sufficient to guarantee that the network includes non-English

speaking providers. DHCF should consider a more effective strategy to ensure children can access culturally competent behavioral health services in their native language.

All network adequacy standards should be tied to accountability mechanisms that are regularly and transparently enforced. In *A Path Forward*, we recommend that DHCF:

- Strengthen reporting of access-to-care standards in MCOs specific to behavioral health, including specific metrics for children, and require MCOs to publicly report on those standards on a regular basis.
- Implement transparent strategies to enforce MCO network adequacy standards and compliance measures, as well as publish regular reports.
- Consider strategies such as monetary penalties for failure to meet network adequacy standards and/or a backstop dispute resolution process, whereby independent medical experts determine when patients need to go out of network to receive necessary medical care.[19]

Setting sensible protocols and sufficient rates supports an adequate provider network.

Enforcement is necessary to improve network adequacy in future years. However, in the meantime, DHCF must also guarantee that the pool of current providers will continue to be available through MCOs *this* year. This is the foundation of a successful transition. Steps DHCF must take this year include:

- Require universal contracting for "critical providers" to ensure enough providers are in place immediately following the carve-in of behavioral health services in October.
- Set reasonable, uniform credentialing requirements for behavioral health professionals (including tele-health providers) and compel quicker credentialing turnaround time for all MCOs.
- Require MCOs to use standardized and simplified authorization and billing processes and protocols.
- Offer competitive reimbursements to encourage behavioral health providers to participate in public health insurance plans.

DHCF should require universal contracting for "critical providers" to ensure enough providers are in place immediately following the carve-in of behavioral health services.

When behavioral health services are integrated in October, DHCF will be several months into its contracts with the three new Medicaid MCOs. DHCF is responsible for setting policies and infrastructure so that beneficiaries do not experience major disruptions to their treatments during the transition. Further, for some "critical" services, a patient should have access to any therapist or provider that is participating in any of the MCOs; nobody should have to lose a therapist or change MCOs entirely after the carve-in takes effect.

MCOs should be required to offer at least an initial contract to all child-serving providers to ensure there is an adequate network for children immediately following

the carve-in of behavioral health services.[20] DHCF has shared that all DBH-certified providers wishing to participate are automatically included as critical providers for a minimum of 18 months.[21] Hospitals and Federally Qualified Health Centers are also covered as critical providers. We are not aware what other kinds of providers qualify. We hope that providers of Community Based Intervention (CBI) and Assertive Community Treatment (ACT) TEAM providers will also be included.

MCOs should have uniform credentialing requirements for behavioral health professionals, with quicker credentialing turnaround time.

Generally, formalizing relationships between providers and payors is a necessary, but laborious, process. To make it easier for child-serving providers to join all three MCOs, DHCF should require uniform, standardized credentialing requirements for all MCOs. As part of that requirement, all MCOs should be required to accept DBH certification as meeting MCO standards and credential DBH-certified behavioral health provider organizations and FQHCs at the organizational level (rather than at the individual staff level). There also needs to be a consistent process for determining which organizations are paneled and credentialed through group practice and facility standards. Whether or not MCOs are required to credential at the organization or individual level, DHCF should require electronic exchange of provider organization staff records using standardized processes, forms, and formats to be adopted by all MCOs. We support the use of the Council for Affordable Quality

Healthcare as a centralized platform for paneling or credentialing by all MCOs contracted with DHCF.

In addition to standardizing the process, we also recommend amending contracts so that providers are credentialed with an MCO much faster than they are now. Specifically, we ask for DHCF to adopt a "timely credentialing" process. Similar to "timely payment" standards, this would require that 90 percent of providers be credentialed within 30 days and 99 percent credentialed within 60 days. Credentialing professionals is the last step in an already-lengthy process that begins with provider groups enrolling as a Medicaid Provider with DHCF, which may take up to 120 days, then paneling a roster of practitioners, followed by credential with MCOs.[22] Under current standards, it could take up to 240 days – about eight months – from the first application for a provider to be able to serve MCO patients. Quicker credentialing will reduce barriers to providers joining the MCO networks and help build an adequate network of child-serving providers.

MCOs can ease burden on providers with standardized and simplified authorization and billing processes and protocols.

Standardized processes ease administrative burden for providers, as well as yielding consistent data for District-level analyses. Providers should not be dissuaded from seeing Medicaid clients because of excessive or painful authorization and billing processes. Determination of protocols should involve all relevant stakeholders, and the implementation should involve training providers. At a minimum, authorization and

utilization management should conform to evidence-based, publicly available, nationally accepted standards of care developed by clinical provider associations or societies. All codes eligible for billing under DC Medicaid FFS should be available for billing by any provider paneled with any MCO. Which organization types are eligible for facility credentialing, group credentialing, or individual credentialing should be consistent across all MCOs, and credentialing should use a standardized electronic process or clearing house accessible to all MCOs and all providers and provider organizations.

Insurance programs must offer competitive provider reimbursements to encourage behavioral health providers to participate in public health insurance plans.

Practitioners delivering behavioral health care to children and preventive services should be compensated at a level that is commensurate with the time and effort expended. A report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[23] Research showed that for every $10 increase in Medicaid reimbursement per visit, parents were 0.5 percentage points more likely to report no difficulty finding a provider for their Medicaid-insured children. Additionally, the same $10 increase in payment per visit reduced reported school absences among primary school-aged Medicaid recipients by 14 percent.[24] Provider reimbursements rates should be updated regularly to remain competitive in evolving markets.

Additionally, billing processes should be easy to navigate and reimbursements should be timely enough to avoid disruptions to providers' businesses. There should be an established mechanism for consulting providers on all major billing and reimbursement decisions (whether operational or strategic). Additionally, MCOs' coverage limits should be based on national standards of care, which take into account the full continuum of behavioral health care services when defining medical necessity.[25] The criteria for medical necessity should be made transparent to providers as well as the public, be consistent across MCOs, and be formed by an independent party.

We recognize that DC is undergoing a behavioral health reimbursement rate study, which is intended to improve reimbursement rates and rate-setting methodologies. It is important that this rate study prioritizes reimbursement of children's behavioral health services. We expect the forthcoming rate study to reflect the realities of the workforce landscape, such as adjustments for high turnover and retention costs, national salary data.[26]

Across all programs and services, provider reimbursement rates should be adjusted annually for inflation in order to sustain and broaden provider network. As a matter of parity, behavioral health services should be adjusted or rebased as frequently as comparable medical and surgical services.

2. **DHCF should prioritize collection and sharing of data that improves quality and performance, without excessive burden on providers.**

Data related to children's behavioral health in DC, including service utilization and outcomes data, is not regularly reported by agencies in a user-friendly manner beyond agencies' annual performance oversight responses to the DC Council. This prevents government and nongovernment organizations from using local evidence to make informed policy decisions, evaluate system functioning, and increase accountability. The *Path Forward* report includes several relevant recommendations for data and transparency, described below.

First, DHCF should prioritize and support the development of a sustainable system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions, with data disaggregated by race, ethnicity, age, and geographic location as appropriate. At a minimum, data should be routinely collected on key indicators and case definitions for surveilling substance abuse and mental health that were identified by the Council of State and Territorial Epidemiologists' Workgroup for Substance Abuse and Mental Health Surveillance.[27] DHCF should collaborate with MCOs, DBH, and others to support the required capacity building and establish data-sharing agreements to support a behavioral health surveillance system.

Relatedly, all relevant government agencies should collectively develop an updated strategic plan for children's behavioral health, in collaboration with stakeholders.

Finally, DHCF should require MCOs to have uniform standards for data collection and minimal standards for reporting. Behavioral health data collection within the MCOs must be able to represent the unique issues and metrics of the specific behavioral health patient population, as well as work toward a greater understanding of publicly insured populations under an integrated managed care system. The data reported by MCOs should include metrics specifically targeting children and families, including dollars per child spent on behavioral health services and service utilization rates for children. Data should be stratified by sex, race, age, socioeconomic status, and geographical location, when possible. At the same time, it is important that reporting requirements does not make it overly burdensome for providers to participate in MCO networks. We believe this balance is possible by aligning reporting requirements across MCOs, DBH, and DHCF. We note that the new MCO contract includes the following relevant performance reports:

- Three CAHPS surveys per year: adults, children, and children with chronic conditions.
- The Agency for Healthcare Research and Quality (AHRQ) Experience of Care and Health Outcomes (ECHO) survey each year, which accesses the experiences of adults and children who have received mental health or Substance Use Disorder Services ("The Contractor shall include any additional questions requested by DHCF […] in the surveys").[28]

- Identification of “disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language),” social determinants of health, and the causes for health disparities. Further, MCOs “shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions […] to DHCF. This plan of action shall include a performance measurement and evaluation component.”[29]
- CMS reporting categories for collecting service event data and costs associated with each category of service, with the ability to generate “aggregated, unduplicated service counts provided across service categories, Enrollee demographic and health characteristics, Provider types, and treatment facilities.”[30]

These reporting requirements suggest that DHCF could compile comprehensive data about behavioral health services and costs for children and young people by demographics, as described above. DHCF also calls on MCOS to analyze disparities by groups – the start to measuring whether certain groups are being left behind (by age, language, etc.), and how this may relate to provider networks. The contracts do not specify how DHCF would use or share this information.

Ultimately, all transitions and infrastructure should serve the goal of equitable access to better care and good health outcomes at reduced costs. Overall research has

found mixed results on the impacts of managed care on quality, access, and costs of health services.[31] That may be because MCOs could be incentivized to limit payments to providers through minimizing service utilization and/or provider reimbursement rates to maximize their profits.[32] This can negatively impact provider networks (and, therefore, access to care). To guard against this, the government should require and enforce MCOs' reporting on standard quality of care measures, including targeted, validated measures specific to behavioral health services for children and behavioral health outcomes.[33] Another countermeasure is mandated value-based payment approaches that are tied to behavioral health outcomes.

We are also looking forward to the Medicaid Quality Strategy (MQS) revision we expected to be published for public comment late fall 2022 or this winter, where DHCF will outline new targets for performance metrics for Medicaid providers over the next three years. Reviews of past MCO quality targets reveal below-average performance as well as reporting gaps. Namely, the 2021 Medicaid Managed Care Annual Technical Report, which reports back on these indicators, showed that the District's performance on most HEDIS measures related to behavioral health[34] was "below the NCQA Quality Compass National Medicaid HMO average," or not collected.[35] The HEDIS Mental Health Utilization measure and others related to screening for depression were excluded from the public report. In the full slate of HEDIS measures, the only metrics relating to the behavioral health of young people in the report were: Follow-Up After

Emergency Department Visit for Mental Illness; Follow-Up After High-Intensity Care for Substance Use Disorder; Metabolic Monitoring for Children and Adolescents on Antipsychotics; Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment; and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Not only did these measures fail to meet standards, but this collection is not representative of the breadth and scope of children's behavioral health. We are glad to learn that DCHF is planning a new Performance Improvement Project (PIP) targeting "enrollee access to behavioral health services, to achieve the DHCF goal of improved access to quality, whole-person care."[36] We hope that DHCF's new strategy will not only better enforce existing behavioral health measures for MCO performance, but also increase the volume and availability of useful data related to this population.

3. DHCF must ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.

DC's Child and Family Services Agency (CFSA) shares responsibility with DHCF and DBH for provision of behavioral health care for children and youth in the foster care system. There are very nuanced issues and unique realities for this population which require special attention. For example, DC often places children in foster care in Maryland due to the small geographic borders of DC and the unique makeup of housing options. In fact, 70 percent of DC foster children resided in Maryland in FY21 and FY22. Children placed in Maryland technically continue to be eligible for services in

the District, but that is often impractical and inconvenient for caregivers and families. Complications include distance between placement and service providers or school services, the increased stress of long commutes during an already stressful time, the consequence of either changing service providers or acquiring transportation, and transition of services upon reunification.

Children need services near where they are located. We are worried that children placed in Maryland will struggle to be connected with the appropriate behavioral services after the carve-in of behavioral health services into MCOs. The primary concern would be the lack of behavioral health organizations in Maryland that accept DC Medicaid. There is also diligence required to ensure children are not erroneously unenrolled from DC Medicaid during these placements. In summary, we implore DHCF to stay on top of the potential barriers for these special populations and concentrate attention on cultivating a sufficient care network.

4. The District must sustain its investment in the HealthySteps program.

The District has made significant investment in the HealthySteps program. Through HealthySteps the District can ensure more infants and toddlers, and the adults who care for them, have a place to get the resources and strategies all families need to raise healthy children. In January 2023, DC Health released a request for application (RFA) for a sixth locally funded HealthySteps site, and tenth HealthySteps site across

the District.[37] The expansion of HealthySteps has an immense impact on District families.

HealthySteps is an evidence-based national program model that provides infants and toddlers with social-emotional and development support by integrating child behavioral health professionals into primary care.[38] District families rely on HealthySteps to address issues within the pediatrician's office, improve the mental health of caregivers, and connect them with resources and referrals to ensure that our children are not left behind or put at increased risk. Importantly, HealthySteps works with the whole family which is particularly needed as we see growing rates of adults reporting worsening mental health. As of October 2022, 24 percent of adults living in DC households with children reported feeling felt down, depressed, or hopeless for more than half of the days or nearly every day for the past two weeks.[39] Even higher, 37 percent reported that they felt nervous, anxious, or on edge for more than half of the days or nearly every day in the past two weeks; only 10 states saw higher numbers.[40]

The worsening behavioral health of children and families, however, can be mitigated by integrated care programs like HealthySteps that help families access appropriate and timely behavioral health services. One of the core components of HealthySteps in the District is the care coordination and system navigation provided by the Family Services Coordinators (FSCs). FSCs are trained DC residents who provide dedicated case management and care coordination for families by drawing on their own

lived experiences navigating systems.[41] FSCs build ongoing relationships with families and connect them to community resources.

Under the current financing structure, however, this type of care coordination is not eligible for Medicaid reimbursement, meaning the soon to be ten HealthySteps in the District must rely on local or philanthropic funds to continue operations. These funding streams are often time-limited or not sufficient to cover the true cost of services rendered.[42]

This is not an issue unique to DC, and there are other jurisdictions that have begun to use Medicaid to fund the program.[43] We ask that this Committee work with DHCF to find funding pathways suitable for sustaining HealthySteps outside local and philanthropic dollars. We strongly encourage DHCF to incorporate HealthySteps into the ongoing Medicaid rate study, a recommendation of the Behavioral Health Integration Stakeholder Advisory Committee.[44] This is a critical step forward in helping sustain this invaluable program.

5. **The District must remedy recent changes to the Respite Benefit that make the benefit almost impossible to use.**

Health Services for Children with Special Needs (HSCSN) is a non-profit MCO that coordinates care for children and young adults with disabilities and complex medical needs. District residents under the age of 26 years who receive Supplemental Security Income (SSI) disability benefits or have an SSI-related disability are eligible to apply for enrollment in HSCSN. Some of our clients who are HSCSN enrollees utilize

the respite services benefit provided by HSCSN. This benefit allows our client families to receive temporary care services scheduled to relieve the primary caregiver with activities of daily living (ADL) care. The respite benefit provides critical assistance to families by reducing a caregiver's stress levels while maintaining a safe environment for the child. It can be difficult for a caregiver to balance their many responsibilities and respite care allows them to focus on themselves, daily responsibilities, and other loved ones. The respite services benefit helps keep families healthy and strong.

As of April 1, 2022, DHCF entered a new contract that changes the definition of the respite services benefit and on February 1, 2023, executed a modification that changes the administration of this benefit for HSCSN enrollees. Unfortunately, this has changed a functioning program into one that is now almost impossible to use and virtually useless to most of our clients. We are raising this issue to the attention of this Committee in hopes that it will work with DHCF to remedy this issue. Respite is an immensely valuable benefit to District children and families and helps promote family stability. We want to ensure the benefit remains a useful tool in family's cache of resources and supports. We ask this Committee in partnership with key stakeholders and DHCF work together to address this issue and come up with a solution.

There are two changes to the contract that we would like to highlight below.

With the new contract, respite can only be provided by a Personal Care Aide (PCA) from a Home Care Agency in the HSCSN network.

This change means that Department of Disability Services (DDS) providers, nurses, and Applied Behavioral Analysis (ABA) providers, among others, cannot provide respite. This is a huge decrease in the number of available respite providers. Additionally, it means there is no skilled respite available as PCAs are not able to provide things like medication administration, intravenous infusions, tracheotomy care, etc. Therefore, the new contract is requiring that an adult be available to assist with care during the respite care period. Depending on the child's needs this could mean that another adult aside from the respite provider must be present to handle the medical or behavioral needs that are outside the PCAs services. This places an immense burden on families who often do not have another trusted adult they can turn to who has the necessary skills to care for their child. The purpose of respite care is essentially defeated by requiring adult be in the home the entire time in most situations.

All respite now must be pre-planned.

While emergency respite was not a requirement under the previous contract it was something HSCSN was able to provide as a resource to families as there were no explicit restrictions against it. The new change removes the ability for HSCSN to provide this to families. Now, all respites require notice to the agency along with a reason for the request of respite care. If a request is less than 12 hours, require 10-days' notice; if over 12 hours, then require weeks' notice. This places another burden on caregivers who are already stretched thin. It is important to note the National Respite

Network and Resource Center recommends includes having emergency respite options as part of its national respite guidelines. Additionally, in the District, there are no real options that are sustainable or in the best interest of the enrollees when an emergency comes up except for families to turn to respite care. This leaves families in an extremely difficult place that could ultimately impact family safety and stability.

Conclusion

Access to behavioral health services is essential to our children's well-being and future success. The District is on the path of systemic transformation, which presents many opportunities to build a stronger network of timely, accessible, high-quality, culturally appropriate, and affordable behavioral health services for DC's children and families. As we have shared, there are several gaps for populations who need more support, and opportunities for improvement in administration and oversight in the Medicaid program. We are optimistic about DHCF's ability to take on these recommendations and remedies. The need is urgent, and the moment is right.

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

[1] *A Path Forward — Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, December 2021, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.
[2] *Id.*
[3]DHCF, DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts, (September 11, 2019), *available at*: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.
[4] DHCF, Office of the Senior Deputy Director/State Medicaid Director, Letter RE: Behavioral Health Transformation: Updated Timeline, p. 2 (December 2, 2021), *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MDL%2021-06%20BH%20Transformation%20Update%20Timeline%2020211202-signed.pdf.
[5] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, DC Behavioral Health Transformation, p. 1 (January 6, 2021), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DHCF%20Demonstration%20STCs%20with%20Evaluation%20Design%20and%20Monitoring%20Protocol%20010621.pdf.
[6] Andy Schneider & Alexandra Corcoran, *Standards for Provider Network Adequacy in Medicaid and the Marketplaces*, Georgetown University Health Policy Institute Center for Children & Families (May 16, 2022), *available at*: https://ccf.georgetown.edu/2022/05/16/standards-for-provider-network-adequacy-in-medicaid-and-the-marketplaces/.
[7] Contract CW83148: Managed Care Organization (MCO) – MedStar Family Choice, Base Period 10/1/2020 - 9/30/2021, C.3.2, C.5.28.10.2, C.5.29.12.1, p. 11–12, 92, 120 (September 3, 2020), *available at*: https://contracts.ocp.dc.gov/contracts/attachments/Q1c4MzE0OMKmQmFzZSBQZXJpb2TCpns4RDQ5RUVEMS1FRDhFLTRBQkMtODg4RC03RDk5QzM4QkY5NjN9.
[8] 42 C.F.R. § 438.68 – Network Adequacy Standards, *available at*: https://www.law.cornell.edu/cfr/text/42/438.68.
[9] Jane M. Zhu, et al., *Medicaid Managed Care Network Adequacy Standards for Mental Health Care Access: Balancing Flexibility and Accountability*, 2 JAMA Health Forum, p. 1–2 (2021), available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779945.
[10] Contract CW83148: Managed Care Organization (MCO) – MedStar Family Choice, Base Period 10/1/2020 - 9/30/2021, C 5.29.1.4, p. 108 (September 3, 2020), *available at*: https://contracts.ocp.dc.gov/contracts/attachments/Q1c4MzE0OMKmQmFzZSBQZXJpb2TCpns4RDQ5RUVEMS1FRDhFLTRBQkMtODg4RC03RDk5QzM4QkY5NjN9.
[11] *Id.* at C 5.29.8.6, p. 119.
[12] *Id.* at C.5.29.18.4, p. 125.
[13] *Id.* at C.5.29.18.5.1, p. 125.
[14] *Id.* at C.5.29.18.5.2, p. 125.
[15] *Id.* at C.5.29.18.5.3, p. 125.
[16] *Id.* at C.3.159, p. 32.
[17] *Id.* at C.5.29.2.4.1, p. 113.
[18] *Id.* at C.5.29.15.2, p. 121.
[19] Mark Hall & Paul B. Ginsburg, *A Better Approach to Regulating Provider Network Adequacy*, Brookings Institute, p. 23 (2017), *available at*: https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/.

[20] *See* Abigail A. Fagan, et al., *Scaling up Evidence-Based Interventions in US Public Systems to Prevent Behavioral Health Problems: Challenges and Opportunities*, 20 Prevention Science (2019), *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6881430/pdf/11121_2019_Article_1048.pdf.
[21] DHCF & DBH, Public Forum on Integrated Care, Slide 13 (November 30, 2022), *available at*: https://dhcf.dc.gov/page/public-forum-on-integrated-care.
[22] Contract CW83148: Managed Care Organization (MCO) – MedStar Family Choice, Base Period 10/1/2020 - 9/30/2021, C 5.29.1.15.1, p. 110 (September 3, 2020), *available at*: https://contracts.ocp.dc.gov/contracts/attachments/Q1c4MzE0OMKmQmFzZSBQZXJpb2TCpns4RDQ5RUVEMS1FRDhFLTRBQkMtODg4RC03RDk5QzM4QkY5NjN9.
[23] Robin McKnight, *Increased Medicaid Reimbursement Rates Expand Access to Care*, National Bureau of Economic Research (October 2019), *available at*: https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care.
[24] *Id.*
[25] Valerie A. Canady, *NABH Access to Care Resolution to Address Unfair Managed Care Practices*, 29 Mental Health Weekly (2019), available at: https://onlinelibrary.wiley.com/doi/abs/10.1002/mhw.31847.
[26] DHCF & DBH, Public Forum on Integrated Care, Slide 16 (November 30, 2022), *available at*: https://dhcf.dc.gov/page/public-forum-on-integrated-care.
[27] Richard S. Hopkins, et al., *Development of Indicators for Public Health Surveillance of Substance Use and Mental Health*, 5 Public Health Report (2018), *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6134563/pdf/10.1177_0033354918784913.pdf.
[28] Contract CW83148: Managed Care Organization (MCO) – MedStar Family Choice, Base Period 10/1/2020 - 9/30/2021, C 5.32.5.4, p. 171 (September 3, 2020), *available at*: https://contracts.ocp.dc.gov/contracts/attachments/Q1c4MzE0OMKmQmFzZSBQZXJpb2TCpns4RDQ5RUVEMS1FRDhFLTRBQkMtODg4RC03RDk5QzM4QkY5NjN9.
[29] *Id.* at C.5.32.5.7, p. 171.
[30] *Id.* at C.5.37.6.2, p. 210.
[31] Ashley Palmer & Anne Rossier Markus, *Supporting Physical–Behavioral Health Integration Using Medicaid Managed Care Organizations*, 47 Administration & Policy in Mental Health & Mental Health Services Research (2020), *available at*: https://link.springer.com/content/pdf/10.1007/s10488-019-00986-3.pdf.
[32] Andy Schneider, *How Can We Tell Whether Medicaid MCOs are Doing a Good Job for Kids?* Georgetown University Health Policy Institute, Center for Children and Families (2018), available at: https://ccf.georgetown.edu/2018/02/26/how-can-we-tell-whether-medicaid-mcos-are-doing-a-good-job-for-kids/.
[33] Ashley Palmer, Managing Managed Care Plans to Promote Physical-Behavioral Health Integration in States (Masters dissertation, George Washington University) (May 21,2017), *available at*: https://www.proquest.com/docview/1886474833/abstract/94C68CD2CD3B45B0PQ/1.
[34] HEDIS measures relating to behavioral health include:

- Antidepressant Medication Management (AMM)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Diabetes and Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (SSD, SMD, SMC)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

- Pharmacotherapy for Opioid Use Disorder (POD)
- Mental Health Utilization (MPT)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (EMS-E)
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Prenatal Depression Screening and Follow-up (PND-E)
- Postpartum Depression Screening and Follow-up (PDS-E)

[35] DHCF, District of Columbia Medicaid Management Care 2021 Annual Technical Report, Appendix A1 (2022), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/2021%20DC%20ATR%20Report_FINAL.pdf.

[36] DHCF, Department of Health Care Finance FY22-23 Performance Oversight Responses, p. 4 (2023), *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAAjkxJyAOZUprEPbWJOK7WUa/COH%20Performance%20Oversight/DHCF/Agency%20Responses/Q23?dl=0&lst=&preview=Q23.docx.

[37] On file with the Children's Law Center.

[38] HealthySteps DC ensures access to behavioral health services in a setting children frequent, their pediatric primary care practice. Children are more likely to go to their primary care provider due to scheduled well-child visits; thus, a primary care provider is well positioned to detect the early onset of behavioral problems. However, a primary care provider may not have the knowledge or skill set to address developmental, behavioral, social, and emotional needs of a child. *See* HealthySteps, Our Model, *available at:* https://www.healthysteps.org/what-we-do/our-model/.

[39] Annie E. Casey Foundation, Kids Count Data Center, Adults Living in Households with Children who Felt Down, Depressed or Hopeless for More than Half of the Days or Nearly Every Day for the Past Two Weeks in the United States, October 5, 2022 – October 17, 2022 (Updated December 2022), *available at*: https://datacenter.kidscount.org/data/tables/11219-adults-living-in-households-with-children-who-felt-down-depressed-or-hopeless-for-more-than-half-of-the-days-or-nearly-every-day-for-the-past-two-weeks?loc=1&loct=2#detailed/2/10/false/2484,2480,2476,2472.

[40] Annie E. Casey Foundation, Kids Count Data Center, Adults Living in Households with Children who Felt Nervous, Anxious or on Edge for More than Half of the Days or Nearly Every Day for the Past Two Weeks in the United States, October 5, 2022 – October 17, 2022 (Updated December 2022), *available at*: https://datacenter.kidscount.org/data/tables/11217-adults-living-in-households-with-children-who-felt-nervous-anxious-or-on-edge-for-more-than-half-of-the-days-or-nearly-every-day-in-the-past-two-weeks?loc=1&loct=2#detailed/2/10/false/2502,2484,2480,2476,2472,2465,2458,2463,2448,2418/any/21608.

[41] Early Childhood Innovation Network, *May 2019 Newsletter, Innovation Spotlight: HealthySteps DC* (2019), available at: https://www.ecin.org/newsletter-may-2019.

[42] HealthySteps, *Funding HealthySteps: Sites & System Snapshots* (2021), *available at*: https://www.healthysteps.org/wp-content/uploads/2021/06/Funding_HealthySteps_Site_System_Snapshots.pdf.

[43] In January, California launched new dyadic benefits that are modeled after HealthySteps and provide an opportunity to offer services to children and families during a child's pediatric visits. *See* California Department of Health Care Services, Medi-Cal Children's Initiatives (2022), *available at*: https://www.dhcs.ca.gov/services/Documents/DHCS-Childrens-Initiatives.pdf; First 5 Center for Children's Policy, New Children's Medi-Cal Behavioral Health Benefits 101: Family Therapy and Dyadic Services, *available at*: https://first5center.org/blog/new-childrens-medi-cal-behavioral-health-benefits-101-

family-therapy-and-dyadic-services. Additionally, starting in January, Maryland will have Medicaid enhanced payments for CenteringPregnancy and HealthySteps services. The payments will provide an enhanced $15 rate per well-child and sick visits for all children birth to age 4 at HealthySteps sites in Maryland (and in DC if children with Maryland Medicaid coverage seek care at DC HealthySteps sites). *See* Maryland Department of Health, Maryland Medical Assistance Program, Deputy Medicaid Director Letter RE: Coverage of CenteringPregnancy and HealthySteps Services (December 16, 2022), *available at*: https://health.maryland.gov/mmcp/Documents/PT%2030-23%20Coverage%20of%20CenteringPregnancy%20and%20HealthySteps%20Services.pdf.

[44] DHCF, Medicaid Behavioral Health Integration Stakeholder Advisory Group, *available at*: https://dhcf.dc.gov/page/public-forum-on-integrated-care.