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

Testimony Before the District of Columbia Council
Committee on Health
April 29, 2024

Public Hearing:
Budget Oversight Hearing
Department of Health Care Finance

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

Introduction

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

Thank you for the opportunity to testify about the proposed Fiscal Year 2025 (FY25) budget for the Department of Health Care Finance (DHCF). Our clients often have significant behavioral health needs – whether they are involved in the child welfare system or navigating other upheavals – yet are frequently unable to find the services they need. Their greatest obstacles are a) the lack of behavioral health care professionals practicing in public programs, and b) the challenges of navigating between and through services and across agencies.[2] According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[3] This is why we have supported DHCF's recent projects to better integrate

behavioral health care with physical health, and to broaden the network of providers with whom it contracts.

We are glad DC is a jurisdiction that strives to expand access to services. However, our public healthcare system still needs significant work in many areas to provide timely, accessible, high quality, culturally appropriate, or affordable care to thousands of children who need it. This is why Children's Law Center joined with partners and community members to write *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, which details the many needs and recommends 94 actions to improve the system.[4] The behavioral health system envisioned in *A Path Forward* would deliver high-quality mental health and substance use services along the full continuum of care (early identification, treatment, recovery and rehabilitation services, and long-term supports) that meets the evolving needs of children in DC. Service networks would be actively coordinated with accountability and efficiency, and care would be integrated for ease of access.

As you know, DHCF has recently halted integration of behavioral health services into Managed Care Organizations (MCOs) which was in the works for years – also referred to as the behavioral health "transformation" or "carve-in." While we understand the revenue constraints driving this decision, our testimony today will: 1) underscore why the District's goal of integration should not be abandoned, 2) call for more meaningful stakeholder engagement in this and DHCF's other ongoing system

improvement projects, and 3) re-iterate the imperative for network adequacy and higher payment in the Medicaid provider network. We also ask the Committee to maintain its oversight and hold public hearings for the sake of transparency and community engagement.

The District's Goal of Behavioral Health Integration Has Been Years in the Planning and Should Not be Abandoned.

DHCF has undertaken multiple projects in recent years to expand services in Medicaid and implement models that incentivize better whole-person care. First, DHCF started moving most Medicaid beneficiaries from a fee-for-service model to a managed care model in 2019.[5] With built-in care coordination and value-based purchasing requirements, managed care rewards good patient outcomes instead of high volume,[6] helping the District move toward the "triple aim" of better care, better health outcomes and reduced costs.[7]

In 2020, through the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration Waiver, DHCF began preparing to integrate[8] a "broader continuum of behavioral health treatment" into its managed care contracts.[9] "Carving in" behavioral health services to Medicaid would allow the District to pull in federal matching dollars for the carved-in services, as opposed to only using local dollars through the Department of Behavioral Health (DBH), as well as improve system navigation for patients.[10]

We shared DHCF's goals to expand Medicaid services and better integrate care for the District's low-income residents and children. The World Health Organization defines integrated care as "health services organized and managed so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[11] Research has linked pediatric integration models to improved behavioral health outcomes in children.[12] Integrated behavioral health services also help to reduce stigma for individuals who may not have otherwise sought services in a behavioral health clinic.[13] For children, care integration ensures access to behavioral health services in settings they already are, such as child care centers, K–12 schools, and pediatric primary care practices.[14] We were optimistic that the carve-in would facilitate this access and improve outcomes. However, there have been significant challenges for the provider network in this transition, as well as protracted delays.

In part due to the disruptions of the COVID-19 Public Health Emergency, the integration was delayed from 2022 to October 2023, and again to April 2024. Despite the longer ramp-up, at the January and February 2024 performance oversight hearings for DBH and DHCF respectively, the Committee heard testimony from several providers and advocates expressing pessimism about the system's readiness for – and communication about – the imminent change.[15] The mechanics were still not ready, nor were all the payment rates set.[16] If unable to transition seamlessly from DBH contracts to

their new MCO payors, providers stood to lose revenue, potentially displace their patients, and undermine the intentions of the transformation.[17]

Then, on February 28, less than five weeks before the carve-in date, DHCF officially announced to stakeholders that the MCO carve-in was "paused."[18] At that time, they did not share details, other than generally citing budgetary reasons. Questions about the future timeline went unanswered. At DHCF's budget presentation on April 11, Deputy Mayor Wayne Turnage stated that the FY25 budget maintained behavioral health services in Fee-for-Service and walking back the carve-in created $13.7 million is "savings" for the year.[19] He explained that the carve-in would only move forward if future revenue increased significantly enough.[20]

We understand that this decision came in the middle of a difficult juncture in budget formulation for FY25. However, we are frustrated that the years-long cooperation of providers and advocates has not been honored with clear answers about the future. Community-based organizations (CBOs) were required to 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.[21] Ultimately, we are most disappointed that the systemic barriers keeping our clients and other residents from care will no longer see a remedy. We hoped that the carve-in – though not a panacea – would more effectively align services, expand access, ease navigation, and better support children and their families by integrating all care

through one case management hub. It is not clear how these goals will now be pursued, or how else the District's systems will be reformed to produce better behavioral health outcomes than the status quo.

The indefinite delay of the carve-in will also impact other notable projects across government. As just one example, DBH has publicly committed to create a strategic plan for Children's behavioral health, beginning this year.[22] We have called for such a plan, specifically one that is developed through interagency collaboration, with input from relevant stakeholders, including families, youth, service providers, and education agencies, to outline the long-term goals for children's behavioral health in DC. We are concerned that without clarity on DHCF's short- and long-term plans for a carve-in, it will be very difficult to create this plan. District families who rely on the public behavioral health system for critical services – as well as the Council – deserve more clarity about how integration will be pursued and achieved in the immediate future.

More Meaningful Stakeholder Engagement in DHCF's Ongoing System Improvement Projects is Necessary

DHCF has the responsibility to not only effectively communicate changes to 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 do not believe that DHCF or DBH put sufficient technical assistance in place to support providers through the lead up

to the carve-in – or enough communication about the decision to pause.[23] In fact, as of this hearing date, DHCF's website still heralded April 1 as the effective date for the carve-in.[24]

The issues with communication go beyond the technical assistance or the budget shortfalls for the carve-in, extending to other components of the original (2019) 1115 Waiver.[25] According to an evaluation by American Institute for Research (AIR), the District has met only two of the 11 goals of the original 1115 Waiver.[26] We only saw these evaluation results this month when DHCF released its proposed application for its upcoming 2024 waiver. We are concerned that DHCF has not been transparent enough – with this Committee or the community – about the costs, delays, capacity issues, and success of its system improvement projects. In this light, we were troubled that along with the carve-in pause, future meetings of the Public Forum on Integrated Care – where stakeholders received updates and provided input on the carve-in project – have been cancelled.

Separately, but related, the community engagement processes for the new 1115 Waiver application has been constrained because DHCF has created tight deadlines for input during busy times of year. Specifically, it published a survey to collect stakeholder suggestions right before the November holiday and announced the public comment period on the proposed application for one month in the middle of the District's contentious budget process.

Diverse, inclusive collaborations with community stakeholders, especially families and youth, should be actively sought in all of DHCF's activities, not just to satisfy legal requirements but to lead to better results. In regard to managed care behavioral health integration, a Center of Health Care Strategies report states, "there is no such thing as too much stakeholder outreach, education, and communication."[27] We call on DHCF to more clearly communicate about the future of the entire integration project – from the 2019 1115 Waiver activities to plans for the 2024 application – beginning with resuming monthly meetings of the Public Forum on Integrated Care.

DHCF Must Dedicate More Attention to Building Network Adequacy

A Path Forward highlights "network adequacy" as a key goal to improving the public behavioral health system, as Children's Law Center has testified at several hearings over the last year.[28] 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."[29] The MCOs are also required to comply with network adequacy standards and "availability of services standards,"[30] as well as the Mental Health Parity and Addiction Equity Act of 2008[31] and the District of Columbia Behavioral Health Parity Act of 2018.[32] 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, DC has an insufficient number of behavioral health providers and facilities, especially for perinatal and pediatric populations.[33] 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.[34] Similar needs for increases to the perinatal mental health workforce are reported by the Perinatal Mental Health Task Force, which also recommends improving cultural and linguistical representation in providers, expansion training of perinatal mental health screening.[35] We also need more providers with training in family therapy and specific evidence-based treatments (e.g., parent-child interaction therapy).[36] Networks should include all needed facilities for populations like parents suffering from significant perinatal mental health conditions or children with high behavioral health needs, like inpatient psychiatric units, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers.[37]

Network adequacy is one of the myriad areas we hoped the carve-in could improve, by sharing the imperative with MCOs. If the carve-in is indefinitely delayed, it becomes even more critical for DHCF to intentionally cultivate and enforce network adequacy. Meaningful measures of access should be tied to accountability mechanisms that are regularly and transparently enforced, but we are not aware of any enforcement

measures being levied to date, despite external reviews documenting inadequacies.[38] Going forward, we want to learn more from DHCF about how it plans to improve its provider network. We encourage the Committee on Health to continue to hold our government partners accountable in this area.

The foundation of an adequate network of community-based behavioral health service providers in public programs is to pay adequate rates. There is high demand for services and a limited pool to provide them. It is imperative in this market for the District to sufficiently pay professionals in hospitals, health centers, primary care, and private practice offices to serve Medicaid beneficiaries. Mayor Bowser's own Healthcare Workforce Task Force recommended in 2023 to "address current supply and demand challenges in the healthcare workforce" by, among other strategies, increasing provider compensation.[39]

Through a combination of a carve-in and last year's rate study, DHCF could have leveraged federal Medicaid dollars to enhance provider payments, but this is another area where progress has stalled. As of this month, reimbursement rates for nearly two-thirds of DBH provider network services (Community Support Services[40]) are still lagging 17.3% behind inflation.[41] Review of these rates is not scheduled to begin any earlier than July 2024, and the FY25 budget does not include changes to Community Support Services payment rates at all.[42] If the District were to bridge this inflationary gap, it would require $4.9 million additional dollars.[43]

In this budget environment, there may be no easy solution to fix provider rates. However, we know it is ultimately less expensive to connect patients to community-based care before their needs become costly crises. By paying providers competitively to deliver upstream therapies and support, DHCF can reduce the need for patients to endure – or the system to pay for – hospitalization or other catastrophic outcomes of under-treated behavioral health needs. Therefore, we ask DHCF – and this Committee – to stay devoted to the goal of an integrated, efficient, and adequately staffed behavioral healthcare system.

If the District cannot dedicate all the local dollars needed in this budget, it must sustain its investments of time and creativity to the task. Success can only be achieved by working with the providers, consumers and advocates, honoring the resources that have already been dedicated to integration projects, and adequately sustaining the provider network with technical and financial resources. We believe it would be helpful for the Committee on Health to facilitate public hearings related to system integration and network adequacy, to ensure these investments are made.

Conclusion

We hope to see the District continue its ambitious – and desperately needed – projects to improve the public behavioral health care system. Unfortunately, we have significant concerns that this work is being abandoned. We are disappointed about the indefinite pause on the "carve-in" of behavioral health into managed care contracts, and

the communication and transparency from the agency about its plans. We call on DHCF to be more forthcoming and publicly, transparently respond to this important question: What will the fate be of our community's work to integrate behavioral health care as a part of whole-person health? We appreciate the Committee's oversight to ensure this is answered.

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

[1] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org. 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. A Path Forward is a blueprint for creating a successful public behavioral health system, one that supports children and families and, in doing so, strengthens our entire community. The recommendations in this report build on the commitment shown by DC government leaders and is informed by the expertise and experiences of youth, parents, experts, and best practices from across the country.

[2] Megan Conway, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Megan-Conway-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf;
William Cox, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Wil-Cox-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf;
Rachel Ungar, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/RU-Draft-Testimony-EM-updated_-narrative_final.pdf.

[3] American Academy of Pediatrics, *Mental and Behavioral Health Needs of Children in Foster Care,* (2021), *available at*: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/*; see also* Children's Law Center, Testimony before DC Council Committee on Health and Committee on Facilities and Family Services, (December 6, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-behavioral-health-for-children-and-youth-in-foster-care/.

[4] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.

[5] DHCF, DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts, (September 11, 2019), available at: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[6] *Id.*

[7] 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.

[8] 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.

[9] DC Department of Health Care Finance, *1115 Demonstration Waiver, available at:* https://dhcf.dc.gov/1115-waiver-initiative.

[10] KFF State Health Facts Data, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier: FY 2025, 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.

[11] World Health Organization, I*ntegrated Health Services: What and Why?* (2008), *available at:* https://www.who.int/healthsystems/service_delivery_techbrief1.pdf.

[12] Burkhart K, Asogwa K, Muzaffar N, et al, *Pediatric Integrated Care Models: A Systematic Review*, Clin Pediatr (Phila). 2020;59(2):148-153. doi:10.1177/0009922819890004.

[13] Miller-Matero LR, Khan S, Thiem R, et al, *Integrated Primary Care: Patient Perceptions and The Role of Mental Health Stigma*, Prim Health Care Res Dev. June 19, 2018:1-4. doi:10.1017/S1463423618000403.

[14] SAMHSA, *The Integration of Behavioral Health into Pediatric Primary Care Settings* (2017), *available at:* https://www.nashp.org/wp-content/uploads/2019/09/The-Integration-of-Behavioral-Health-into-Pediatric-Primary-Care-Settings.pdf.

[15] FY 2023 Performance Oversight Hearing on the Department of Behavioral Health, *District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://dc.granicus.com/MediaPlayer.php?view_id=9&clip_id=8636

[16] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

[17] *Id.*

[18] DHCF, Behavioral Health Integration, *available at:* https://dhcf.dc.gov/page/behavioral-health-integration

[19] Notes from Department of Health Care Finance Budget Briefing on Thursday, April 11, 2024, on file with Children's Law Center.

[20] *Id.*

[21] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

[22] DBH, FY 2023 Performance Oversight Responses, responses to Q66, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[23] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (January 29, 2024), *available at:* https://childrenslawcenter.org/resources/2023-24-oversight-testimony-department-of-behavioral-health/.

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

[25] DC Department of Health Care Finance, District of Columbia Section 1115 Medicaid Demonstration Renewal Request: Draft 1115 Renewal Application for Public Comment (April 1, 2024), page 7-8, *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DRAFT%201115%20Renewal%20Application_For%20public%20comment_V2.pdf.

[26] *Id.*

[27] Soper MH, *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators*, Cent Health Care Strateg. April 2016:13.
[28] Sharra Greer, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Sharra-Greer_CLC_Performance-Oversight_DBH_General_February-1-2023_final-1.pdf; Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (February 16, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/02/Amber-Rieke_DHCF-Performance-Oversight_FINAL-2.16-and-2.17.pdf
Leah Castelaz, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (April 3, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L-Castelaz_Testimony-before-DC-Council-Committee-on-Health_DHCF_4.5.23_FINAL.pdf;
Amber Rieke, *Testimony before the District of Columbia Council Committees on Health, Judiciary and Public Safety, and Recreation, Libraries and Youth Affairs*, (December 13, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Amber-Rieke-CLC_Public-Safety-BH-Roundtable-Testimony_Dec-13-2023.pdf.
[29] "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.
[30] "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).
[31] 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.
[32] "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. https://code.dccouncil.gov/us/dc/council/laws/22-242.
[33] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.
[34] *Id.*
[35] Department of Health Care Finance, Perinatal Mental Health Task Force Report, (January 2024), p. 27-29, *available at*:

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Perinatal%20Mental%20Health%20Task%20Force%20Report%20and%20Recommendations.pdf.

[36] Tami Weerasingha-Cote, Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Childrens-Law-Center-Testimony-for-Dec-6-2023-Hearing-on-B25-0500-and-Foster-Youth-Behavioral-Health_FINAL.pdf.

[37] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: http://www.pathforwarddc.org.

[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] *Report and Recommendations of the Mayor's Healthcare Workforce Task Force* (September 2023), *available at:* https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf.

[40] DHCF's recent rate study has provided justification to increase rates for over 20 behavioral health billing codes. *See: Angelique Martin, DHCF Performance Oversight response to question from CM Henderson, February 8, 2024.* Those rates do not include H0036, the billing code used for Community Support Services. *See: DHCF Providers and Associations Presentation, Slide 31 "88% of FFS Behavioral Health Expenditures were for MHRS and 63% were for Community Support Services in FY23," (April 16, 2024), on file with Children's Law Center.*

[41] CMS Medicare Economic Index, 2023Q2-2016Q2, adjusted by 6.2% for cumulative intervening adjustments.

[42] DCHF Medicaid Care Advisory Committee Budget Presentation, Slide 22, "Behavioral Health Cost Drivers: FY23 and FY24 Implementation of Comprehensive BH Rate Study Recommendations," (April 24, 2024), *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/April%202024%20MCAC%20Presentation.pdf.

[43] DBH is budgeted to spend $44.638M for behavioral health rehab services (Medicaid local match) in FY 25. Given 63% of $44.6M needs to be increased by 17.3%, $4.9M is needed to increase Community Support Services payment rates to meet inflation-adjusted expected costs. *See:* RM0-4 expenditure code H04317, Budget Vol. 4, p. E-25.