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VIA EMAIL: dbh.policy@dc.gov

September 12, 2025
Mia Olsen
Interim Deputy Director, Data, Quality and Compliance
Department of Behavioral Health
64 New York Ave NE
Washington, DC 20002

Re: Comments on Community Support Proposed Rulemaking

Dear Mia Olsen:

Thank you for the opportunity to comment on the Proposed Rulemaking for Community Support clinical necessity criteria and authorization requirements. I write to submit these comments on behalf of Children's Law Center (CLC), which fights so every DC child can grow up with a stable family, good health, and a quality education. Our clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Our team of guardians ad litem (GAL) represent over half the kids in DC's foster care system. Over a quarter of the children represented by our GAL team last year were diagnosed with behavioral health conditions.[1] The submitted comments challenge the notion set forth by the rulemaking that measured improvement is needed to justify a consumer continuing to receive services and that measured functional decline is needed to receive a higher frequency of services. At the core of this issue, we contest whether the functional assessment used for children is a sufficient measure to use for these purposes due to its subjective nature.

Subsection 3421.15

Progress in behavioral health care takes time. This subsection proposes that after 180 days of Community Support, if there is not measured improvement in functioning or progress toward goals, then Community Support must not be working for the consumer and thus won't be reauthorized. This is an issue because the Child and Adolescent Functional Assessment Scale (CAFAS) tool used for children contains some subscales that are more resistant to change than others. For example, within the School/Work subscale, a child can score a 20, reflecting moderate impairment, by having a grade average lower than "C".[2] This grade average could persist after 180 days due to factors outside of what Community Support services can directly impact. This should not prevent a child from receiving a reauthorization of services.

There are also CAFAS subscales with a level of subjectivity that contradicts DBH's desire to have objective clinical necessity criteria. A case study in Michigan highlighted concerns around the subjectivity and superficiality of the CAFAS as a reason that some providers hesitated to use it to determine service eligibility.[3] For instance, in the Behavior Toward Others subscale, a

score of 10, reflecting mild impairment, can be assigned if a child is "unusually quarrelsome, argumentative, or annoying to others".[4] These are subjective behaviors that could persist after 180 days, leading to an incorrect interpretation that progress hasn't been made and Community Support isn't working. The subjective nature of parts of the CAFAS if not paired with consistent, repeated training also may encourage unethical behavior by qualified practitioners through false inflation or deflation of scores in order to meet the criteria DBH is proposing. Plan of Care goals may also be set that rather than being meaningful to the consumer, are amenable to change, thus more easily meeting the criteria established by DBH.

Our clients have experienced issues with the quality of Community Support services being offered, which is not addressed by this rulemaking. A child's lack of improvement could be due to the Community Support Worker's lack of engagement or poor skills. To prevent reauthorization of services based on lack of improved CAFAS scores punishes children who receive low-quality services.

Subsection 3421.16

This subsection also presents a problem due to the subjective nature of some CAFAS subscales, leading to a contradiction between service frequency and clinical effectiveness. A consumer may not experience measured functional declines but could still require more time with their provider than allotted in a 180 period in order to make progress. Waiting for a decline or a significant negative event to occur in order for a consumer to get more time with their provider goes against clinical principles of responding to consumer needs. For instance, waiting for a child to be hospitalized instead of providing the additional Community Support that could help to prevent hospitalization does not put clinical necessity first.

Concerns raised about the content validity of the CAFAS present a roadblock in measuring functional decline in the way DBH is expecting in this proposed rulemaking. Within each CAFAS subscale, there are behaviors described within each level of impairment that arguably should not be grouped together.[5] For instance, in the Home subscale, frequent use of profane, vulgar, or curse words to household members is rated as moderate impairment with a score of 20, but so is the act of deliberate damage to the home.[6] It is understandable how these two behaviors could be perceived to have different severities, but the CAFAS doesn't allow for that. So, a child's behavior could change from cursing in the home to damaging the home, and the CAFAS score would stay the same, preventing authorization for more Community Support units even though many would say the child's behavior has worsened.

We recommend that DBH allow the clinical summary written by a qualified practitioner to explain why a consumer needs more Community Support units despite the CAFAS score not worsening. There needs to be room for clinical judgement rather than relying too much on the results of an assessment to determine what services may benefit a consumer.

Conclusion

Thank you for the opportunity to provide comments on this Proposed Rulemaking. We share DBH's goal of ensuring children receive effective services, but the proposed means of determining the success and utility of Community Support does not help accomplish this. If you have any questions or would like to discuss anything further, please feel free to reach out to me at cgamble@childrenslawcenter.org.

Sincerely,

Chris Gamble
Behavioral Health Policy Analyst
Children's Law Center
cgamble@childrenslawcenter.org

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[1] Internal Children's Law Center Data Collection, "GAL Deep Dive," January 2024 through December 2024.
[2] Kay Hodges, *CAFAS Self-Training Manual*, Multi-Health Systems Inc, (2012).
[3] Patti Banghart & Janice L. Cooper, *Unclaimed Children Revisited: Focusing on Outcomes – A Case Study of the Michigan Level of Functioning Project,* National Center for Children in Poverty (May 2010), *available at*: https://www.nccp.org/unclaimed-children/.
[4] Kay Hodges, *CAFAS Self-Training Manual*, Multi-Health Systems Inc, (2012).
[5] Michael Phillip Bates, *The Child and Adolescent Functional Assessment Scale (CAFAS): Review and Current Status*, Clinical Child and Family Psychology Review, (April 2001), *available at:* https://www.semanticscholar.org/paper/The-Child-and-Adolescent-Functional-Assessment-and-Bates/86838aede278e44cb11160b7de32ff22c53fbb97.
[6] Kay Hodges, *CAFAS Self-Training Manual*, Multi-Health Systems Inc, (2012).