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Via email: dhcf.waiverinitiative@dc.gov

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Alice Weiss, Director
Health Care Policy and Research Administration
Department of Health Care Finance
441 4th Street NW, Suite 900S
Washington, DC 20001

Re: Comments on Proposed District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program

Dear Ms. Weiss:

Thank you for the opportunity to comment on the proposed Section 1115 Medicaid Behavioral Health Transformation Demonstration Program.[1] The draft program, released by the Department of Health Care Finance (DHCF) on April 12, 2019, proposes to expand the District's Medicaid plan to cover certain services for individuals with serious mental illness (SMI) or substance use disorder (SUD). Among other initiatives, the draft program proposes additional community-based services designed to improve treatment capacity and strengthen transitions from emergency, inpatient and residential treatment for both adults and children.

I am submitting these comments on behalf of Children's Law Center (CLC),[2] which, in the last year, provided services to more than 5,000 low-income children and families, with a focus on children in foster care and children with special health and education needs. Almost every one of CLC's clients is a Medicaid beneficiary. Our comments are based upon our experience representing those children and families.

CLC is committed to ensuring the District of Columbia has a full array of high-quality behavioral health services that are easily accessible for children, youth, and families. Towards that end we frequently help families navigate the behavioral health care system so they can obtain the services their children need. CLC also works to raise awareness in this area; for example, we recently partnered with the District of Columbia Behavioral Health Association and Children's National Health System in issuing a report (Behavioral Health Report) describing the current state of the District's mental health delivery system for children.[3] In addition, CLC has worked closely with the Mayor, the Council, District government agencies, and the community in developing legislation and policies to increase the number of mental health providers, improve funding for mental health services, and break down barriers that prevent children from getting quality mental health care. Most recently, for example, we worked with key stakeholders in creating a comprehensive plan to expand and improve school-

based mental health services. CLC is a member of the Coordinating Council on School Mental Health that was formed to guide the expansion of these services.

In these comments, CLC recommends some key principles to help guide the District in developing and implementing the Proposed Demonstration Program. These comments also support DHCF's plan to increase the availability of community-based interventions. In particular, we support the expansion of Medicaid coverage to psychologists and licensed clinical social workers in *all* clinical settings, including hospitals and stand-alone offices, as described in the comments filed by Children's National Health System (CNHS).

A. Guiding Principles

CLC supports the District's overarching goals for the Proposed Demonstration Program. Providing a broader continuum of treatment for individuals with serious mental illness or substance use disorder is a critical public health objective. So too is reducing the alarming rise of opioid misuse and deaths in the District. CLC also strongly supports DHCF's goal of "[s]upporting the District Medicaid program's movement towards a more integrated health care experience that facilitates coordinated treatment of behavioral and physical health needs."[4]

In seeking to achieve these goals, CLC urges DHCF and other stakeholders to keep the following principles in mind. First, the District should strive to simplify and facilitate access to timely, quality mental health services. The current system is highly fragmented and complex, involving multiple agencies and programs. Families, service providers, social workers and other professionals often are unaware of what resources are available and how to access those services. All of this creates significant barriers for families seeking help in very difficult circumstances, and ultimately delays and sometimes prevents the delivery of much-needed care. CLC is consequently encouraged by the statement in the draft that, "[t]hrough this demonstration, DHCF will strive to reduce regulatory silos and barriers to care across agencies and programs...."[5]

Second, in developing and implementing the Proposed Demonstration Program, DHCF and other agencies should pay particular attention to the unique, important needs of children and youth. As stated in the recent Behavioral Health Report, "children are disproportionately at risk for developing social and emotional problems when exposed to adverse childhood experiences, and/or living in an adverse environment with stressors, and without buffers such as adequate adult support. Stressors include poverty, abuse or neglect, homelessness/foster care, and children born with developmental disabilities or delays, and racism. Yet, with a strong public behavioral health care system, risk does not have to equal inevitability, and recovery, within home and community, is possible for all."[6]

Third, DCHF should consider the racial equity implications of the current and proposed mental health care system and assess whether aspects of the care system create or exacerbate racial inequities. The Behavioral Health Report emphasizes the importance of this issue: "A

recent study ... found significant racial and ethnic disparities in accessing mental health care for children and young adults. Recognizing that the children, youth and families served by the public behavioral health care system in the District are primarily individuals of color, approaching improvements to our system as a matter of equity is fundamentally necessary."[7] For example, "[g]eographic access to mental health providers and facilities is a tangible barrier to mental health treatment in Wards 7 and 8."[8] DHCF should explore ways to reduce this racially inequitable barrier by expanding services in these wards though the Proposed Demonstration Program.

B. DHCF Should Ensure that Psychologists and Licensed Social Workers in *All* Clinical Settings Are Qualified Provider Types Under DC Medicaid

Many of the children CLC works with – children in the foster care system or receiving special education services – only need our help because their mental health needs have gone unaddressed. Families with at risk children face many obstacles in accessing timely, quality and appropriate mental health treatment for their kids. Appointment delays and high staff turnover rates plague many of the Core Service Agencies (CSAs) that provide mental health services to many Medicaid-eligible children. More generally, the current, fragmented behavioral health system is not ensuring a sufficient number of quality mental health providers to meet the mental health needs in the community.

To help address this problem, the Demonstration Program proposes a plan "to bolster the availability of community-based interventions."[9] One aspect of this proposal would "increase access to Medicaid-enrolled providers for treatment" by extending Medicaid coverage to "[p]sychologist and licensed clinical social worker providers operating independently outside of a clinic or facility."[10] CLC strongly supports expanding the number of mental health care providers for Medicaid-eligible children. In particular, we support the comments filed by Children's National Health Systems on this issue.

As explained in CNHS's comments, the District's current State Plan for Medical Assistance (State Plan) does not recognize psychologists and licensed clinical social workers in certain health care delivery settings, including hospitals and independent provider offices, as qualified provider types for credentialing and, therefore, reimbursement through Medicaid. This creates a significant barrier to accessing mental health services, particularly for children insured under the Medicaid Fee-for-Service (FFS) program.[11] This includes children under the custody of the Child & Family Services Agency, children linked with the Department of Youth Rehabilitation Services, and children with certain disabilities or residing in long-term care facilities. The current State Plan is thus impeding the provision of vital mental health services to many of the children most in need of these services.

CLC consequently agrees with CNHS that psychologists and licensed clinical social workers in *all* clinical settings, including hospitals and stand-alone offices, should be covered as qualified provider types and eligible for reimbursement under DC Medicaid, regardless of

whether the services are covered through FFS or a managed care organization (MCO) plan. This will significantly enhance the timely delivery of much-needed behavioral health services to children and youth in the District.

Thank you considering these comments. We have kept our specific comments limited to the scope of the current proposed waiver. We understand that this is the beginning and not the end of the process and we look forward to having the opportunity to engage in a broader effort to reform the behavioral health system in the coming months.

If you have any questions about these comments, please feel free to contact me at (202) 467-4900 ext. 565, or sgreer@childrenslawcenter.org.

Respectfully,

Sharra Greer
Policy Director

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[1] District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program, Draft for Public Comments (published April 12, 2019) (Proposed Demonstration Program), *available* at https://dhcf.dc.gov/release/department-health-care-finance-publishes-first-proposed-medicaid-demonstration-mental-health.

[2] Children's Law Center fights so every DC child can grow up with a loving family, good health and a quality education. Judges, pediatricians and families turn to CLC to be the voice for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With nearly 100 staff and hundreds of pro bono lawyers, CLC reaches 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year.

[3] Children's Law Center, Children's National Health System, and District of Columbia Behavioral Health Association, "Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System" (2019) (Behavioral Health Report), available at https://www.childrenslawcenter.org/resource/behavioral-health-district-columbia-children-youth-families-understanding-current-system.

[4] Proposed Demonstration Program at 13.

[5] *Id.* at 11.

[6] Behavioral Health Report at 5 (footnote omitted).

[7] *Id.* at 4 (*citing* L. Marrast, D. Himmelstein, S. Woolhandler, "Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study," 46:4 *International Journal of Health Services* 810-824 (2016)).

[8] Ollie Ganz, *et al.*, "Barriers to Mental Health Treatment Utilization in Wards 7 and 8 in Washington, DC: A Qualitative Pilot Study," *Healthy Equity* (2018), *available at:* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6128444/ . *See also* DC Healthy Communities Collaborative, "DC Community Health Assessment," 25 (June 2016) (noting "lack of specific mental health services – such as psychiatric services for children – in certain areas of DC"), *available at:* http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf .

[9] Proposed Demonstration Program at 11.

[10] *Id.* at 12.

[11] As CNHS explains in its comments, although in certain circumstances DHCF currently provides coverage to providers through single case agreements, establishing such agreements creates delays and burdens for families seeking care and creates unnecessary costs for the system.