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Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Chris Gamble. I am a Behavioral Health Policy Analyst at Children's Law Center, a Ward 5 resident, and a Licensed Professional Counselor with experience providing behavioral health care to children, teens, and families in the District's public behavioral health system. I am testifying today on behalf of Children's Law Center. Our more than 100 staff work with DC children and families, community partners and pro bono attorneys toward a future where every child can 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.

Thank you for the opportunity today to testify about the performance of the Department of Health Care Finance (DHCF) over the past year. Children's Law Center's clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Almost all our clients are Medicaid beneficiaries, so access to a public healthcare system that meets all their diverse behavioral and physical health needs is crucial. Relevant research has focused on the health outcomes of children with simultaneous physical and mental conditions, finding that these conditions potentially influence each other in ways that worsen overall functioning. Mitigating the impacts of the complex relationship between

physical and behavioral health can be done through better coordination among typically siloed care systems.[1]

It is DHCF's stated strategic priority to build a health system that provides whole person care.[2] Whole person care encompasses practices that address biological, behavioral, social, and environmental aspects of health, through prevention and restoring health rather than focusing on only treating a specific disease.[3] A bright spot in the agency's progress toward whole person care is their work around the 1115 demonstration waiver extension, particularly regarding the community engagement activities involved. The 1115 demonstration waiver allows for Medicaid funds to be spent on expanding behavioral health services, justice-involved re-entry services, and health-related social needs.[4] Through the Health System Re-Design (HSR) Subcommittee, DHCF has done a great job engaging the stakeholder community around implementing the 1115 demonstration waiver, offering a space for direct input and opportunity to speak directly to DHCF representatives.[5]

When it comes to developing a fully integrated system of coordinated behavioral and physical health care, however, DHCF has faced challenges in execution and communicating with the public about strategies to overcome these challenges. The importance of an integrated system in achieving the goal of whole person care will be addressed in our testimony today.

Integrating behavioral health services into the District of Columbia Healthy Families Program's (DCHFP) Managed Care Organization (MCO) plans[6], referred to as a "carve-in" process, has been years in the making but has still not happened after being paused for the second time in February 2024.[7] By including existing behavioral health services in the DCHFP, the approximately 220,000 people enrolled in those MCO plans are intended to gain the benefit of one organization handling care management responsibilities, including the payment of services, instead of relying on DHCF, DBH, and the MCOs to efficiently collaborate. The reorganization brought about by the carve-in is intended to contribute to improved health outcomes through better oversight and care coordination. The standards followed by MCOs also contribute to broader goals within our behavioral health system, like ensuring network adequacy and availability of the full range of types of care people need.[8]

DHCF has identified financial constraints as the main reason for pausing the carve-in[9], but there are not clear immediate solutions to this financial roadblock. Even with this very real cost issue, we hope that DHCF uses the carve-in pause not as a waiting period, but as a time to make improvements in our health care system such as data sharing and quality control that can be achieved and ultimately prepare stakeholders for the eventual carve-in.

Pausing The DCHFP Carve-In Has Left Medicaid Enrollees Without A System Of Organized Oversight, Quality Assurance, And Care Coordination

Pausing the DCHFP carve-in is keeping people from engaging with a more cohesive health care system that can better meet their needs and be held accountable to shared care standards. It has already been acknowledged by DHCF that our current system "sometimes result[s] in data gaps, confusion about referrals, and siloing of beneficiaries' physical and behavioral healthcare" due to DHCF, DBH, MCOs, schools, the child welfare system, and the justice system not having shared processes when it comes to providing care.[10] Currently, the behavioral health care a person receives is not "visible" to the MCO they're enrolled in. For a child in foster care, the behavioral and physical health impacts of neglect or abuse, home removal, and placement changes can be better addressed with coordinated treatment. The carve-in would give providers shared standards of care coordination to ensure children receive the right care at the right time. The problems inherent to our siloed health care system have been identified by DHCF, with the carve-in meticulously planned for as part of the solution, but now those enrolled in the DCHFP managed care plans remain waiting for the improved practices and health outcomes that come along with integrating behavioral health services.

Quality care coordination can reduce duplicative tests, medication errors, and use of emergency care, all of which add to overall healthcare costs[11], but if MCOs are unaware of the behavioral health services someone is getting, as they are now, they

can't assist their enrollees and providers in making informed care coordination decisions. This potential impact on the care experience and treatment progress of patients' physical and behavioral health conditions is what the carve-in can mitigate. Even with integrated care settings in DC, where people can get physical and behavioral health care in the same building, the lack of an integrated payment system can unnecessarily complicate the process for MCOs to know what care their enrollees are receiving and assist in managing their care.

Additionally, since behavioral health care providers are not yet carved into the DCHFP MCO plans, the measurement and improvement standards used by the MCOs are not applicable. We want DBH providers to be moved into using the MCO standards to improve accountability. Clinical practice guidelines, specific quality assurance indicators, and health information system requirements are used by MCOs to measure their own effectiveness, in part by holding the providers in their network accountable for the care they provide.[12] Leaving behavioral health care providers out of these processes of regular assessment and targeted improvement maintains a system without shared standards, which impacts the quality of care people receive.

The carve-in is also supposed to serve as a pathway away from fee-for-service payment to value-based payment (VBP) models. With VBP, care is incentivized by quality of outcomes, not units of time spent with clients. It is a model that benefits providers and enrollees by putting the focus of healthcare on outcomes. Specifically, it

encourages providers to utilize preventative measures, adhere to evidence-based practices, and coordinate with all members of a patient's care team.[13] This change in priorities also has the potential to alleviate health care professional burnout and thus turnover by not pushing volume of patients and time spent with them as metrics of care.[14] Almost a tenth of our GAL clients experienced care access issues due to staff turnover in the last year[15], so delaying shifts to VBP may impact much needed availability of providers. It is a stated objective for MCOs to increase the percentage of expenditures under the VBP structure annually[16], so the carve-in is a mechanism needed to achieve the benefits of VBP.

DHCF Paused The DCHFP Carve-In Due To Cost Concerns, But It Is Important That This Transition Continue

Shortly after the carve-in pause was announced in February 2024, the decision was touted by Deputy Mayor Turnage as "saving" $13.7 million.[17] Yet, DHCF has acknowledged that "healthcare costs for individuals with FFS coverage are typically four-to-five times greater than persons in managed care, as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays".[18] As a result, the combined benefits of healthcare cost savings and improved organization, quality assurance, and care coordination made achievable by the carve-in in the long run would seem to outweigh the purported "cost savings" resulting from delaying the carve-in.

Transparent updates on projected cost and timeline for the DCHFP carve-in are needed

Stakeholder spaces that were used to help prepare for the carve-in, like the Integrated Care Forum and DBH provider meetings, established with the goal of training, sharing information, and getting feedback from participants, met less frequently last year. [19] The DCHFP carve-in pause was announced on February 21, 2024 and discussed further in the Integrated Care Forum meeting held on February 28, 2024. In this meeting, there were indications that behavioral health transformation efforts would still continue through infrastructure and quality improvements and supporting providers. [20] Success in raising rates for Community-Based Intervention (CBI) and Multi-Systemic Therapy (MST) were touted as positive steps forward.[21] Although it is still stated online that these Integrated Care Forum meetings would continue in May 2024, the next meeting did not take place until October 2, 2024 [22], leaving the public in the dark for months about the continuing work to transform the behavioral health system.[23] DHCF should re-engage with public stakeholders on a consistent basis around care integration, and we ask the Committee to inquire how the agency plans to do so.

The District Dual Choice Program carve-in offers learning opportunities for the DCHFP carve-in

In the October Integrated Care Forum meeting, there was planning for a smaller, targeted carve-in process .[24] The District Dual Choice Program, contracted with UnitedHealthcare (UHC), integrates dually eligible beneficiaries covered by Medicare and Medicaid, who are age 21 and up, into one plan.[25] Out of 13,000 Dual Choice

enrollees, about 1600 use the currently carved-out behavioral health services on a monthly basis.[26] Given this much smaller number of people being integrated into only one plan under UHC, it's understandable that this carve-in process is less cumbersome than the DCHFP carve-in. Still, DHCF has again identified fiscal impact as a potential barrier to whether the Dual Choice carve-in will happen on the planned date of January 1, 2026, placing those enrollees in a similar position of waiting for improved care coordination and health outcomes.[27] We ask the Committee to seek clarity from DHCF on if they are on track to implement the Dual Choice carve-in on the planned date. If not, we would like DHCF to provide public transparency on why and what their plans are to solve potential problems with the process.

If DCHF proceeds with the Dual Choice carve-in as planned, we see opportunity for this process to inform decisions around the DCHFP carve-in. In their pre-hearing responses, DHCF identified plan readiness and provider readiness practices that will be used for the Dual Choice carve-in, such as Behavioral Health Readiness Reviews and training, support, and monitoring activities to ensure smooth transition.[28] Lessons learned from successes and challenges with these processes can be applied to the DCHFP carve-in.

There Are Reasonable Improvements DHCF Can Make To Our Current Health System As Steps Toward Resuming The DCHFP Carve-In

Working with providers to make changes to data sharing, quality control, and reimbursement methodology should be done to both improve quality of care in our

existing system, as well as to prepare for an eventual DCHFP carve-in. DHCF can work with DBH to help prepare for certain challenges of a fully integrated system. We have highlighted in the past the challenges providers anticipate in making the transition to the MCOs, such as contracting with the new insurance companies, and adjusting to new billing procedures, timelines, and methodologies.[29] This time of the carve-in pause should be used constructively to work through these issues.

We recommend the following improvements to prepare our current health system for the carve-in:

- **Increase and strengthen data sharing for improved care coordination through CRISP DC.** In 2024, DHCF supported over 85 mental health, substance use disorder, and waiver providers in connecting to CRISP DC, a Health Information Exchange (HIE) that makes select health information accessible to connected providers.[30] We recommend that DHCF continue to add providers to CRISP DC and offer support around utilizing the system to build coordination capacity in our siloed system. By allowing more providers across sectors to see a patient's relevant health information, better care decisions can be made, leading to better outcomes.
- **Enable high-level data sharing between DBH and MCOs.** We ask that the Committee work with DHCF to implement data sharing between DBH and the MCOs, such as aggregate outcome data that DBH already has. While not the

individualized care coordination expected under the carve-in, it could at least allow the MCOs to have a better picture of the behavioral health care available to their beneficiaries.

- **Update reimbursement structures for more behavioral health services.** DHCF has shown some success in altering reimbursement structures in ways that improve service provision and care outcomes. We ask them to continue this work. The changing of Assertive Community Treatment (ACT) reimbursement from fee-for-service to a monthly rate is an example of what can be done.[31] Not only were changes to the reimbursement structure made with the interest of improving ACT fidelity and decreasing administrative burden, but DHCF and DBH were also responsive in making further adjustments when providers indicated that the initial formulation of the monthly rate structure was not easy to comply with.[32] Children's services, like CBI, could benefit from similar changes, but the key would be close collaboration between DHCF, DBH, and the provider network to make sure changes are sensible, easy to follow, and improve care. As with the previous points made about value-based payment, movement away from reimbursement structures that value quantity over quality makes providing clinical services less burdensome for providers and allows them to focus on delivering better care for consumers.

- **Develop a new timeline for the DCHFP carve-in.** In the December 2024 Medical Care Advisory Committee (MCAC), 2025 milestones for DHCF were highlighted, notably missing anything regarding the DCHFP carve-in.[33] A timeline, even if just in terms of how long the DCHFP carve-in would take once funding is secured, would let stakeholders know that the goal of whole-person care has momentum. We ask that the Committee inquire about the agency's plan to develop a new timeline.

Conclusion

A more cohesive health care system is worth working towards by finding ways through obstacles and not limiting what changes can be made in the present. The DCHFP carve-in should not become a distant goal, because the need for better health outcomes exists here and now. The children and families we serve along with all Medicaid beneficiaries in DC deserve it. Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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[4] Department of Behavioral Health, *1115 Demonstration Waiver, available at:* https://dbh.dc.gov/node/1394436.

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[23] *Id.* The next Integrated Care Forum meeting, scheduled for January 29, 2025 has been postponed to March 26, 2025.

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