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

Testimony Before the District of Columbia Council
Committee on Health
Thursday, June 5, 2025

Public Hearing:
Budget Oversight Hearing
Department of Health Care Finance

Chris Gamble
Behavioral Health Policy Analyst
Children's Law Center

Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Chris Gamble, and I am a Behavioral Health Policy Analyst at Children's Law Center. Children's Law Center's 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 to testify today about the FY26 budget for the Department of Health Care Finance (DHCF). First, we would like to thank DHCF for their steadfast partnership and engagement. In particular, DHCF has been a leader in moving forward maternal health priorities in the District including being selected for the Transforming Maternal Health (TMaH) Model through the Centers for Medicare and Medicaid Services (CMS). We are excited to partner with DHCF on moving this work forward including improving the implementation of Medicaid reimbursement for doula services, perinatal community health workers, and home visiting services. We are grateful to see DHCF maintain funding for home visiting services in their FY2026 budget and continue to encourage the agency to implement the Home Visiting Medicaid Reimbursement Act of 2023. While the agency is not required through TMaH to implement perinatal community health workers or home visiting – we strongly

encourage the agency to consider these optional services. Moreover, we encourage the agency to ensure sufficient infrastructure including Medicaid reimbursement is available for these optional services to make the shift under TMaH seamless. We appreciate DHCF's continued commitment to improving maternal health in the District and acknowledge their leadership.

We also appreciate DHCF continuing to move forward the 1115 Waiver and their strong partnership with the community to inform the Waiver and support eventual implementation. We look forward to continuing to work with the agency in both the maternal health and the 1115 Waiver spaces.

However, we must also acknowledge the difficult budget reality that DHCF is facing in the coming months and years. Federal cuts to Medicaid are already expected to make maintaining coverage more difficult with the inclusion of work requirements and more frequent renewal periods.[1] Adding to these impending federal changes, we knew coming into this budget season that DHCF would have to make $182 million in cuts to account for what the agency identifies as increased provider rates and enrollment.[2] When cuts are on the table, a strategy of minimizing harm becomes the rational approach. Although policies like Early and Periodic Screening, Diagnostic and Treatment (EPSDT) require coverage of specific health services for children, these policies are insufficient to protect our vulnerable client populations from cuts made to the Medicaid program in the proposed budget. The choice to freeze provider payment

rates and drop parents and caretakers from Medicaid eligibility will have direct impacts on the services children receive and the well-being of their families.

In my testimony, I will discuss (1) the harm that will be done to children as a result of cutting Medicaid eligibility for parents and caretakers; (2) how freezing provider rates will impact service availability for children; and (3) how moving fee-for-service enrollees to MCOs will allow for cost savings and improvements to the quality and availability of care.

Proposed Changes To Medicaid Eligibility Determinations Will Directly Harm Children

The FY26 budget proposes cutting Medicaid for those who are either single, childless adults or parents and caretakers with incomes greater than 134% of the federal poverty line (FPL), a total of 25,575 people.[3] Out of that total, 8,300 fall in the parent and caretaker category which includes parents, siblings, grandparents, stepparents, stepsiblings, aunts and uncles, nieces and nephews, and first cousins who care for dependent children.[4]

Those cut from the Medicaid rolls due to the proposed new eligibility determinations will have the option to join a Basic Health Program (BHP) or a Qualified Health Plan (QHP) through the HBX.[5] However, the BHP must be designed in a way that keeps costs low so that obtaining and maintaining coverage is not difficult for low-income residents. The budget's fiscal impact statement (FIS) says that "insurance offered through the HBX Basic Health Program will be available to eligible individuals at little

or no cost since federal subsidies will cover the monthly insurance premiums of enrolled individuals."[6] A major concern is the reconciliation bill currently working its way through Congress, which eliminates the premium tax credit that the FIS refers to.[7] Even if premium tax credits are not eliminated in the reconciliation bill, people will still need to have the cash on hand to pay for health insurance before getting reimbursed through the tax credit.

The most direct effect the proposed cuts will have on children is those whose parent or caretaker loses Medicaid coverage and has to navigate acquiring a plan through the HBX. A caretaker becoming sick, disabled, or dying due to inadequate health insurance has an enormous impact on the children they care for. Research has shown that insured children with uninsured parents are at higher risk of poor overall health and more likely to have asthma, ADHD, developmental delays, learning disabilities, and mental disabilities.[8] The family's financial stability is also damaged when a parent or caretaker is uninsured and has to manage medical expenses on their own.[9] It is encouraging to hear that the HBX is working to design the BHP to have no premiums and no or more limited cost sharing like co-pays and deductibles[10], but we ask the Committee to ensure HBX commits to this design regardless of federal policy changes.

Freezing Provider Rates Will Limit The Services Available to Children

DHCF states that freezing the behavioral health inflation adjustment, which includes Mental Health Rehabilitative Services (MHRS), Free Standing Mental Health Clinics (FSMHC), and Behavioral Health Waiver Services totals $224,387 in reduced cost.[11] While a seemingly small impact, if the proposed freeze to provider payment rates continues, service-providing organizations will be forced to make finance-based decisions to limit services. Further, individual providers will leave or choose not to join the Medicaid network in such a way that children's services effectively do get cut. The continuum of care in DC needs to expand, providing children with the services they need when they need them, rather than being limited by the changes made in the proposed budget.[12]

Finding qualified behavioral health professionals willing to work in the public system will also become more difficult if payment rates do not grow with inflation. Payment rates play a role in determining how many weekly face-to-face clinical hours employees have to perform and may even affect what salaries organizations can afford to pay. Many children, including our clients, already struggle with receiving consistent behavioral health services due to staff turnover.[13] The therapeutic relationship that is central to improved behavioral health outcomes can't be formed when staff continuously rotate through employers.[14] Creating another barrier to recruitment and retention by freezing rates keeps children from making progress in treatment. We

therefore ask the Committee to support providers by not freezing payment rates and allowing them, at minimum, to grow with inflation.

Budget Constraints Should Not Hinder Opportunities To Build Toward Long-Term Improvements In Medicaid

Since 2019, DHCF and DBH have been working toward a transformation of the behavioral health system.[15] This three-phase process is supposed to create a whole-person, population-based, integrated system,[16] but has yet to achieve that goal. While the first phase has continued to successfully move forward through the 1115 Waiver,[17] other important parts of the transformation process have stalled. The carve-in of behavioral health services into managed care has been paused since April 2024 with no clear timeline for when the effort will continue.[18]

A separate and broader goal was also set by DHCF in 2019 to transition all Medicaid enrollees from Fee-For-Service (FFS) coverage to managed care.[19] It is a goal we have advocated for particularly in the interest of the 10% of child Medicaid enrollees who were in FFS at that time.[20] DHCF has yet to complete this transition, but it holds the potential for major program cost savings.

Deputy Mayor Wayne Turnage noted in this year's performance oversight that in FY23, the FFS population made up only 20 percent of Medicaid enrollees but accounted for 50 percent of the program cost. Specifically, DHCF spent $38,431 per FFS beneficiary compared to $8,438 per Managed Care Organization (MCO) beneficiary.[21] As of April 2025, there were 34,201 FFS enrollees.[22] Moving these enrollees into MCOs would bring

about a cost saving of over $1 billion.[23] Not all categories of FFS enrollees may be able to be shifted to managed care, but there are still significant potential savings in continuing the transition efforts. Improving procedures for oversight of MCOs is important and should be part of the process of transitioning our health system into one with quality control measures, more care coordination, lower hospitalization rates, and improved health outcomes.[24]

While the transition from FFS to MCOs is a more extensive process than the immediate savings DHCF is seeking in the FY26 budget, it goes to show that possibilities exist beyond the present constraints on our budget. We need to be able to acknowledge present challenges while maintaining a forward-looking vision to create the health care system we've been working toward for years. We urge this Committee to ask DHCF to commit to a timeline for when a transition of enrollees from FFS to MCOs could be completed.

Conclusion

In a time of economic difficulty, the DC Council can choose to take the long view; it can choose to protect important investments in our community's future health and economic development. Health care is a foundational need across the lifespan. Individuals, families, and communities are affected when access to health care is limited. Despite difficult budget realities, the District truly cannot afford to defer

maintenance on our health care system. Thank you for the opportunity to testify and we welcome any questions the Committee may have.

---

[1] *Health Provisions in the 2025 Federal Budget Reconciliation Bill,* (May 2025), *available at*: https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/.
[2] *Performance Oversight of DMHHS & Department of Health Care Finance, Gov Only*, YouTube, (February 2025), *available at*: *https*://www.youtube.com/watch?v=nAWE0V7phXo.
[3] DHCF FY26 Budget Testimony, *available at*: https://lims.dccouncil.gov/Hearings/hearings/832.
[4] Parents and Caretaker Relatives, *available at:* https://dhcf.dc.gov/node/892382.
[5] Fiscal Impact Statement- FY26 Budget Support Act of 2025, *available at*: https://static1.squarespace.com/static/5bbd09f3d74562c7f0e4bb10/t/6835dee493ad9c1c05cb325c/1748360932599/FIS+Fiscal+Year+2026+Budget+Support+Act+of+2025+as+introduced+May+27+2025.pdf.
[6] *Id*.
[7] Ana Teresa Sola, *House Republican tax bill skipped ACA credits — marketplace health insurance will get pricier without them,* (May 23, 2025), *available at*: https://www.cnbc.com/2025/05/23/big-beautiful-tax-bill-skipped-aca-credits.html.

[8] Ilhom Akobirshoev, et al., *Does Parental Health Mediate the Relationship Between Parental Uninsurance and Insured Children's Health Outcomes? Evidence from a U.S. National Survey*, Health and Social Work, (2017), *available at*: https://www.researchgate.net/profile/Ilhom-Akobirshoev/publication/315305654_Does_Parental_Health_Mediate_the_Relationship_between_Parental_Uninsurance_and_Insured_Children%27s_Health_Outcomes_Evidence_from_a_US_National_Survey/links/5b3abbaeaca2720785051913/Does-Parental-Health-Mediate-the-Relationship-between-Parental-Uninsurance-and-Insured-Childrens-Health-Outcomes-Evidence-from-a-US-National-Survey.pdf.

[9] Jennifer M. Haley, et al., *More Than 4 Million Parents of Young Children Were Uninsured in 2017-18*, Urban Institute, (October 2020), *available at*: https://www.urban.org/sites/default/files/publication/102985/more-than-4-million-parents-of-young-children-were-uninsured-in-2017-18.pdf
[10] HBX FY26 Budget Testimony, *available at*: https://lims.dccouncil.gov/Hearings/hearings/832.
[11] DHCF FY26 Budget Testimony, *available at*: https://lims.dccouncil.gov/Hearings/hearings/832.
[12] *A Path Forward: Transforming the Public Behavioral Health System for Children and their Families in the District*, (December 2021), available at: https://childrenslawcenter.org/wpcontent/uploads/2021/12/BH.System.Transformation.2023.Update.Round4_.pdf
[13] Internal Children's Law Center Data Collection, "GAL Deep Dive," January 2024 through December 2024.
[14] Rachael Ryan, et al., *Therapeutic relationships in child and adolescent mental health services: A Delphi study with young people, carers and clinicians,* International Journal of Mental Health Nursing, (2021), *available at*: https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12857.
[15] Behavioral Health Integration, *available at*: https://dhcf.dc.gov/page/behavioral-health-integration.
[16] *Id*.
[17] Section 1115 Demonstration, *available at*: https://dbh.dc.gov/node/1394436.

[18] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 12, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/02/DHCF-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.12.25.pdf.

[19] Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program, Children's Law Center, (2020), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/07/AddressingChildBHNeedsThroughDCMedicaidChanges_Feb2020-FINAL.pdf.

[20] *Id*.

[21]*Performance Oversight of DMHHS & Department of Health Care Finance, Gov Only,* YouTube, (February 2025), *available at: https*://www.youtube.com/watch?v=nAWE0V7phXo.

[22]*District of Columbia Department of Health Care Finance Monthly Enrollment Report - February 2025, available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/MCAC%20Enrollment%20Report%20-%20February%202025.pdf.

[23] This number is derived using FY23 costs and FY25 enrollment. $38,431-$8,438= $30,007. $30,007 x 34,201= $1,026,269,407.

[24] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Committee on Health, (February 12, 2025), *available at:* https://childrenslawcenter.org/wp-content/uploads/2025/02/DHCF-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.12.25.pdf.