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Testimony Before the District of Columbia Council
Committee on Health
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# Public Performance Oversight Hearing: Department of Health Care Finance

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**Introduction**

Good morning, Chairperson Henderson, and members of the Committee. My name is Leah Castelaz. I am a Policy Attorney 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.

Thank you for the opportunity to testify today regarding the Department of Health Care Finance's (DHCF) performance over the past year, as well as the changes underway in Medicaid. Nearly all of Children's Law Center's clients are Medicaid beneficiaries. We want our clients – and every District resident – to be able to access the most appropriate therapeutic intervention or service that will meet their diverse physical and behavioral health needs to build a solid foundation for life. Health access is important for children – who represent over one-third of DC's Medicaid enrollment – as well as their parents.[1] Medicaid also insures and pays for nearly half the births in the District.[2] The environment and experiences of early childhood, including the parent-child relationship, help form

the foundations for learning, health, and behavior for the rest of a child's life.[3] Unfortunately, disparities in health access and outcomes persist in the District, keeping cycles of inequity and poverty in motion.[4] District children and families need systemic solutions that increase access to health support and services from pregnancy onward.

We are, therefore, troubled that over the past year perinatal health and behavioral health outcomes have remained poor or worsened.[5] The District continues to see some of the poorest perinatal physical health outcomes in the nation.[6] Perinatal mental health outcomes do not fare much better - increasing an infant's risk of exposure to toxic stress, which can delay language, cognitive, and social-emotional development in infants.[7] Older children are experiencing a youth mental health crisis of their own, as symptoms of poor mental health, including depression and suicidal ideation, have been steadily increasing for over a decade.[8]

Children's Law Center clients and their families continue to face persistent, sometimes insurmountable, barriers that keep them from critical resources to address their health concerns.[9] In our experience this is due, in part, to the lack of an effective and complete continuum of care that includes the promotion of behavioral health, prevention of mental illnesses and substance use disorders, early identification, treatment, recovery and rehabilitation services, and long-term supports. Having the right supports in place can positively impact parents and their children by decreasing maternal deaths, addressing perinatal mood and anxiety disorders, mitigating adverse childhood

experiences, preventing child welfare involvement, improving parent-child relationships, promoting family economic security, and supporting child development and school readiness. DHCF plays a critical role in breaking down barriers and building a continuum of care in the District that supports residents from pregnancy onward.

Our testimony today will reflect on DHCF's contributions to a more complete continuum of care in the District, and note continued areas for improved investment, collaboration, interagency coordination, and stringent oversight. Specifically, our testimony will discuss: (1) the extent to which DHCF-led initiatives result in actual improvements to DC's healthcare system; (2) the necessary and continued focus on the provider and beneficiary experience as DHCF works to integrate behavioral health services into Managed Care Organizations (MCOs); (3) DHCF's responsibility to hold MCOs accountable for network adequacy; and (4) how DHCF can use the 1115 Waiver process to meet health-related social needs of DC residents as well as provide continuous coverage to children, ages 0-5.

**DHCF's Efforts to Expand Medicaid Services and Enhance Whole-Person Care Must Result in Improved Health Outcomes for District Residents**

In recent years, DHCF has undertaken multiple projects to expand services in Medicaid and implement models that incentivize better whole-person care. These on-going initiatives include:

- DC's Section 1115 Medicaid Behavioral Health Transformation Demonstration and the further expansion of the 1115 Waiver in 2024.[10]

- The transition to a managed care Medicaid program to be completed in 2024.[11]
- The integration of behavioral health services into the District's managed Medicaid program beginning April 2024.[12]
- New behavioral health service rates based on the ongoing rate study conducted by Public Consulting Group (PCG).[13]
- An updated DC Medicaid Managed Care Quality Strategy for 2024-2027 to set performance measures for Medicaid insurers.[14]
- The passage by the DC Council of B25-0419: Childhood Continuous Coverage Act of 2023 and B25-0321: Home Visiting Services Reimbursement Act of 2023.[15]
- Transfer of First Time Mother's home visiting program to the purview of DHCF.[16]
- The relaunched 211 Warmline, which is led by Child and Family Services Agency (CFSA) but requires all human support services to participate.[17]

These efforts have been coupled with the COVID-19 Public Health Emergency (PHE) as well as the ending of the PHE which restarted Medicaid eligibility redeterminations.[18] We share DHCF's underlying goal for to DC to be a jurisdiction that strives to ensure healthcare enrollment and expand access and services for all. To succeed in this goal, however, all these initiatives by DHCF, the Council, and sister agencies must actually result in better health outcomes for District residents.

To date, we have not yet seen improved health outcomes as a result of the District's many efforts. For example, in FY 2023, DC Health reported that severe maternal morbidity increased across all races in the District.[19] In the same year there were increases to preterm births and greater number of pregnant teens.[20] These alarming new statistics

highlight worsening perinatal health outcomes for pregnant and postpartum people in the District over the last year.

While we are grateful for the engagement and innovation lead by DHCF to move forward improvements to the perinatal healthcare system, including Medicaid reimbursement for doulas, the recently released the Perinatal Mental Health Task Force (Task Force) Report, and restarting the Maternal Health Advisory Group as well as the work yet to come with Medicaid reimbursement for home visiting services.[21] We remain concerned that this work and the other efforts identified above continue to be focused on outputs of products instead of the health outcomes of residents.

As reported by DHCF in December there are currently only four doulas enrolled in Medicaid reimbursement.[22] Additionally, the Task Force report highlighted the ongoing behavioral health workforce shortage to address perinatal mental health in the District.[23] The District also continues to not meet most national standards for prenatal and postpartum care.[24] Without significant investment of time, energy, and money in creating a significant network of providers that are adequately reimbursed, these trends will continue.

The perinatal health work provides an example that illustrates an issue that has become pervasive in this work – there are a significant number of outputs without the improved outcomes. While we want DHCF to continue to be a leader of innovation for perinatal health as well as other areas, we also must hold DHCF and their sister agencies

accountable to create actual, meaningful improvements to our healthcare system, not just lists of projects and activities.

**DHCF is Working to Create Structure for "Whole-Person Care" by Transitioning to Managed Care Models and Integrating Behavioral Health Services**

Through Medicaid transformation efforts, DHCF is remaking the District's health delivery landscape in two major ways. First, DHCF started moving most Medicaid beneficiaries from a fee-for-service model to a managed care model in 2019.[25] With built-in care coordination and value-based purchasing requirements, managed care rewards good patient outcomes instead of high volume,[26] helping the District move toward the "triple aim" of better care, better health outcomes and reduced costs.[27] At the same time, upon approval of the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration waiver in 2020, DHCF has also been preparing to integrate[28] a "broader continuum of behavioral health treatment" into its managed care contracts.[29] "Carving in" behavioral health services to Medicaid also allows the District to pull in federal matching dollars for the carved-in services, as opposed to using local dollars through the Department of Behavioral Health (DBH).[30]

These transformations to our care delivery services should have a positive impact but will also be significantly disruptive. Community-based organizations (CBOs) and Core Service Agencies (CSAs) must make significant administrative changes to participate in the Medicaid infrastructure, certify and contract with the new insurance companies, and adjust to new billing procedures, timelines, and methodologies.

In part due to the disruptions of the COVID-19 Public Health Emergency, the integration – or "carve-in" – was delayed from 2022 to October 2023, and again to April 2024. Despite the longer ramp-up, as of this hearing, the mechanics are still not ready, nor are all the payment rates set.[31] The Committee heard testimony from several providers and advocates at DBH's January 29 Performance Oversight Hearing expressing pessimism about their readiness for the change. If providers cannot transition seamlessly from DBH to their new MCO payors, they may lose revenue they cannot afford to lose, and potentially displace their patients. Any loss of capacity in the provider network will hurt patients and undermine the intentions of the transformation. DHCF has the responsibility to not only effectively communicate the processes, procedures, and payments to providers and patients – with enough time for them to respond and adjust – but to better support these community-based businesses and their thousands of patients every step of the way. We ask that DHCF ensure that they have sufficient technical assistance in place and their workforce is ready to lend support to these providers. We also need attentive Council oversight in the coming months, especially attune to the provider and beneficiary experience of the transformation.

**DHCF Must Hold Managed Care Organizations Accountable for Network Adequacy, Which Includes a Sufficient Array of Providers that are Accessible and Culturally Congruent**

"Network adequacy" refers to the mandate in federal Medicaid regulations that participating states must maintain an adequate network of providers "to achieve greater

equity in health care and enhance consumer access to quality, affordable care."[32] The MCOs, commercial insurance companies contracted by the state to manage Medicaid plans,[33] are also required to comply with network adequacy standards and "availability of services standards,"[34] as well as the Mental Health Parity and Addiction Equity Act of 2008,[35] and the District of Columbia Behavioral Health Parity Act of 2018.[36] As the government agency tasked with both implementing the District's Medicaid program and administering the MCO contracts, DHCF is principally responsible for ensuring the District's Medicaid program has an adequate network of providers.

Despite these requirements, the reality is that DC has an insufficient number of perinatal and child-serving behavioral health providers and facilities. Specifically, in our work at Children's Law Center, we see a need for more child psychiatrists, specialists, child psychologists, and social workers, especially for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays. Similar needs for increases to the perinatal mental health workforce are reported by the Task Force, which also recommends improving cultural and linguistical representation in providers, as well as expanded training for perinatal mental health screening.[37] We also need more providers with training in family therapy and specific evidence-based treatments (e.g., parent-child interaction therapy). Networks should include all needed facilities for populations like parents suffering from significant perinatal mental health conditions or children with high behavioral health

needs, such as inpatient psychiatric units, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers.

It is critical for DHCF to not only routinely monitor but also enforce network adequacy. Meaningful measures of access should be required for MCOs, and tied to accountability mechanisms that are regularly and transparently enforced, such as monetary penalties. We, however, are not aware of any enforcement measures being levied to date, despite recent external reviews documenting inadequacies.[38]

*The DC Medicaid Managed Care Quality Strategy Should Reflect Expanded Measures for Timely Access to Care*

As required every three years, DHCF has also been setting new performance goals and measures for its managed care organizations. It released a DC Medicaid Managed Care Quality Strategy (MMCQS) 2024-2027 in December 2023 for public comments.[39] The MMCQS provides an opportunity to assess how DHCF is holding MCOs accountable for Key Performance Indicators (KPIs), Performance Improvement Projects (PIPs), and measures of "Timely Access" to care. Without proper accountability of MCOs, the expansion of Medicaid coverage will remain incomplete.

In Children's Law Center's public comment on the MMCQS, our primary recommendation was to add a Timely Access Standard for "diagnosis and treatment of mental health condition (not urgent)" of an appointment within 30 calendar days from request. Currently, the only Timely Access Standard for mental health is for outpatient

care after hospitalization. This focus on acute and residential care is important but excludes a significant – and growing – range of care.

There are further benefits of adding a Timely Access measure for non-urgent mental health appointments. First, it would mirror the standards for Primary Care – diagnosis and treatment of health condition (not urgent); routine appointment; non-urgent referrals; etc. Second, it would allow DC to quantify the difference in supply and demand for outpatient behavioral health care. Third, it would align with the DC Department of Insurance, Securities and Banking's (DISB) recent rulemaking which requires health carrier provider networks – including private insurance – to establish standards for appointment wait times for services within the network.[40] Notably, DISB's new standard is both more inclusive of treatment types than current MCO standards, and more ambitious from a time-to-care perspective: the first appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use Treatment must be within seven business days.[41] Finally, we believe that by tracking the time to *all* behavioral health care, DHCF will have a barometer of whether its transformations in managed care and integration are resulting in actual access for beneficiaries.

*Reimbursement Rates Must Be Higher to Attract and Retain Providers in Medicaid*

All the reform underway won't lead to improved access or better outcomes unless there are providers in place to serve people. DHCF must set sufficient rates to support an

adequate provider network – in quantity and quality. 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.[42] If we expect to attract and retain providers in the public network, rates should be competitive with private markets and adjusted annually for inflation. Instead, the financing continues to be outdated and inadequate, which harms the provider network and constrains service availability.

The rate study that DBH and DHCF have been developing for years is still not released in full.[43] Even now, with two months until the carve-in, providers are still not informed what reimbursement to expect for all anticipated services, with some changes already delayed until July 2024. Updates have been very piecemeal, which raises concern about whether the results will actually support today's true cost of service delivery. While providers waited for these results to plan for future business with MCOs, they shuffled through another year on rates based on 2016 costs, which have only been adjusted by 6.2 percent, despite over 23 percent inflation, since 2016. We cannot expect practices or businesses to operate this way.

Since *A Path Forward* was released, we have also recommended the District ease burdens related to credentialing and billing so no willing provider is thwarted by administrative procedures. Unfortunately, community-based organizations (CBOs) and Core Service Agencies (CSAs) that are currently paid through DBH are struggling to

completely overhaul their businesses to be able to participate in the Medicaid infrastructure, certify and contract with the new insurance companies, and adjust to new billing procedures, timelines, and methodologies. If providers are not able to transition seamlessly on day one, they may lose revenue and potentially displace their patients. Any loss of capacity in the provider network will hurt patients. DHCF – with DBH – must increase support and information sharing to their provider networks before April 1 arrives.

*DHCF Must Implement the Recommendations of the Mayor's Healthcare Workforce Task Force and Perinatal Mental Health Task Force to Broaden DC's Labor Pool and Provider Networks.*

As stated above, the District must improve enforcement of MCO network adequacy standards and pay to providers in the public system. It must also guarantee that the pool of current providers will continue to be available to MCOs. Fittingly, Mayor Bowser's Healthcare Workforce Task Force reported its recommendations in 2023 to "rebuild, strengthen, and expand the District's healthcare workforce" and to "address current supply and demand challenges in the healthcare workforce."[44] Recommendations tasked to DHCF include:

- Set a payment floor for District healthcare workforce wages at 120 percent of the District's Living Wage or minimum wage, whichever is greater, to ensure competitive wages and access to apprenticeship training funding (contingent on available funding).

- Adopt healthcare reimbursement policies that support workforce retention for experienced members of the healthcare workforce, including creating mechanisms that value and more highly compensate tenure and experience in given roles in addition to quality of care and health outcomes, and adjusting provider payment rates based on beneficiary social risk stratification.
- Reduce systemic factors contributing to healthcare workforce burnout by reducing documentation burden, insurance prior authorization requirements for routine care, and improving healthcare workforce quality of life.

Unlike the Mayor's Workforce Task Force, the Perinatal Metal Health Task Force did not assign specific workforce recommendations to a specific agency. However, as DHCF restarts the Maternal Health Advisory Group to move forward the Perinatal Mental Health Task Force's recommendations, we ask that it ensure special considerations for recommendations that are within its purview. This may include the following recommendations:

- Expand the workforce by investing in community health workers, peer support, and other paraprofessionals to help prevent and address PMH disorders.

- Provide enhanced Medicaid reimbursement for mental health providers (holding any type of clinical license) who have specialized training and certifications in perinatal mental health.

Additionally, there are opportunities for DHCF as a leader in this space to bring in its sister agencies to ensure other recommendations move forward that would create a sufficient workforce in the District to address health and behavioral health needs across populations. An important component of health system transformation is implementing recommendations from these experts, which included all agencies at work in the behavioral health workforce, as well as leaders in the education, employment, and healthcare sectors.

**DHCF Can Use the 1115 Waiver Process to Meet Health-Related Social Needs of DC Residents As Well As Provide Continuous Coverage to Children, Ages 0-5**

Looking further into the future, DHCF is taking opportunities to expand Medicaid services and eligibility even further through the 1115 Waiver, to encompass supports for health-related social needs (HRSN) in addition to behavioral health services.[45] We believe the 1115 Waiver presents possibilities to finance prevention activities rather than simply reacting to illness. The Biden administration has encouraged Medicaid programs to propose waivers that expand coverage, reduce racial disparities, and/or advance whole-person care, including addressing HRSN. In November 2023, DHCF shared a survey with stakeholders to evaluate the current 1115 Waiver's progress and provide input into the expansion. Children's Law Center submitted responses to that survey, as well as a formal

letter, and has continued to engage with the agency to inform this important work.[46]

By design, Medicaid waivers create experiments to push the health system forward, and good experiments require sound measurement and close attention to lessons learned. Therefore, we ask that as DHCF works to move forward the 1115 demonstrations to better meet behavioral health and social needs, that the agency has continued, robust engagement with community members, the provider community, and its sister agencies.

The 1115 Waiver has the opportunity to bring healthcare to residents in new ways including in the housing space by using Medicaid to pay for a beneficiary's home modifications, repair and remediation services, and/or medically necessary devices to maintain a healthy living environment.[47] This, however, cannot be done without engagement from those moving forward safe and healthy housing in the District. Ensuring relevant stakeholder engagement will help DHCF gather all relevant perspectives and data to ensure the goals are met, and to make true improvements in healthcare delivery in the District.

Additionally, the Council recently passed legislation B25-0419: Childhood Continuous Coverage Act of 2023 ("Continuous Coverage Act") which would require DHCF to provide continuous Medicaid coverage for children ages 0-5.[48] While we understand this legislation is not fully enacted yet, we are hopeful that it will move

swiftly through the remaining legislative processes. As the Director indicated in the October 2023 hearing, if fully enacted DHCF will need to utilize the 1115 Waiver to make the necessary changes for continuous coverage.[49] The time to move on continuous coverage for District children five and under is now.[50] We, therefore, have asked DHCF to include it in their 1115 Waiver to enable children up to age five to maintain continuous Medicaid coverage without yearly redeterminations which would likely (1) promote greater utilization of Medicaid covered services and (2) reduce parental stress.[51] We ask this Committee to work with DHCF to ensure the inclusion of continuous coverage, as well.

**Conclusion**

We would like to acknowledge the work of this Committee which has increased transparency and created the space to have these important conversations. We would encourage the Committee to continue to hold our government partners accountable for their performance in the District. While DHCF is the lead on the majority of these efforts, they cannot do this work alone. There must be a meaningful, coordinated effort between DHCF and its sister agencies who provide many of the physical and mental health services needed in the continuum of care. We recognize these are enormous undertakings by DHCF and ask that this Committee continue to be engaged through continued, timely oversight, as well as provide any necessary support to the agency in these endeavors.

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

[1] District of Columbia Department of Health Care Finance, Monthly Enrollment Report, April 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MCAC%20Enrollment%20Report%20-%20April%202023.pdf.

[2] DC Council Committee on Health, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, (December 14, 2023), *available at*: https://www.youtube.com/watch?v=NsQaTDG7_jc&t=10261s.

[3] Nadine Burke Harris, Toxic Childhood Stress: The Legacy of Early Trauma and How to Heal (2020).

[4] Leah Castelaz, Testimony before the DC Council Committee on Health, (December 14, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-public-hearing-on-public-safety-behavioral-health-services-and-support-for-youth/; Amber Rieke, Testimony before the DC Council Committee on Health, (December 13, 2023), *available at:* https://childrenslawcenter.org/resources/testimony-public-roundtable-on-maternal-and-infant-health/; Judith Sandalow and Danielle Robinette, Testimony before the DC Council Committee of the Whole, (December 12, 2023), *available at*: https://childrenslawcenter.org/resources/hearing-committee-of-the-whole-chronic-absenteeism-truancy/.

[5] DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232; DHCF, Perinatal Mental Health Task Force, December 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf; District of Columbia's Maternal Mortality Review Committee Annual Report, 2021, published September 2023, available at: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/MMRC2021Annual%20ReportFinal.pdf; GAL Deep Dive, internal Children's Law Center Data Collection, 2022-2023; Ayan Sheikh and Chris Remington, *Why do so many Black infants in D.C. die before their first birthday*, January 30, 2024, *available at*: https://wamu.org/story/24/01/30/listen-why-do-so-many-black-infants-in-d-c-die-before-their-first-birthday/; Rachel Metz, *DC Must Continue Tackling Youth Mental Health Crisis*, DC Action, August 21, 2023, *available at*: https://www.wearedcaction.org/blog/dc-must-continue-tackling-youth-mental-health-crisis.

[6] In the most recent Maternal Mortality Review Committee case review, of the 4 maternal deaths reviewed from 2018, 100 precent of the cases were birthing people of color. Additionally, during a five-year period (2014-2018), 36 District-residents' lives were lost during pregnant or within one year following the end of pregnancy from any cause. One maternal death was to a Hispanic birthing person, one was to a Non-Hispanic White person, and one maternal death was to a birthing person with race classified as Other and ethnicity non-Hispanic. The other 33 deaths were attributable to Non-Hispanic Black birthing persons. See District of Columbia's Maternal Mortality Review Committee Annual Report, 2021, published September 2023, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/MMRC2021Annual%20ReportFinal.pdf; *See also*

District of Columbia's Maternal Mortality Review Committee Annual Report, 2014-2018, published December 2021, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf. In the recent DC Health performance oversight responses, there were 11 maternal deaths and the five-year DC maternal mortality rate was 24.2 per 100,000 live births for 2017-2021. *See* FY2023 DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232. In a recent report from the Georgetown University Center for Child and Human Development, examined the role of racism, racial disparities, and social determinants of health play in perpetuating perinatal health disparities in access and outcomes for Black mothers in wards 5, 7, and 8. See Perinatal Needs Assessment, 2023, Georgetown University Center for Child and Human Development, *available at*: https://gucchd.georgetown.edu/Perinatal.php. Notably, it is difficult to find consistent reporting on DC's maternal mortality rate. This highlights a gap in data reporting on perinatal health which will be discussed throughout this testimony. One stat shared is from the United Health Foundation, which found the city's maternal mortality rate in 2018 was roughly 36 per 100,000 live births, compared to the national rate of 20.7. According to Georgetown University Center for Child and Human Development Needs Assessment, DC's maternal mortality rate is 39 deaths per every 100,000 live births (no year given). According to the Maternal Mortality Review Committee, DC pregnancy-related mortality rate for 2014-2018 is 44.0 deaths per 100,000 live births. And according to March of Dimes, which uses the National Center for Health Statistics, mortality data, 2018-2021, DC's maternal mortality rate was 30.7 per 100,000 births, which shows the death rate of birthing people from complications of pregnancy or childbirth that occur during the pregnancy or within 6 weeks after the pregnancy ends. These numbers all appear to be higher or near the reported national maternal mortality rate for 2021, which was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. Colleen Grablick, Black People Accounted For 90% Of Pregnancy-Related Deaths In D.C., Study Finds, April 28, 2022, DCist, *available at*: https://dcist.com/story/22/04/28/dc-maternal-mortality-study-2022/; District of Columbia's Maternal Mortality Review Committee Annual Report, 2014-2018, published December 2021, *available at*: https://ocme.dc.gov/sites/default/files/dc/sites/ocme/agency_content/Maternal%20Mortality%20Review%20Committee%20Annual%20Report_Finalv2.pdf; Perinatal Needs Assessment, 2023, Georgetown University Center for Child and Human Development, *available at*: https://gucchd.georgetown.edu/Perinatal.php; 2023 March of Dimes Report Card for District of Columbia, *available at*: https://www.marchofdimes.org/peristats/reports/district-of-columbia/report-card; and Donna L. Hoyert, Maternal Mortality Rates in the United States, 2021, Centers for Disease Control and Prevention, March 2023, *available at*: https://www.cdc.gov/nchs/data/hestat/maternalmortality/2021/maternal-mortality-rates-2021.htm#Table.

[7] DHCF, Perinatal Mental Health Task Force, December 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.

[8] U.S. Office of the Surgeon General (OSG), U.S. Surgeon General Advisory: Protecting Youth Mental Health, p. 8 (December 7, 2021), *available at*: https://www.hhs.gov/sites/default/files/surgeon-general-youthmental-health-advisory.pdf; American Academy of Pediatrics, Mental and Behavioral Health Needs of Children in Foster Care, (2021), *available at*: https://www.aap.org/en/patientcare/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/.

[9] Leah Castelaz, Testimony before the DC Council Committee on Health, (December 14, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-public-hearing-on-public-safety-behavioral-health-services-and-support-for-youth/; Amber Rieke, Testimony before the DC Council Committee on Health,

(December 13, 2023), *available at:* https://childrenslawcenter.org/resources/testimony-public-roundtable-on-maternal-and-infant-health/; Judith Sandalow and Danielle Robinette, Testimony before the DC Council Committee of the Whole, (December 12, 2023), *available at*: https://childrenslawcenter.org/resources/hearing-committee-of-the-whole-chronic-absenteeism-truancy/.

[10] Department of Behavioral Health, 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; Department of Health Care Finance, Medicaid Reform, *available at*: https://dhcf.dc.gov/1115-waiver-initiative; Department of Health Care Finance, Medicaid Director Letter – MDL 23-03 – 1115 Waiver, *available at*: https://dhcf.dc.gov/node/1689761.

[11] Department of Health care Finance, Transition to Managed Care, *available at*: https://dhcf.dc.gov/page/transition-managed-care001.

[12] Department of Health Care Finance, Behavioral Health Integration, *available at*: https://dhcf.dc.gov/page/behavioral-health-integration.

[13] The following transmittal references the rate study with the Public Consulting Group (PCG). *See* Department of Health Care Finance, Transmittal 23-29, Changes to Delivery and Billing Requirements to Receive Reimbursement for Assertive Community Treatment (ACT) , *available at*: https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/31577.

[14] Department of Health Care Finance, Medicaid Care Quality Strategy December 2024-2027, *available at*: https://dhcf.dc.gov/managed-care-quality-strategy.

[15] B25-0321 - Home Visiting Services Reimbursement Act of 2023; B25-0419 - Childhood Continuous Coverage Act of 2023.

[16] FY2023 Department of Health Care Finance Performance Oversight Responses, response to Q80, *available at*: https://lims.dccouncil.gov/Hearings/hearings/282.

[17] Jess Arnold, *Yes, DC neighbors are using the new 211 warmline*, WUSA9, January 24, 2024, *available at*: https://www.wusa9.com/article/news/local/dc/dc-neighbors-call-211-warmline-social-services-violence-intervention/65-cd80795d-43a3-4c83-bfd2-50098aa2584d#:~:text=D.C.%20responded%20by%20launching%20a,warmline%20received%20785%20connected%20calls; Child and Family Services Agency, FY2024 Performance Plan, December 1, 2023, *available at*: https://oca.dc.gov/sites/default/files/dc/sites/oca/page_content/attachments/Child%20and%20Family%20Services%20Agency_2023-12-01.pdf.

[18] "At the start of the pandemic, Congress enacted the Families First Coronavirus Response Act (FFCRA), which included a requirement that Medicaid programs keep people continuously enrolled through the end of the COVID-19 public health emergency (PHE), in exchange for enhanced federal funding. As part of the Consolidated Appropriations Act, 2023, signed into law on December 29, 2022, Congress delinked the continuous enrollment provision from the PHE, ending continuous enrollment on March 31, 2023. The CAA also phases down the enhanced federal Medicaid matching funds through December 2023. Primarily due to the continuous enrollment provision, Medicaid enrollment has grown substantially compared to before the pandemic and the uninsured rate has dropped." *See* Jennifer Tolbert and Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*, KKF, June 09, 2023, *available at*: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.

[19] FY2023 DC Health Performance Oversight Responses, response to Q43, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.

[20] *Id.*

[21] FY2023 Department of Health Care Finance Performance Oversight Responses, responses to Q77; Q80, *available at*: https://lims.dccouncil.gov/Hearings/hearings/282; B25-0321 - Home Visiting Services Reimbursement Act of 2023.
[22] DC Council Committee on Health, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, (December 14, 2023), *available at*: https://www.youtube.com/watch?v=NsQaTDG7_jc&t=10261s.
[23] DHCF, Perinatal Mental Health Task Force, December 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.
[24] DC Council Committee on Health, Roundtable: Maternal and Infant Health: Addressing Coverage, Care, and Challenges in the District, (December 14, 2023), *available at*: https://www.youtube.com/watch?v=NsQaTDG7_jc&t=10261s.
[25]Department of Health Care Finance, 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.
[26] *Id.*
[27] Donald Berwick, *The Triple Aim: Why We Still Have a Long Way to Go*, Institute for Healthcare Improvement (February 14, 2019), *available at:* https://www.ihi.org/insights/triple-aim-why-we-still-have-long-way-go.
[28] Integrated care can take many forms, but the focus in DC has been to better incorporate behavioral health care and coordination into existing conventional healthcare systems. A team approach to healthcare allows professionals specializing in different areas to working together to enhance a patient's overall wellbeing. We have seen success across numerous programs from integrating healthcare. For example, through the HealthySteps program, embedding a behavioral health professional in the primary care setting has increased earlier identification of behavioral health issues for both child and caregiver, as well as greater connection to community supports and resources. Integrated care allows for children and families to access care more seamlessly, as well. Patients after giving birth, for example, are more likely to keep a well-child visit than their own postpartum visit. Pediatric care offers parents six or more interactions with their child's pediatrician within the first year following delivery. Therefore, pediatrician offices, when integrated with professionals who can care for parents as well, can offer a safe and consistent space for parents to access the support and resources they need for a successful first year.
[29] Department of Health Care Finance, District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration, *available at*: https://dhcf.dc.gov/1115-waiver-initiative
[30] *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,* KKF, *available at*:https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[31] *Id.*
[32] "A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section." *See* Centers for Medicare & Medicaid Service, Department of Health and Human Services, 42 Fed. Reg. § 438.68 (June 19, 2020). *See also* 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/. National Conference of State Legislatures, *Health Insurance Network Adequacy Requirements*, June 1, 2023, *available at*: https://www.ncsl.org/health/health-insurance-network-adequacy-requirements;

Karen Pollitz, *Network Adequacy Standards and Enforcement,* KFF, February 4, 20233, *available at*: https://www.kff.org/affordable-care-act/issue-brief/network-adequacy-standards-and-enforcement/#:~:text=The%20Affordable%20Care%20Act%20(ACA,out%2Dof%2Dnetwork%20providers.

[33] Kate Bradford and Kathryn Costanza, *Medicaid Managed Care 101,* National Conference of State Legislatures, *available at*: https://www.ncsl.org/health/medicaid-managed-care-101.

[34] "Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68." *See* Centers for Medicare & Medicaid Service, Department of Health and Human Services, 42 Fed. Reg. § 438.206(a), (June 19, 2020).

[35] The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* amended ERISA to require U.S. if health insurance companies provide coverage for mental health and substance abuse, the coverage must be equal for conditions such as psychological disorders, alcoholism, and drug addiction. *See* Labor, EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM, 29 U.S. Code § 1185a - Parity in mental health and substance use disorder benefits.

[36] "To require health insurers offering health benefits plans in the District to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any guidance or regulations implementing the act…" *See* D.C. Law 22-242. Behavioral Health Parity Act of 2018.

[37] DHCF, Perinatal Mental Health Task Force, December 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.

[38] 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/.

[39] Department of Health Care Finance, Medicaid Care Quality Strategy December 2024-2027, *available at*: https://dhcf.dc.gov/managed-care-quality-strategy.

[40] The Department of Insurance, Securities and Banking (DISB) published the network adequacy final rulemaking in the D.C. Register on February 17, 2023 (Vol 70/7; N129228; 26-A4700), *available at*: https://disb.dc.gov/page/network-adequacy.

[41] *Id.*

[42] McKnight R., 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.

[43] On the path to this carve-in of behavioral health services, efforts since at least 2021 have been focused on conducting a behavioral health rate study. The Behavioral Health Integration Stakeholder Advisory Group has been supporting planning of the transformation and the rates. *See* Department of Health Care Finance, Public Forum on Integrated Care, *available at*: https://dhcf.dc.gov/page/public-forum-on-integrated-care; Department of Health Care Finance, Behavioral Health Integration, *available at*:

[44] https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf.

[45] The main mission of Medicaid at its inception was to finance the delivery of primary and acute medical services. The current and expanded 1115 waiver, however, can push the envelope on this narrow way of thinking of healthcare delivery. Section 1115 of the Social Security Act allows for Medicaid programs at the state-level to submit experimental, pilot, or demonstration projects that likely assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations is to give states additional

flexibility to design and improve their programs, and to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations. *See About Section 1115 Demonstrations,* Medicaid.gov, *available at*: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

[46] Children's Law Center, Comment: Renewal of the Behavioral Health Transformation 115 Waiver, (January 16, 2024), *available at*: https://childrenslawcenter.org/resources/comment-renewal-of-the-behavioral-health-transformation-115-waiver/.

[47] For example: (1) poor ventilation, pest infestations, and mold contamination can cause and exacerbate asthma and other respiratory conditions; (2) the inability to maintain comfortable thermal conditions places residents, especially those with pre-existing health problems, at increased vulnerability during extreme temperatures; (3) peeling and chipping paint in housing built before 1978 increases the risk of lead poisoning, especially among children; and (4) exposed heating sources, inadequate lighting, and floors and stairs in disrepair increase the risk of injury.

| State | Approved Services Related to Safe and Healthy Housing |
|---|---|
| North Carolina | • Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing an individual's health condition<br>• Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure an individual's health |
| Oregon | • Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention<br>• Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation |
| Massachusetts | • Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment<br>• Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation |
| Arizona | • Medically necessary home accessibility modifications and remediation services |

*See* Department of Health & Human Services Center for Medicare & Medicaid Services letter Jay Ludlam, North Carolina Department of Health and Human Services, July 7, 2023, Attachment G: Table 3, *available at*: https://www.medicaid.gov/sites/default/files/2023-07/nc-medicaid-reform-demo-ca.pdf; Department of Health & Human Services Center for Medicare & Medicaid Services letter to Dana Hittle Oregon Health Authority, September 28, 2022, p. 39, *available at*: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf; Department of Health & Human

Services Center for Medicare & Medicaid Services letter to Amanda Cassel Kraft, MassHealth, September 28, 2022, p. 118, *available at*: https://www.mass.gov/doc/masshealth-extension-approval/download; *Special Terms and Conditions: Arizona Health Care Cost Containment System Medicaid Section 1115 Waiver Demonstration*, Centers for Medicare & Medicaid Services, *available at*: https://www.azahcccs.gov/Resources/Downloads/Federal/AHCCCS_ExtensionSTCs.pdf.

[48] B25-0419 - Childhood Continuous Coverage Act of 2023

[49] *Id.*

[50] DC can look to other states that have advanced multi-year continuous eligibility for children, including Oregon and Washington (where it has been implemented) and New Mexico, California, Colorado, Minnesota, Illinois, Ohio, and North Carolina (where it is in development). *See* Elisabeth Wright Burak, *North Carolina and Hawaii Make 10: States Advancing Medicaid/CHIP Multi-Year Continuous Eligibility for Young Children,* Center for Children & Families (CCF) of the Georgetown University McCourt School of Public Policy, November 16, 2023, *available at*: https://ccf.georgetown.edu/2023/11/16/north-carolina-and-hawaii-make-10-states-advancing-medicaid-chip-multi-year-continuous-eligibility-for-young-children/.

[51] Leah Castelaz, Testimony before the DC Council Committee on Health, (October 4, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-home-visiting-services-reimbursement-and-childhood-continuous-coverage-acts-of-2023/.