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Testimony Before the District of Columbia Council
Committee on Health
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Public Hearing:
Public Oversight Roundtable
Managed Care Organizations (MCOs) in the District's Medicaid Program

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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 (CLC). 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 to testify today about the Managed Care Organizations (MCOs) in the District's Medicaid program. As of June 2025, there are 240,000 District residents who are enrolled in an MCO: Wellpoint DC, Amerihealth Caritas DC, MedStar Family Choice DC, Health Services for Children with Special Needs, or United Healthcare (Dual Choice program).[1] The District spent nearly 2 billion dollars in 2022 on services administered by MCOs.[2] This level of investment requires reliable accountability processes to ensure high performance. It is the Department of Health Care Finance's (DHCF) stated strategic priority to build a health system that provides whole person care.[3] Our MCOs must be held to high standards that are enforced by DHCF to continue making progress toward an integrated health system at both the plan and provider level.

Managed care plans can implement creative program designs to meet beneficiary needs. The collaboration between Amerihealth Caritas DC and CLC's Healthy Together

medical-legal partnership shows the type of innovation possible through managed care. Amerihealth and CLC created the nation's first pay-for-performance contract between a legal services organization and an MCO,[4] and the success of this partnership is tangible. The health improvements achieved through CLC's legal interventions saved $14 million in healthcare spending over three years.[5] We value this partnership and want to see more of this kind of innovation applied throughout the city.

In this testimony, I will address the need to assess communication between Social Security, DHCF, and HSCSN to protect children's healthcare coverage; needed improvements in case management and care coordination; opportunities for improving how access to behavioral health services is measured, and why the behavioral health carve-in remains a crucial priority.

Communication Gaps Between Social Security And HSCSN Create Challenges With Maintaining Coverage

For some of the families supported by CLC's Healthy Together program, HSCSN is the best fit insurance plan to meet their children's physical and behavioral health needs. A child can qualify for HSCSN coverage by either receiving Supplemental Security Income (SSI) or having an SSI-related disability.[6] For some of our clients, there have been lags between approval for SSI and the information being viewable to HSCSN, leading to a delay in accessing care. Parents have reported receiving a phone call confirming SSI approval but are then told by HSCSN that this information is not in the

system and they have to wait for an approval letter to arrive from Social Security, which can take months.

On the other hand, when a parent's income changes and puts them above the threshold for SSI, our clients are dropped from HSCSN coverage swiftly. So, communication between systems happens efficiently when cutting children's access to healthcare, but not the other way around. Even more worrisome is that some of these are improper losses of coverage because even though a child no longer receives SSI, if they have a qualifying disability, HSCSN coverage should be maintained. We have clients who lost coverage in this manner and instead of being shifted to another MCO, were dropped from Medicaid completely, left with no insurance at all.

This was the experience of a Healthy Together client whose mother's income increased over the SSI eligibility threshold. The child still had a qualifying disability, but lost access not only to HSCSN but Medicaid altogether. The child had an urgent need for medication that the mother could not afford out of pocket. It took two months for coverage to be restored and the child to continue receiving necessary care.

To be clear, this is a systems issue that does not fall on any one entity. We ask the Committee to inquire about the system integration between Social Security, HSCSN, and DHCF. Information including income and diagnosed disabilities should be up to date and easily accessible between Social Security and HSCSN so children can get access to care quickly and do not improperly lose access. If a child legitimately no

longer qualifies for HSCSN, they should be automatically enrolled in another plan to prevent gaps in coverage.

In light of the issues described, upcoming changes to DC's Medicaid and the Alliance programs raise concerns about how well MCOs will be able to field questions and respond to confusion about eligibility. We are pleased that DHCF is working with MCOs to assist with this preparation, but there may be a need to assess all systems to ensure enrollment information is accessible at all necessary points of communication.

Case Management And Care Coordination Services Need Clarity And Consistency In How They Are Delivered

In managed care, care coordination and case management play an important role to ensure patients receive integrated, patient-centered care. The two roles differ in scope and focus, as exemplified in the DC MCO contract which provides distinct definitions for them. Care Coordination is defined as "services that ensure all Medicaid, Alliance and ICP Enrollees gain access to necessary medical, behavioral, social and other health-related services (including education related health services) as described in section C.5.31."[7] While case management is defined as "comprehensive services furnished to assist Enrollees, eligible under the State Plan with access to needed medical, social, educational and other services including all of the following in accordance with (42 C.F.R. § 440.169(d))."[8]

However, in our experience, it appears that each of DC's MCOs has its own approach to providing both case management and care coordination. Within these

approaches, definitions and practices appear to overlap or be used interchangeably by the MCOs. It is important that the District aligns definitions for care coordination and case management to ensure beneficiaries are receiving the appropriate resources and support that meet their needs. As currently practiced, case management and care coordination are not consistently meeting families' needs.

Our clients' experiences with HSCSN's case management demonstrate both the successes and opportunities to raise the standards of the service. HSCSN sets itself apart from DC's other MCOs by automatically assigning a care manager to work with a family. Care management responsibilities range from making appointments and arranging transportation to helping parents understand their child's condition and how to manage it. According to their policies, care managers are supposed to call the parent or caregiver within five days of being enrolled,[9] but this does not happen in that timeframe for some of our clients. Some parents have had to reach out themselves to find out who their care manager is.

Once connected with an HSCSN care manager, we have seen variation in the service provided. In one instance, a client's care manager attended progress meetings when the child was receiving inpatient care, helping to set up post-discharge services which took a lot of the burden off the parent. This is the kind of support that helps parents manage their own stress that can accumulate when navigating the healthcare system for a child with complex needs.

When care management falls short, the burden of system navigation falls back on parents or other supporters in their lives. In one example, we had a parent who was given therapy referrals for their child that simply contained a list of names. A Family Outreach Worker with CLC's Healthy Together team ended up having to locate the phone numbers and addresses of each therapist herself. The Family Outreach Worker has had to fill in gaps in care management like this on multiple occasions.

Given that all of DC's MCOs were deemed by Qlarant's independent review to have met standards for coordination and continuity of care,[10] the Committee must question what meaningful standards can be set to capture the experiences families are having with case management. The Committee should also ask about the MCOs' internal policies in regard to reviewing and responding to the performance of case managers.

Care Coordination Provided By Health Care Service Providers Needs Investment and MCO Collaboration

In addition to MCOs, health care service providers at times also provide care coordination to their patients. As a result, care coordination is currently being provided by both our MCOs and by health care service providers in multiple settings. MCO care coordination is mostly done from an office, via the telephone, or other online communications. Care coordination, to be done right, requires a relationship and time.

For those external providers, they are not being reimbursed for providing care coordination – whether that be the provider or another individual that steps in to

provide the care coordination, none are being reimbursed by Medicaid for their time. For example, HealthySteps utilizes family service coordinators (FSCs) to provide resources and specific care coordinators to amplify the work of the HealthySteps Specialists who are focused on providing more direct clinical services.[11] These non-clinical pieces of HealthySteps are not able to be billed.

The District needs to consider how it can streamline both the MCO and established community-based care coordination. There have been numerous recommendations on how to create a more comprehensive, cohesive system. First, the behavioral health integration work group recommended establishing rates for care coordination for both non-clinical and clinical providers to create the opportunity to make those efforts billable. Providers (i.e. behavioral health, primary care, hospital, specialists) should have the option of choosing the right healthcare workforce to provide care coordination in their respective settings. A similar recommendation can also be found in the Perinatal Mental Health Task Force Report, A Path Forward, and reporting on sustainable funding for community health workers, HealthySteps, and other non-clinical work.[12]

We encourage DHCF to explore opportunities to sustain care coordination outside the MCO setting. At minimum DHCF and MCOs should work with external care coordinating providers to better leverage local coordination.

Additionally, the Behavioral Health Integration work group found that "providers would be more inclined to make referrals to MCOs if there was a clear mechanism for closing the loop on those referrals."[13] The District should work towards improving interoperability of clinical care plans, care gaps and engagement efforts into the designated health information exchange to allow for better coordination between providers and MCO care coordinators. We ask this Committee to explore how DC's MCOs are coordinating with local care coordinators and what efforts they have made to engage with local care coordinators to ensure beneficiaries are connected to services, supports, and resources that improve their health outcomes.

MCO Behavioral Health Network Adequacy Standards Should Be Expanded

CLC works with many children with complex health needs.[14] Their physical and behavioral health conditions interact in ways that require comprehensive healthcare services able to address these needs holistically. A way for the District to better know how these needs are being met is for DHCF to add MCO performance standards for behavioral health that lead to meaningful improvement in enrollee care and provide stakeholders with actionable information.

First, network adequacy standards should be strengthened. Currently, DC's MCOs must meet network adequacy standards around time and distance, specifically at least one behavioral health provider type within five miles or thirty minutes travel time.[15] While geographic accessibility is important, there are other accessibility factors

to capture when measuring behavioral health care accessibility. Evolving behavioral health accessibility standards for MCOs requires adopting bundles of measures that assess for the types of services, scope of practice of various clinicians, cultural fit, and the availability of telehealth services in the network, amongst other relevant factors.[16] These are factors that take into account unique features of behavioral health services like clinician type and clinician fit that may not play as big of a role within physical healthcare.

The Behavioral Health Performance Improvement Project (PIP) that DC's MCOs participated in last year shows more ways that current metrics limit improving care in meaningful ways. The Behavioral Health PIP aimed at implementing targeted educational and outreach interventions to improve the rates of follow-up visits.[17] The PIP measures included timeliness of follow-ups after emergency department visits or hospitalization for mental illness.[18] These measures capture the importance of care continuity post-discharge and should even continue to be used as part of regular performance monitoring beyond the PIP, but additional specific timeliness standards can deepen stakeholder understanding of how enrollees are able to access care. An additional standard recommended in the *A Path Forward* report is wait time between appointments, such as time from initial appointment to second appointment.[19] CLC clients sometimes have an intake appointment with a provider and then experience a gap before another appointment, which if not tracked can make it look like treatment is

being accessed sooner than it is. We ask the Committee to work with DHCF on implementing more precise behavioral health metrics for MCOs.

The Carve-in Of Behavioral Health Services Offers Avenues For Improved Accountability And Care

Any behavioral health performance standards our MCOs are held to will be made more meaningful when they have the capacity to administer all the care their members receive. We have previously testified about the need for behavioral health services to finally be carved into managed care plans, a goal that was initially set in 2019 but has been paused multiple times, most recently in February 2024.[20] The upfront financial demands of the carve-in can't be ignored, but it is important to understand the benefits to provider accountability and quality of care that await us in a fully integrated managed care system.

Giving DC's MCOs the ability to "see" all the care their enrollees receive allows them to implement the performance standards that can strengthen and expand our behavioral health provider network. The carve-in would also give MCOs an incentive to hold providers accountable for providing quality care, adding another source of oversight for our system. We urge the Committe to maintain the carve-in as a priority and ask DHCF to determine a new timeline for completion.

Conclusion

DC residents need quality healthcare to live healthy lives. Holding our MCOs accountable to their responsibilities ensures the care they receive continues improving

and remains responsive to opportunities for promoting healthy lifestyles in new ways.

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

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[2] The cited DHCF report does not specify whether the $1.8 billion DC spent in 2022 was inclusive of federal FMAP dollars or not. Department of Health Care Finance, *Medicaid Managed Care Performance Report CY 2022*, (March 2024), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/District%20of%20Columbia%20CY2022%20Medicaid%20Managed%20Care%20Performance%20Report%20.pdf.

[3] Department of Health Care Finance, Public Forum on Integrated Care, *available at*: https://dhcf.dc.gov/page/public-forum-on-integrated-care.

[4] Jean Edward, et al., *Establishing a Pay-for-Performance Contract Between a Legal Services Organization and a Medicaid Managed Care Organization*, (May 2025), *available at*: https://medical-legalpartnership.org/wp-content/uploads/2025/05/Establishing-a-Pay-for-Performance-Contract-DC-MLP-Case-Study.pdf.

[5] *Id*.

[6] Health Services for Children with Special Needs, *See If You Qualify*, *available at*: https://www.hscsnhealthplan.org/enroll/qualify.

[7] Managed Care Contract accessed at, Department of Health Care Finance, Medicaid Managed Care Plans, *available at*: https://dhcf.dc.gov/page/medicaid-managed-care-plans-mcps.

[8] *Id*.

[9] Health Services for Children with Special Needs, *Your Care Manager*, *available at*: https://hscsnhealthplan.org/enroll/care-manager

[10] Qlarant, *District of Columbia Managed Care Programs 2024 Annual Technical Report*, *available at:* https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

[11] ZERO to THREE, HealthySteps, Family Screening and Connection to Services, *available at*: https://www.healthysteps.org/our-impact/the-evidence-base/family-screening-and-connection-toservices/; ZERO to THREE, HealthySteps, Maternal Depression, *available at*: https://www.healthysteps.org/our-impact/the-evidence-base/maternal-depression/.

[12] *Perinatal Mental Health Task Force: Recommendations to Improve Perinatal Mental Health in the District*, (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; *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] Behavioral Health Integration: Stakeholder Advisory Group Draft Charter, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/BH_Integration_Stakeholder_Advisory_Group_Charter_FINAL.pdf.

[14]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

[15] Qlarant, *District of Columbia Managed Care Programs 2024 Annual Technical Report*, *available at:* https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.
[16] National Committee for Quality Assurance, *Improving Accountability for Behavioral Health Care Access: Evaluating the Current Evidence for Behavioral Health Network Adequacy Standards* (2024), *available at*: https://wpcdn.ncqa.org/www-prod/NCQA-Improving-Accountability-for-Behavioral-Health-Access-Whitepaper.pdf.
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