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Introduction

Good Afternoon, Chairperson Henderson and members of the Committee on Health. My name is Sharra E. Greer, I am the Policy Director at Children's Law Center and a resident of the District. 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.

I appreciate this opportunity to testify regarding the performance of the Department of Behavioral Health (DBH) over this past year. The goal of my testimony is to highlight the urgency and scope of behavioral health needs of DC's children. Last year we presented findings from a new report we helped author with several partners, *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*.[1] The report detailed 94 unique recommendations to better meet the needs of DC children and families. As we pursue these reforms to the system with our partners in and outside of District government, we will highlight a few key issues for the Committee. There are areas to celebrate, where DBH is making

progress in meeting children's needs, and some key areas that need continued investment and oversight in the coming year:

1. Healthy Futures offers important behavioral health supports to young children and their caregivers and needs support to continue expansion.
2. DC MAP extends the capacity of pediatricians with on-call specialty consultations, but oversight is necessary to maintain levels of quality and utilization.
3. Careful planning and oversight are required to provide youth in the foster care system to behavioral health services, as well as successfully transition to Managed Care Organizations.
4. DBH should work with DC Health to remedy the workforce disruptions caused by changing eligibility rules for Community Based Intervention (CBI) workers
5. Comprehensive systemic reform – including increased provider reimbursement – is required to meet needs of children and families navigating DC's behavioral health system.

Despite increasing need, DC's children continue to struggle to access quality behavioral health services in a timely manner.

In October 2021, The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association – together representing more than 77,000 physicians and more than 200 children's hospitals – declared a national state of emergency in child and adolescent mental health.[2] In December 2021, the U.S. Surgeon General issued an advisory highlighting the urgent need to address the nation's youth mental health crisis.[3] The pandemic has accelerated trends in worsening mental health for children and adults, creating a deepening crisis that requires urgent action to improve access to, and quality of, behavioral health care.

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, and challenges to their stability and security. 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 any services or treatment. Despite their significant and urgent needs, many of these children and their families consistently struggle to access quality behavioral health services in a timely manner. Over the past year, the services our clients have most frequently struggled to access include 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 (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 our clients accessing 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 waitlist for an appointment is prohibitively long.

Our clients also encounter problems with the process of being connected to providers through DBH's Access HelpLine or via other District agencies that are supposed to have established procedures for coordinating referrals. These connection problems reflect both a problem with interagency coordination around the provision of behavioral health services and an overall lack of adequate resources and providers.

The lack of providers also means the District's behavioral health system for children does not include the full spectrum of services needed. For example, DC lacks stepdown services and care coordination for children transitioning out of acute care or hospitalization programs. Intermediate levels of care are also not available to children who need regular services but don't need acute care or hospitalization. In short, although DC has some services available for children in crisis – we don't have the intermediate services needed to prevent children from reaching a crisis point, or to ensure children emerging from a crisis are able to fully recover.

Even when our clients successfully connect with a provider, they also encounter issues of quality and cultural competence (issues that are both rooted in the overall lack of providers), as well as frequent turnover. The services our clients need most – therapy and counseling – rely on interpersonal connections. Providers with appropriate language skills and cultural competence are critical to these services being successful. We have also found that some providers lack the time and attention our clients need – resulting in poor communication and inconsistent care. Overstretched providers are

undoubtedly another symptom of the District's overall lack of providers. Finally, many of our clients need in-person services because virtual/online therapy simply isn't as effective for them. The pandemic, however, restricted the provision of many services to virtual settings.

The difficulties in the behavioral health services landscape described are experienced nationwide. The District has undertaken efforts to change the paradigm. Through new programs and shifts in public insurance models, the District is making strides to intervene at the most critical times in the lifespan – childhood. Below I will describe the background and status of a few of these important efforts operated through DBH, as well as recommendations for improvements.

Healthy Futures offers important behavioral health supports to young children and their caregivers – but needs support to continue expansion.

One of the most critical factors in a child's healthy development and readiness for school and life success is their social emotional health.[4] To help a child develop good social emotional health requires effective mental health services within programs that are already supporting young children, including early childcare and education.[5] Programs that target the District's youngest residents and improve social, emotional, behavioral outcomes are a smart investment with a large return. Prevention and promotion-based programs are critical components of the District's continuum of care for behavioral health. We applaud DBH for their continued work to bolster programs that aim to encourage and increase protective factors and healthy behaviors in the

District's youngest residents.

One such program is DBH's Healthy Futures program, which integrates behavioral health services in settings where children are already present at child development centers and home providers and has been a critical investment for the District. Healthy Futures is based largely upon the Early Childhood Mental Health Consultation (ECMHC) model developed by Georgetown University Center for Child and Human Development (GUCCHD).[6] ECMHC creates a collaborative relationship between a professional consultant with early child mental health expertise and one or more caregivers, typically an early care and education provider and/or family member.[7] The collaborative relationship of consultant and caregiver aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children and their families.[8]

Slow and steady often wins the race, and while we had bigger ambitions for Healthy Futures when the Birth-to-Three for All Act of 2018 (Birth-to-Three) passed, we have been encouraged and happy with the growth of Healthy Futures.[9] Despite the challenges of the COVID-19 pandemic, incorrect budget programming, and workforce shortages, Healthy Futures has consistently grown in the number of child development centers and home providers it operates in. In FY20, Healthy Futures was working with 58 child development centers and home providers and in FY21, the number of child development centers and home providers grew to 87.[10] In FY22, Healthy Futures was

working in at 102 child development centers and home providers.[11] On average, Healthy Futures has grown by 22 sites between FY20 and FY22.[12]

Additionally, DBH's Healthy Futures has made progress with implementing a pilot program to expand Healthy Future services by providing on-site mental health services, including direct clinical support to children, at eight early learning programs in the District that participate in the childcare subsidy program.[13] These additional services will help connect children with early intervention services that will serve them in the long term.

Healthy Futures' growth, including increasing the number of consultants and supervisors, allows the program to have a greater impact.[14] Funding for FY23 currently supports 26 early childhood clinical specialists, three supervisors, and a Program Manager. All leadership positions are currently filled and 16 of the 26 early childhood clinical specialist positions are filled.[15]

Some hiring has been slowed due to incorrect budget programming. It is critical that in the budget, the funds for Healthy Futures are correctly programmed. For the FY23 budget, the funds were programmed as "non-personnel" when the funds should have been programmed as "personnel" as they are used to hire consultants directly to DBH's staff under the Healthy Futures program. DBH is working alongside the CFO's office to remedy this error. However, this incorrect programming delayed DBH's ability to use the funds. We want to call the Council's attention to this error to ensure first it

does not happen again and two to ensure that there are no cuts to DBH's Healthy Futures funding even if they are not able to utilize all the funds this year to make the necessary hires due to these delays.

DBH is moving forward with an evaluation of Healthy Futures. In August 2022, DBH released a request for application for an evaluator of the Healthy Futures program. DBH awarded the evaluation contract to GUCCHD to conduct the evaluation for a period of two years. GUCCHD evaluated Health Futures between 2011 and 2015; given how much has changed since then we believe an evaluation will be an invaluable tool to understand the challenges the program faces and what it needs to move forward and be successful.[16]

This is an immensely valuable program and needs continued smart investment. We ask the Council to continue to uplift and support this program during this time to ensure Healthy Futures can serve children for generations to come.

DC MAP extends the capacity of pediatricians with on-call specialty consultations, but diligent oversight is necessary to maintain levels of quality and utilization.

The impact of a shortage of mental health professionals noted above means that many children who need specialty evaluation or treatment remain locked out. Since 2015, the DC MAP program has improved mental health integration within pediatric primary care that helps address this problem. Pediatricians who have mental health-related inquiries about specific children have real-time phone access to psychiatrists, psychologists, social workers, and care coordinators through DC MAP.[17] Research

shows that integrating mental health care within pediatric primary care settings improves service delivery and patient health outcomes, while also reduces care costs.[18] Critical components of DC MAP include providing education and technical assistance to pediatricians regarding how to identify and address mental health issues, improving pediatricians' abilities to assess patients and treat patients with anxiety and mood disorders. The program also facilitates referrals and coordination for patients who need community- based specialty services. DC MAP can even be used to identify services for parents who need post-partum depression support services. We have previously testified to the cost-effectiveness and innovation of the DC MAP's population-based, prevention framework and the ways it helps to address the mental health needs of the District's children by reaching them where they already are.[19]

This extremely successful program[20] is funded by DBH and was previously administered by Children's National Hospital and MedStar Georgetown University Hospital from 2015 to 2021.[21] In that time, the number of consultation requests from primary care settings has increased from 96 in FY15 to 1,480 in FY21, showing substantial growth of this program in a short amount of time. Additionally, the number of patient consults increased from 776 unique patients in FY20 to 1252 unique patients in FY21, representing a 38% increase in unique patients.[22] Most of DC MAP's consultation requests are for children covered by DC Medicaid – DC's most vulnerable children and their families.[23] Since the start of the pandemic, the need for DC MAP's

services has become even more pronounced. Providers and care coordinators report that symptoms have been more acute and time-sensitive, and many cases have been more complex, requiring involvement from multiple clinicians on the team. There has also been an increase in requests for grief counseling and behavioral and parenting support for struggling children and families.[24]

With the increased need for services, DC MAP is more essential than ever. Beginning November 2021, the program transitioned to a new provider, Paving the Way.[25] As with any significant change in an important program it is important that there is a smooth transition and continued quality service provision. Since the transition over one year ago, the reported number of consultations seem to have decreased by nearly one-third from FY21 to FY22.[26] To ensure the program's continued success, and that physicians feel the confident enough to continue using the service, we ask the Committee to focus oversight on the program’s implementation. We hope to see DC MAP continue to serve as a valuable resource to pediatricians and meet the behavioral health needs of District children and families. Renewed oversight during the transitional period would greatly support this goal.

Careful planning and oversight are required to provide youth in the foster care system to behavioral health services, as well as successfully transition to Managed Care Organizations.

The behavioral health system for children and families and its surrounding landscape are not only complex, but also rapidly evolving. In 2019, DHCF announced

plans to move exclusively toward a managed care model in the Medicaid program over the next five years.[27] That shift will involve transitioning individuals currently in Medicaid's Fee-for-Service (FFS) program to a Medicaid managed care organization (MCO). Also, 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.[28] A key element of this ongoing systemic reform is the addition of behavioral health services into the District's managed care contracts beginning October 1, 2023.[29] This "carve-in" effort should serve to improve care coordination and bolster whole-person care for DC Medicaid beneficiaries. Careful planning and intentional oversight are needed to ensure this addition of behavioral health services into the District's managed care contracts is successful.[46]

Special attention is warranted for the provision and coordination of services to DC youth involved in foster care. According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[30] This is due to a variety of factors for young people: ongoing and complex trauma; lack of stable presence of - or relationship with - at least one nurturing, responsive caregiver; disruptions in routines or constant life transitions; family relationship problems; and increased use of psychotropic medications for this population.[31]

Create better information sharing between CFSA and DBH to ensure children and youth in care are receiving appropriate and timely behavioral health services

In 2018, Child and Family Services Agency (CFSA) began providing some in-house behavioral health services to children in foster care.[32] CFSA's Office of Well Being (OWB) has four dedicated in-house therapists, as well as one psychiatric nurse, to screen, evaluate, assess, diagnose, and provide short-term mental health treatment to children entering care.[33] If children in care are determined to need more or longer-term services (or, if in-house practitioners are at capacity) the child will be referred to DBH for behavioral health services. Specifically, CFSA contracts with MBI Health Services LLC (MBI), a DBH Core Service Agency which has capacity to serve 150 children and youth, and up to 75 birth parents for longer-term or specialized mental health treatment.[34] During FY21, MBI served 12 clients referred by the agency. CFSA initiates most referrals to MBI within one business day of discharge and the mental health supervisor confers directly with the two therapists assigned to the MBI contract to discuss the transition and "warm hand-off."[35] We appreciate CFSA and DBH working to create timely connection to long-term service, and coordinating a warm handoff for foster youth transitioning from OWB to MBI.

However, there remains significant confusion around other services that youth in CFSA's care may receive from DBH. OWB and MBI are not the only places where our clients receive services. In both 2021 and 2022, we reviewed hundreds of guardian-ad

litem cases and found that on average 173 clients were accessing outpatient behavioral health services, representing over 40 percent of our clients.[36] This is significantly more than what CFSA and DBH reported in terms of delivering behavioral health services through OWB and MBI. We are unsure where the discrepancy is, and urge the two agencies to work together to better understand what and how data needs to be collected and reported to accurately capture all foster children and youth accessing behavioral health services and supports in the District.

Additionally, the capacity of OWB and MBI is significantly lower than what is truly needed. OWB only has capacity to serve 72 individuals and MBI can serve 150 foster children and youth, but in FY21 there were 614 children and youth in care, 467 whom were above the age of five.[37] Not every child in care will need or want behavioral health services, but we have a responsibility to ensure every child can have access to them if needed or desired. It is vital that we recognize being in foster care often comes with complex and ongoing trauma, and therefore we should ensure consistent and timely access to appropriate behavioral health services.[38]

In CLC's case review, at least 15 percent of our clients experienced delays trying to access behavioral health services in 2022. Many of the reasons and barriers to access overlap with findings in CFSA's FY22 Needs Assessment: lack of evening appointments or flexible hours, transportation issues, and availability of alternative therapy modalities.[39] CLC also found barriers due to insurance, lack of in-person services,

delays in communication, and workforce issues like high turn-over, long waitlists, and lack of specialized services.

Finally, there is concern around the current structure of the OWB and MBI contract. In practice, a child could be doing well with the CFSA practitioner, but then must transition to a DBH provider because the maximum amount of time OWB can serve a child has been met (12 months). Switching providers disrupts therapeutic relationships, can cause a loss in treatment momentum, and impacts the outcomes of treatment. Even if referral and service begin quickly (CFSA initiates most referrals to MBI in one business day), it can be difficult to reengage and create the same trust and rapport. Again, it is important to recognize that many foster children and youth need longer term services due to the stress and trauma from removal and/or other adverse childhood experiences. Therefore, it may not make sense to start at OWB knowing full they will have to switch to another provider.

In summary, the system for behavioral health services for foster children and youth is very unclear. It would be prudent of DBH and CFSA to update policies on the initial evaluation of children's health – these have not been updated since September 2011.[40] Additionally, it would be helpful for DBH and CFSA to participate in more clear data-sharing to ensure foster children and youth have access to receiving appropriate and timely behavioral health services.

Ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.

CFSA places some children in foster care in Maryland due to the small geographic borders of DC and the unique makeup of housing options. In the context of the transition from fee-for-service (FFS) payment model to MCOs, there must be clear pathways to accessing care across the District as well as in Maryland, where 70% of DC foster children resided in FY21 and FY22.[41] Children placed in Maryland continue to be eligible for services in the District, but that is often impractical and inconvenient for many caregivers and families. Complications include distance between placement and service provider 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 with the carve-in of behavioral health services into MCOs, children in Maryland will struggle to connected with the appropriate behavioral services due to the lack of behavioral health organizations in Maryland that accept DC Medicaid. This transition will take concentrated attention to cultivate a sufficient care network for this special population.

Provide full transparency of specific data collection regarding medication monitoring, and publicly report these data regularly.

CFSA's behavioral health services also include prescribing psychotropic medicine to children in foster care. Historically, at the national level, overprescribing

psychotropic medication has been prevalent among youth served by the foster care system, and anecdotally, that has been noted in the District.[42] Experts have called upon child welfare systems to mitigate this problem by improving screening, assessment, and treatment planning, carefully taking into account safety concerns surrounding polypharmacy and overmedication.[43] Transparency in this area is lacking in DC.

The District needs to adopt a framework that can provide effective oversight for the use of psychotropic medication by children and youth in foster care. To do so, the District must establish publicly available data that will allow medication utilization to be monitored among District foster care children and will provide a clear indication on any needed changes in policy or access to alternative treatments, where warranted. In developing an effective monitoring framework, the District may look to other jurisdictions. New Jersey uses existing data from its child welfare, Medicaid, and children's behavioral health entities to gain a clear understanding of psychotropic medication use and psychosocial interventions.[44] Texas also can provide an example and was the first state to develop a best practice guide, "Psychotropic Medication Parameters for Foster Children (Parameters)," for oversight of psychotropic medications for children in foster care.[45] Since Parameters' release in 2005, the use of psychotropic medication has steadily declined.

We urge DBH and its agency partners to take steps to help ensure this vulnerable population receives timely, quality and appropriate services.

DBH should work with DC Health to remedy the workforce disruptions caused by changing eligibility rules for Community Based Intervention (CBI) workers.

In light of significant workforce shortages, it is concerning that all levels of Community-Based Intervention (CBI) professionals now require a master's-level license (LGSW, LICSW, LGPC, or LPC). CBI are time-limited, intensive mental health services provided to children and youth aged and their families, including counseling, case management, and referral to community-based sources of support. It is intended to be delivered at home, preventing the utilization of an out-of-home therapeutic resource by the consumer.[46] DBH upgraded the license requirement in late 2019, taking most stakeholders by surprise.

This change has made it almost impossible to get CBI services. CBI is often indicated in our foster care cases, however, since the change our attorneys report that none of their clients can get CBI because the provider pool is so small. We’ve identified several longtime CBI workers who were forced to change jobs or even retire. According to one former provider, they don't have "any workers with a degree who will work those kinds of hours." Another professional with years of experience was not able to meet the requirements or get “grandfathered in,” and is now doing different work.

At one point, when the workforce impacts were clear, DBH explored the possibility of changing the new rule or requesting DC Health not pursue enforcement actions against unlicensed workers being part of CBI teams. However, this was apparently not supported by DC Health’s general counsel or DBH general counsel at

the time. We urge DBH to pick up this issue again, in recognition of the extreme disruption to this service sector as well as the broader workforce supply issues. As with many other types of health services, these interventions can be successfully delivered by staff with a variety of education levels and experiences beyond the most highly licensed social workers. We also urge the Committee to address this urgent challenge.

Comprehensive systemic reform – including increased provider reimbursement – is required to meet needs of children and families navigating DC's behavioral health system.

DBH has made significant investments in programs serving children. These programs aim to efficiently draw on existing resources in a resource-starved landscape. However, these programs do not approach the full need in the larger health system that continuously fails to meet the behavioral health needs of children and their families. DC's behavioral health system for children lacks an adequate supply and range of behavioral health supports. Services are often fragmented and inaccessible due to the scarcity of a particular service or provider, treatment location, inadequate transportation, long wait times, and insufficient care coordination. These shortcomings were prevalent before the pandemic and have only been exacerbated since. Imagine the roadmap of services with large holes cut or burned through where major destinations should be found. Now more than ever, there is an urgent need for system-wide strengthening and reform.

About a year ago, December 2021, Children's Law Center and several partner

organizations developed a blueprint for creating a successful public behavioral health system. *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia* identifies gaps and offers concrete, actionable recommendations in the six domains that the World Health Organization identifies as necessary to a functioning public health system: leadership and governance, financing, workforce, service delivery, information and communications, and technology. These recommendations are informed by best practices around the country, feedback and input from expert stakeholders across the District, and focus groups conducted with District youth and caregivers.

We are pleased to see several recommendations from this report already in progress, specifically the agency finding and funneling resources into expanding settings for care. However, we want to highlight some of the key steps that are necessary to transform the system.

Establish more locations and models to deliver behavioral health care in DC.

One model is hopefully being added to DC. With the Department of Health Care Finance (DHCF), DBH has applied for a federal planning grant to implement Certified Community Behavioral Health Clinics (CCBHCs) in DC – a promising model to expand behavioral health care capacity. Children's Law Center was pleased to offer a Letter of Support in DC's application. CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services, which are so desperately needed

by our clients, improving capacity for patient-centered treatment planning, outpatient mental health and substance use services, primary care screening, targeted case management, psychiatric rehabilitation services, and peer support and family supports. Through the enhanced Medicaid reimbursement rate, DC could leverage the model to better reach low-income families and improve children's services. The inclusion of CCBHCs in the District's behavioral health system is essential to create a more sustainable, accessible, and coordinated service network.

We also understand that the District is persisting in its pursuit of a local Psychiatric Residential Treatment Facility psychiatric care for children. This is important work so families can find care near home, and we look forward to more information and oversight into this process. In the meantime, *Path Forward* describes several potential models for intermediate care, including "bridge clinics," Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and Youth Crisis Stabilization Units that also need to be added to our behavioral healthcare system.

Increase transparency about plans for and performance of DBH services and programs.

The *Path Forward* report calls for increased transparency related to mental health programs and services, including within Medicaid. We ask DBH to make all strategic plans, work plans, and performance reports regarding children's behavioral health publicly available, as well as consistent and transparent reporting of qualitative and quantitative metrics for children's behavioral health. (For example, per-child spending

per month, and number of children served.) Currently, there is no one standard of measures or metrics for assessing and reporting on quality of care and services, across the different agencies and providers of behavioral health services. Relatedly, there is a lack of reliable data available to track the timeliness of access to services due to lenient data collection guidelines and decentralized data reporting. Further, we should be able to track and assess consumers' perceptions of quality of care and quality of life based on the services they are receiving. Therefore, *Path Forward* recommends that DBH, with relevant partner agencies:

1. Develop transparent privacy and confidentiality policies and data-sharing agreements among agencies to support information sharing among providers, MCOs, and government agencies.
2. Develop a surveillance system for population-level behavioral health data and behavioral health services data for children.
3. Require uniform standards for data collection and minimal standards for reporting.
4. Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in DC with leadership from DC youth and families.

The DC DHCF 2019 Annual Technical Report (April 2020) provides an evaluation of the performance of the Medicaid MCOs to assess the quality, access, and timeliness of health care services beneficiaries in the DC Healthy Families program receive.[47] However, the five behavioral health performance measures reported are not specific to children. DBH previously produced a Provider Scorecard that evaluates certified community-based mental health providers, rating on quality and financial

performance, quality of services, and adherence to federal and District policy and regulations. In FY19, DBH indicated that was replacing these Scorecards with an internal performance management system, and the information is not public.

Ensure "network adequacy" in MCOs, including services in non-English languages.

Networks are already inadequate – as we've noted repeatedly here – and that may continue to be a challenge without strong oversight and enforcement. In particular, there is a scarcity of behavioral health care providers that can provide services for children and youth in DC, particularly for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays, which are among the special populations that must be given extra attention. Currently, there is an insufficient number of child-serving behavioral health providers or 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.). That limits the availability of treatment options available to families that are within their plan networks, which results in long wait times for appointments and unmet behavioral health needs.[48]

According to MCO contracts, "failure to maintain a Provider Network that ensures Enrollees have access to covered Mental Health services [...] may result in DHCF requiring the Contractor to develop and implement a corrective action plan

(CAP) to remedy the failure."[49] However, we are not aware of any enforcement measures (such as penalties) of network adequacy standards for having an inadequate network of behavioral providers, despite recent external reviews documenting network inadequacies. Additionally, current MCO contracts that require MCOs to adhere to the federal laws[50] lack sufficient clarity and direction to effectively incentivize payers to improve behavioral health care access.

Current DC Medicaid MCO contracts specify mileage and time provider access standards as within five miles of an enrollee's residence or no more than thirty minutes travel time. However, without complementary focus on time to intake, time to therapy, and time to psychiatry, payors can say they have adequate networks even when services remain severely inaccessible. DBH must continue to work with DHCF to ensure managed care plans include an adequate network of child-serving providers, including 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. All network adequacy standards should be tied to accountability mechanisms that are regularly and transparently enforced.

Support workforce development for future mental health professionals, while also retaining current providers through sufficient reimbursement.

We applaud DBH's recognition of the urgent need for workforce development, and its work partnering with OSSE and DCPS for projects related to the school-based behavioral health (SBBH) workforce. As we describe in our testimony focused on SBBH, the program's vacancy rate for in-school clinicians reflects the national workforce shortage of highly skilled, credentialed clinicians. DBH has steadily increased the grant amount offered to CBOs for clinician compensation, allowing for retention and hiring bonuses as well as increased baseline salaries. Children's Law Center is part of the Strengthening Families Through Behavioral Health Coalition (SFC), a diverse group of advocates across education, juvenile justice, child welfare, and health, as well as representatives of the provider community and community-based organizations.[51] This group continues to ask the Mayor, DBH and the DC Council to stable and adequate funding for providers as the foundation of a sustainable, effective program.

Across all programs and services, provider reimbursement rates should be adjusted annually for inflation in order to sustain and broaden provider network. It is a basic requirement for a functioning behavioral health system that reimbursement rates be sufficient to make it financially feasible for providers to offer the full range of behavioral health services needed in our community. Behavioral health reimbursement rates should also be on par with reimbursement for physical health conditions – and must be adequate for assessment and diagnosis (including medically necessary psychological and neuropsychological testing).

We urge the Committee to review the recommendations in *A Path Forward* closely, keeping in mind that children flourish when they receive the proper behavioral health care at the right time. If the District commits to implementing these recommendations, it can create long-lasting, systemic change that will transform behavioral health care and advance health equity for children now and in the generations to come.

Conclusion

The length of this testimony underscores the scope of behavioral health needs of DC's children as well as the required actions to create a more comprehensive, equitable and accessible system of services. DBH's early childhood and pediatric programs, specifically Healthy Futures, SBBH and DC MAP, offer important behavioral health supports, which require significant oversight from DC Council. As detailed above, careful planning and oversight are required to provide youth in the foster care system behavioral health services, as well as successfully transition to Managed Care Organizations. Finally, we have recommended several reforms for the disjointed, incomplete landscape of services, with a particular focus on workforce development and retention. Thank you for the opportunity to testify and I welcome any questions the Committee may have.

[1] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, December 2021, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.

[2] AAP, AACAP, CHA declaration of a national emergency in children's mental health. American Academy of Pediatrics, October 19, 2021, *available at*: https://publications.aap.org/aapnews/news/17718/AAP-AACAP-CHA-declare-national-emergency-in.

[3] U.S. Surgeon General Issues Advisory on Youth mental Health Crisis Further Exposed by COVID-19 Pandemic, HHS.gov, December 7, 2021, *available at*: https://www.hhs.gov/about/news/2021/12/07/us-surgeon- general-issues-advisory-on-youth-mental-health-crisis-further-exposed-by-covid-19-pandemic.html.

[4] Mary Mackrain, *A Day in the Life of an Early Childhood Mental Consultant*, Center for Early Childhood Mental Health Consultation, December 2021, *available at*: https://www.iecmhc.org/documents/Day_in_the_Life_MH_Consultant.pdf.

[5] *Id.*

[6] Department of Behavioral Health, *Healthy Futures Evaluation of Early Childhood Mental Health Consultation, Year 5,* September 30, 2015, *available* at: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-5.pdf.

[7] Mary Mackrain, *A Day in the Life of an Early Childhood Mental Consultant,* Center for Early Childhood Mental Health Consultation, December 2021, *available at*: https://www.iecmhc.org/documents/Day_in_the_Life_MH_Consultant.pdf.

[8] *Id.*

[9] Under the Birth-to-Three for All Amendment Act of 2018 (Birth-to-Three) Healthy Futures is intended to expand to a total of 300 childcare facilities in four years by adding the program to 75 childcare development centers each year beginning in FY2020 and ending in FY2023.

[10] DBH, FY2020 Performance Oversight Responses, responses to Q54, *available at:* https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf. DBH, FY2021 Performance Oversight Responses, responses to Q45, *available at*: https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf.

[11] During FY22 the Healthy Futures program provided services in 85 child development centers and 17 home providers for a total of 102 locations, information on file with Children's Law Center. Information on file with the Children's Law Center.

[12] FY21 (87 cites) - FY20 (58 cites) = increase of 29 sites between 1 year. FY22 (102 cites) - FY21 (87 cites) = increase of 15 cites between 1 year. Average = 29+15 divided by 2 = 22 sites increase on average over two years.

[13] DBH, FY2021 Performance Oversight Responses, responses to Q45, *available at*: https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf.

[14] *Id.*

[15] Information on file with the Children's Law Center.

[16] Department of Behavioral Health (formerly "Department of Mental Health"), Healthy Futures Year One Evaluation of Early Childhood Mental Health Consultation, September 30, 2011, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20One%20Report.pdf; Department of Behavioral Health, Healthy Futures Year Two Evaluation of Early Childhood Mental Health Consultation,

September 30, 2012, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20Two%20Report.pdf; Department of Behavioral Health, Healthy Futures Year Three Evaluation of Early Childhood Mental Health Consultation, September 30, 2013, available at: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/HealthyFuturesThreeYearEvaluationReport.pdf; Department of Behavioral Health, Healthy Futures Year Four Evaluation of Early Childhood Mental Health Consultation, September 30, 2014, available at: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-4.pdf; and Department of Behavioral Health, Healthy Futures Year Five Evaluation of Early Childhood Mental Health Consultation, September 30, 2015, available at: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-5.pdf.

[17] DBH, FY2020 Performance Oversight Responses, responses to Q54, *available at:* https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf.

[18] Leandra Godoy, et al., Behavioral Health Integration in Health Care Settings: Lessons Learned from a Pediatric Hospital Primary Care System, Journal of Clinical Psychology in Medical Settings 24, no. 3, 245–58, September 19, 2017, retrieved from: https://doi.org/10.1007/s10880-017-9509-8.

[19] "Over the past six years, DC MAP has received over 4,250 consultation requests regarding 3,745 unique patients." "Programs like DC MAP…target children in their natural context support early identification (and thereby, treatment) of behavioral health issues, potentially circumventing escalation to severe behavioral health problems over the lifetime of beneficiaries. In the long-term, effective implementation of [DC MAP] can result in decreases in behavioral health service utilization and related costs "Sharra Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 12, 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/06/SGreer_CLCTestimony_DBHOversightHearing_Updated-5.24.22.pdf.

[20] Since launching in 2015, over 400 pediatric providers from over 50 practices in the DC area have utilized DC MAP services. See DBH, FY2020 Performance Oversight Responses, responses to Q54. *See also A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, December 2021, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[21] DBH, FY2020 Performance Oversight Responses, responses to Q54, *available at:* https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf; DBH, FY2021 Performance Oversight Responses, responses to Q45, *available at*: https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf.

[22] *Id.*

[23] Over 75% of the consultation requests received are for children with DC Medicaid. *See* DBH, FY2019 Performance Oversight Responses, response to Q64. Available at: https://dccouncil.us/wpcontent/uploads/2020/02/dbh.pdf.

[24] Between January 2021 through November 2021 there were 1,285 primary care generated consults and 1,077 unique patients served through DC MAP. As compared to January 2020 through December 2020 when there were 1,065 primary care generated consults and only 886 unique patients. Numbers on file with the Children's Law Center.

[25] DC MAP: Mental Health Access in Pediatrics Homepage, *available at*: https://dcmap.org/. *See* also Paving the Way, DC Map, *available at*: https://www.pavingthewaymsi.org/dc-map.

[26] According to reports shared by Paving the Way during quarterly meetings of the DC Collaborative for Mental Health in Pediatric Primary Care, number of consultations in Fiscal Year 2022 were: 56 in Quarter 1; 259 in Quarter 2, 323 consultations were provided in Quarter 3 of 2022 and 271 in Quarter 4, for a total of 909. Date on file with the Children's Law Center.

[27] Department of Health Care Finance, Transition to Managed Care, *available at*: https://dhcf.dc.gov/page/transition-managed-care001.
[28] Department of Health Care Finance, District of Columbia Section 1115 Medicaid Behavioral Health Transformation Waiver, *available at*: https://dbh.dc.gov/page/district-columbia-section-1115-medicaid-behavioral-health-transformation-waiver.
[29] Department of Health Care Finance, *RE: Behavioral Health Transformation: Updated Timeline*, December 2, 2021, Office of the Senior Deputy Director/State Medicaid Director, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MDL%2021-06%20BH%20Transformation%20Update%20Timeline%2020211202-signed.pdf.
[30] American Academy of Pediatrics, Mental and Behavioral Health Needs of Children in Foster Care, available at: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/.
[31] *Id.*
[32] Child and Family Services Agency (CFSA), FY2021 Annual Needs Assessment, p. 102, November 1, 2021, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY21_Needs_Assessment_FINAL_0.pdf.
[33] The CFSA in-house services include a variety of therapy modalities including child-centered play therapy, grief and loss therapy, cognitive behavioral therapy (CBT), Trauma Systems Therapy (TST), Functional Family Therapy (FFT), Trauma Focused Cognitive Behavioral Therapy, Multisystemic therapy, child parent psychotherapy, and Parent Child Interaction Therapy (PCIT). Child and Family Services Agency (CFSA), FY2021 Annual Needs Assessment, p. 162, November 1, 2021, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY21_Needs_Assessment_FINAL_0.pdf
[34] Child and Family Services Agency, FY2021 Annual Report, February 2022, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/CFSA%20Annual%20Public%20Report%20FY2021.pdf; CFSA FY21 Performance Oversight Responses, response to Q36(n)(iii), https://dccouncil.gov/wp-content/uploads/2022/02/FY21-22-CFSA-Performance-Oversight-Prehearing-Questions-Responses-Final.pdf; and Child and Family Services Agency, FY2022 Needs Assessment, p. 92-98, December 2022, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY22_Needs_Assessment_FY24_Resource_Development_Plan_FINAL.pdf.
[35] CFSA FY21 Performance Oversight Responses, response to Q36(n)(iii), https://dccouncil.gov/wp-content/uploads/2022/02/FY21-22-CFSA-Performance-Oversight-Prehearing-Questions-Responses-Final.pdf.
[36] In 2021 we reviewed 389 cases from June 2020 and May 2021 and 2022 we review 411 cases from June 2021 and May 2022. In 2021, 175 clients were accessing outpatient services and treatment and in 2022, 171 clients were accessing outpatient services and treatments. Please note this is not inclusive of clients who may have in that timeframe access inpatient behavioral health services like hospitalization, psychiatric residential treatments, and other in-patient services.
[37] OWB does not serve children under five due to the challenges associated with providing clinical therapeutic services to younger children. Child and Family Services Agency, FY2022 Needs Assessment, p. 94-95, December 2022, *available at*: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY22_Needs_Assessment_FY24_Resource_Development_Plan_FINAL.pdf.

[38] American Academy of Pediatrics, Mental and Behavioral Health Needs of Children in Foster Care, available at: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/; National Conference of State Legislatures, Mental Health and Foster Care, available at: https://www.ncsl.org/human-services/mental-health-and-foster-care; and Sheppard, S., The Mental Health Effects of Living in Foster Care, verywellmind, February 9, 2022, available at: https://www.verywellmind.com/the-mental-health-effects-of-living-in-foster-care-5216614.

[39] Child and Family Services Agency, FY2022 Needs Assessment, p. 95-96, December 2022, available at: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY22_Needs_Assessment_FY24_Resource_Development_Plan_FINAL.pdf.

[40] Child and Family Services Agency Initial Evaluation of Children's Health Policy, *available at*: https://cfsa.dc.gov/sites/default/ files/dc/sites/cfsa/publication/attachments/Program%20-%20Initial%20Evaluation%20of%20Children's%20Health%20(final)(H)_2.pdf.

[41] According to the CFSA FY2020- FY2021 Performance Oversight Responses, 451 of the 614 children in care with placed Nation Center for Children and Families in Maryland. *See* CFSA FY2020 Performance Oversight ResponsQ78(a), *available at*: https://dccouncil.gov/wp-content/uploads/2021/03/FY20-21_CFSA_POH_PreHearing_Responses_FINAL2.pdf. According to the CFSA FY2021- FY2022 Performance Oversight Responses, 425 of the 614 children in care with placed Nation Center for Children and Families in Maryland. *See* CFSA FY2021 Performance Oversight Responses, response to Q106(a), *available at*: https://dccouncil.gov/wp-content/uploads/2022/02/FY21-22-CFSA-Performance-Oversight-Prehearing-Questions-Responses-Final.pdf.

[42] Wilson ME. *Overmedicated: Foster kids in crisis*. City Univ N Y CUNY Acad Works, *available at*: https://marywilson1.wixsite.com/overmedicated.

[43] Mackie TI, *Psychotropic Medication Oversight among Youth in Custody of State Child Welfare Systems*, 2014, Tufts Medical Center, *available at*: https://www.nmlegis.gov/handouts/LHHS%20102014%20Item%203%20Thomas%20Mackie,%20Ph.D.%20Tufts%20Medical%20Center%20Psychiatric%20Medication%20Oversight%20for%20children%20in%20Foster%20Care.pdf.

[44] Children's Bureau Child Welfare Information Gateway, *Health-Care Coverage for Youth in Foster Care—and After*, January 2022, *available at*: https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf.

[45] Texas Health and Human Services, *Update on the Use of Psychotropic Medications for Children in Texas Foster Care: State Fiscal Years 2002-2019 Data Report*, 2021, *available at*: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/psychotropic-meds-tx-foster-care-fy2002-2019.pdf.

[46] Family Preservation Services of Washington D.C., *Our Services, available at*: https://www.familypreservationdc.com/our-services/.

[47] Department of Health Care Finance, 2019 District of Columbia Annual Technical Report (ATR), *available at*: https://dhcf.dc.gov/publication/2019-district-columbia-annual-technical-report-atr.

[48] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, December 2021, p. 56, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[49] *Id.*

[50] MCOs are subject to ensuring access to behavioral health services in accordance with the 42 CFR § 438.68 (network adequacy standards) and § 438.206 (availability of services), as well as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (ensures that behavioral health coverage is on equal footing with medical and surgical coverage) and the District of Columbia Behavioral Health Parity Act of 2018.

[51] Strengthening Families Coalition Through Behavioral Health, Homepage, *available at*: https://www.strengtheningfamiliesdc.org/.