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Committee on Health
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The Department of Health Care Finance &
Deputy Mayor for Health and Human Services

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Introduction

Good morning Chairman Gray and members of the Committee. My name is Sharra E. Greer. I am the Policy Director of Children's Law Center[1] and a resident of the District. I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a loving family, good health and a quality education. With nearly 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 9 children in DC's poorest neighborhoods –more than 5,000 children and families each year. I also serve as a member of the DC Medical Care Advisory Committee, a forum for key participants and stakeholders in DC's Medicaid program to review the program's operations and provide feedback to the Department of Health Care Finance.[2]

I appreciate this opportunity to testify regarding the performance of the Department of Health Care Finance (DHCF) over this past year. As you know, DHCF is the Medicaid agency for the District. Children (ages 0-20) represent over one-third of DC's Medicaid enrollment, and therefore, they are a key population who are affected by DHCF's practice, policy, and system changes.[3] Children's health needs are unique, and their interests and concerns require distinct attention. At Children's Law Center, nearly all of our clients are Medicaid beneficiaries. Over the past year, we have seen how the pandemic and recent changes to DC's Medicaid program have impacted their ability to access the services they need.

My testimony today will begin by discussing how DHCF responded to the pandemic by increasing the availability of telehealth for behavioral health services – a change that will, hopefully, improve access to services even after the pandemic is over. My testimony will then highlight areas of concern with the evolving changes to DC's public health insurance programs for children and families, as well as provide recommendations for how DHCF can address these concerns. Finally, my testimony will address areas where interagency coordination is necessary to ensure DHCF meets the needs of children and families in the District.

Implementation of Telehealth Has Improved Access to Behavioral Health Services,

During this ongoing pandemic, children are dealing with unprecedented levels of disruption, isolation, and stress due to remote schooling, the loss of social connections and activities, changes in their parents' lives (including job losses), and illness and death from COVID-19 in their families and community. As a result, children are experiencing increased behavioral health issues, with early research noting high rates of irritability, clinginess, distraction, and fear among children, as well as increases in substance use among adolescents.[4] Further, the pandemic has created new challenges for children's access to health services. Services usually provided in-person at school are no longer available, and some parents are delaying care due to social distancing restrictions and concerns about exposure.[5]

DHCF's very quick recognition of telehealth as a solution to some of these challenges, followed by the rapid implementation of telehealth, has enabled numerous children and families to continue accessing critical health services. We commend DHCF for its role in the swift action to expand and simplify telehealth in the District, including supporting providers, coordinating information-sharing, providing authorization for telehealth services, and implementing rule changes.[6]

These actions were critical to allow families to access services. We urge that as we recover from the pandemic many of the changes remain in place, and indeed DHCF has already made some of the changes permanent. This shift will require some additional organizational structures and/or procedures to sustain the delivery of high-quality, evidence-based, and equitable telehealth services in the long-term. For example, DHCF should seek to establish mechanisms for monitoring and evaluating telehealth services to ensure that they meet ethical and quality standards.

Further, while we strongly support sustaining telehealth, there are potential limitations surrounding its benefits for children in the District, which warrant special attention and investigation by DHCF. One recent study examining the use of "telemental health" (providing mental and behavioral health services through technology) during the COVID-19 pandemic found that remote service delivery (especially for psychotherapy) was less preferred for children than adults.[7] Another study noted that there are both therapeutic limitations of telemental health for children

(challenges assessing and treating severe clinical presentations) and physical limitations (challenges in access to reliable technology and confidential spaces), with the latter being exacerbated for children from socioeconomically disadvantaged families.[8] In light of these caveats, we ask DHCF to closely examine the best uses of telehealth for children and provide guidance for Medicaid program managed care organizations, providers, and health care recipients accordingly.

The Needs of DC's Children and Families Must be Prioritized During Upcoming Changes to DC's Medicaid Program

DHCF is in the process of implementing several significant changes to DC's Medicaid program. These changes include:

- Implementing newly-authorized behavioral health services under the "Behavioral Health Transformation" section 1115(a) Medicaid demonstration;[9]
- Transitioning from a partial fee-for-service program to a fully managed care Medicaid program;[10] and
- Awarding new managed care contracts.[11]

Each of these changes will impact services for children and families in the District. It is essential that DHCF, its partner agencies, and the managed care organizations (MCOs) it contracts with give specific consideration to the particular needs of children and families as these changes are planned and implemented to ensure those needs are met.

"Behavioral Health Transformation" Section 1115(a) Medicaid Demonstration

The "Behavioral Health Transformation" section 1115(a) Medicaid demonstration ("1115 demonstration") began in January 2020 and will continue until the end of December 2024.[12] The goal of this demonstration is to maintain and improve access to mental health and substance use disorder services in the District, as well as to improve the delivery system to provide more coordinated and comprehensive treatment for beneficiaries with serious emotional disturbance, serious mental illness, and/or substance use disorder.[13] Authorized services that will directly benefit children include (but are not limited to) new reimbursement methodologies for youth mobile crisis intervention and specific trauma-targeted services.[14] As these services for youth are rolled-out and then evaluated over the coming year, we look forward to seeing the utilization metrics and evaluation results. We also urge DHCF to continue to seek ways the 1115 demonstration can support the development of new services or increase the capacity of existing services for children and youth in the District.

Transition to a Fully Managed Care Medicaid Program

In September 2019, DHCF announced plans to move towards a fully managed Medicaid program over the next five years.[15] This shift will involve transitioning individuals currently in Medicaid's Fee-for-Service (FFS) program to the Medicaid managed care program.[16] DHCF explained that the motivation for this change was to enable individuals to receive care coordination and improved care, with the intended

result of improved health outcomes and lower rates of emergency room use, hospital admissions, and inpatient stays.

As we noted in our testimony last year, we view this transition as an opportunity to strengthen the behavioral health care system for all children on Medicaid – those currently enrolled in MCOs and those who will be transitioning to MCOs – and ensure that all children served by Medicaid have access to the necessary, high-quality services to support their behavioral health.[17] Many of our clients struggled to access behavioral health services over the past year – from basic intakes, to individual and family therapy sessions, to medication management appointments, to intensive outpatient mental health services. With the pandemic continuing to drive ever-increasing behavioral health needs among children, the inadequacies of DC's behavioral health system for children are more apparent than ever.

With a view to addressing these inadequacies, we recently published a paper in collaboration with other health advocates with preliminary recommendations to elevate the provision of appropriate, equitable, inclusive, and high-quality behavioral health services throughout the continuum of care for children and families in the District.[18] These initial recommendations address concerns around service delivery, quality of care, workforce development, network adequacy, financing, and special populations. We strongly encourage all agencies involved in the behavioral health integration to consider these initial recommendations. Suggested strategies include establishing the

full continuum of psychiatric care for children and youth (including acute care, crisis stabilization, and intensive outpatient care), establishing standardized quality of care measurements, and requiring universal contracting for critical child-serving providers to ensure initial network adequacy. This paper is the most recent in a series of papers we have published that seek to inform and advise policymakers on ways to improve DC's behavioral health care system for children and families.[19]

DHCF has not yet provided details on the transition for children and youth currently served by FFS. The agency should, however, pay particular attention during this transition to the entire current and former foster care population, who historically have been placed in the FFS program.[20] Children in foster care typically have adverse childhood experiences prior to being placed in foster care and/or while in foster care, which contributes to these children having complex traumas and higher rates of mental health disorders than those of the general population.[21] Further, they often encounter additional barriers to effective treatment and recovery due to a lack of care coordination and wraparound support as they transition between homes, caregivers, providers, and services.[22] Managing transitions in care for children in foster care can be particularly challenging because DC places many children in foster homes in Maryland (and less frequently, in other states), sometimes an hour or more outside of the District. The ability to readily access behavioral health services in Maryland and other jurisdictions is crucial for this particularly vulnerable population. Therefore, DBH and DHCF should

work with MCOs to ensure there are clear pathways to accessing care across the District, Maryland, and any other jurisdiction where children in the DC foster system, or those who have left the system but retain DC Medicaid coverage as former foster children, reside.

One way DHCF can ensure the needs of children and families are addressed through this transition is by providing a way for their voices to be heard. We commend DHCF for taking an initial step in this direction by creating the Behavioral Health Integration Stakeholder Advisory Group. DHCF intends to include behavioral health services as covered benefits in the District's managed care contracts by October 1, 2022, with the goal of providing whole-person care and strengthening coordination.[23] To this end, DHCF is conducting a behavioral health rate study and forming the Stakeholder Advisory Group to support planning. According to the Stakeholder Advisory Group's draft charter, the group (consisting of a maximum of 30 members) "provides input on key decisions relating to the carve-in of behavioral health services into Medicaid Managed Care, identifies potential issues and operational concerns, and provides solution-oriented feedback for consideration as part of a transparent behavioral health integration planning and implementation process."[24] We appreciate being included in this Stakeholder Advisory Group and hope this group helps inform a successful process.[25]

Lastly, this transition will ultimately affect many children and families – approximately 10% of children served by Medicaid in DC were enrolled in the FFS program.[26] It is imperative that DHCF works to keep family members on one Medicaid managed care plan and a plan that minimizes confusion and disruption to services. When possible, families should be able to maintain the same behavioral health providers for their children as research has shown that strong therapeutic relationships between youth and their providers (which are promoted by consistency in service providers) are associated with positive behavioral health outcomes.[27]

Awarding of New Managed Care Contracts

In addition to transitioning to a fully managed care program, DHCF is also in the process of awarding new managed care contracts.[28] The shift to new Medicaid managed care contracts became effective in October 2020, with hundreds of thousands of people being switched to different plans.[29] During this transition, there was confusion – some consumers were surprised by their plans changing, which in some cases, meant they could no longer use the same providers. Even more challenging, some families found that different members of the family were assigned to different plans (with access to different providers). Consumers may now have to go through this process again since, in December 2020, a judge ruled that the award of the new managed care contracts violated procurement laws, requiring DHCF to reassess contracts.[30] With these multiple ongoing changes, it is again imperative that children

and families' behavioral health services remain consistent without disruption or loss of services. We urge DHCF to make a concerted effort to keep families informed of where and how they can continue to access health services, especially behavioral health services, for their children and ensure that families are on the same plan.

Enrollment in Health Care Services for Children with Special Needs (HSCSN) Has Become More Difficult

HSCSN is a non-profit MCO that coordinates care for children and young adults with disabilities and complex medical needs.[31] District residents under the age of 24 who receive Supplemental Security Income (SSI) disability benefits or have an SSI-related disability are eligible to apply for enrollment in HSCSN.[32] Whether or not a child is considered to have an "SSI-related disability" is a determination made by DHCF, and there is no public written guidance explaining how this determination is made.[33]

Over the past year, we have noticed a change in how DHCF determines whether a child has an "SSI-related disability" in our cases. Most recently, DHCF has refused to accept any applications for switches to HSCSN, saying that it is the responsibility of the Department of Human Services (DHS), but this is clearly incorrect as all MCO determinations happen within DHCF, and DHS only handles eligibility.

Prior to this most recent declaration, DHCF had become much more unpredictable in its interpretation and had limited the scope of information it would

consider when making this determination. For example, in some cases, DHCF will not consider evaluations if they are older than six months old. This is unreasonable given that this is not a diagnostic requirement for any disability, nor is it a requirement for any medical listing for Social Security. Families often wait longer than six months to get off wait lists for evaluations, and it is unreasonable and impossible to expect them to have documentation that is only within that timeframe. For the first time in our many years of handling these matters, we have had to appeal these denials to the Office of Administrative Hearings.

DHCF's approach to assessing whether a child has an "SSI-related disability" is blocking access to key services for particularly vulnerable children and families (and creating a great deal of unnecessary litigation).[34] We urge DHCF to revisit its policies in this area and align its policies with the requirements of the medical determination for Social Security rather than creating a totally different standard. Since the regulations say that SSI-eligible children can utilize HSCSN, it is most logical to align the policy with the Social Security criterion for medical eligibility. We also ask that DHCF state its criteria for determining an "SSI-related disability" in written guidance to help families navigate the application process.

DHCF Should Encourage and Support Innovations Similar to Amerihealth's Approach to Social Determinants of Health

The Centers for Disease Control and Prevention (CDC) defines the social determinants of health as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."[35] There is evidence that addressing social determinants of health – including housing, income, and nutrition – improves health outcomes and/or reduces health care spending.[36] There is some innovation in this area happening with DC's agencies. The Department of Human Services is working with DHCF to launch a new Medicaid Housing Supportive Services benefit in April 2022. This new benefit will enable Medicaid to cover case management services for persons enrolled in the PSH-Individuals program.[37]

In addition, over the past year, one of DC's largest Medicaid MCOs, AmeriHealth Caritas District of Columbia, Inc., has implemented several programs intended to address social determinants of health as a means of improving health outcomes for District families and lowering healthcare costs at the same time. First, AmeriHealth entered into a partnership with Children's Law Center to improve children's underlying health conditions and reduce pediatric hospital visits by targeting unsafe housing conditions.[38] Through this partnership, AmeriHealth care managers and providers refer families with children with asthma to CLC attorneys who work to get landlords to fix poor housing conditions that exacerbate asthma or relocate families

to healthier homes. AmeriHealth pays CLC approximately half of what it averages in cost avoidance. The program is projected to cut government-funded health costs by an average of $10,000 per child in the first 18 months after CLC closes a case. Early data shows that this partnership is working – in cases where CLC has been able to address poor housing conditions, emergency room visits and hospitalizations have been reduced, and in some households, these health improvements have extended to other members of the family (not just the child who had asthma).

AmeriHealth is also working with other community partners to finance a significant expansion of medical respite capacity in DC.[39] The goal of this program is to more effectively address the health needs of individuals experiencing homelessness or housing insecurity. Individuals experiencing homelessness are at increased risk for serious illness, which is often caused or exacerbated by their living conditions.[40] Homeless individuals are disproportionately likely to rely on emergency room care and much more likely to require hospitalization, and yet often have no discharge options besides shelters or the streets. The lack of a safe and supported environment for healing post-discharge increases the likelihood of recurring emergency room visits and hospitalizations, which result in significant healthcare utilization and expenditures. Medical respite is an evidence-based, temporary care strategy that provides short-term care in a safe and supported environment that allows individuals to continue their recovery post-discharge when a return to a shelter or the streets would impede their

recovery or worsen their health condition. By increasing DC's capacity to provide medical respite care for individuals experiencing homelessness, AmeriHealth intends to both improve care and health for those individuals and significantly reduce costs.

We applaud AmeriHealth for its innovative approach to addressing social determinants of health. These types of programs represent a rare win-win situation – improved health for DC residents and cost savings for the District. We commend DHCF for supporting AmeriHealth in its pursuit of these bold solutions, and we urge DHCF to encourage the other MCOs to follow AmeriHealth's lead in seeking to address social determinants of health.

Interagency Coordination is Critical to DHCF's Mission to Improve Health Outcomes for DC Residents

For DHCF to fulfill its primary mission of improving health outcomes for DC residents, the agency must work closely with other agencies – particularly the Department of Human Services (DHS) and the Department of Behavioral Health (DBH).

DHS is responsible for Medicaid's recertification process – the process by which families confirm their eligibility for Medicaid and remain enrolled in the program. During the pandemic, recertification requirements have been suspended, but once the public health emergency is over, thousands of families will need to recertify to receive their benefits. Under the circumstances, it is likely that many people will miss the deadline to recertify – resulting in them losing coverage and then having to reapply to

be re-enrolled in the program. DHS and DHCF need to work together to carefully coordinate the reinstitution of the recertification process. First, the agencies should work to ensure families have plenty of notice and time to prepare their recertification forms. Second, the agencies should coordinate to ensure that if people end up losing and then regaining their coverage, DHCF is able to enroll them in the same plan with the same MCO they had previously to avoid or minimize the disruption or loss of needed services.

DBH and DHCF need to work closely together to ensure DC's children and families have timely access to the full spectrum of behavioral health services they need. When DC transitions to a fully managed Medicaid program, the responsibility for behavioral health services managed by DBH as part of the FFS program will move to the MCOs. DBH and DHCF need to carefully coordinate this shift in responsibility with consumers in mind and ensure there is clarity and transparency regarding the roles of DBH, DHCF, and the MCOs in managing behavioral health care services within the Medicaid program.

Finally, DHCF and DBH must work together to develop and implement a long-term strategy to strengthen and expand the array of behavioral health services available for children and families. As noted above and in our performance oversight testimony for DBH, the inadequacies of DC's behavioral health system for children are more apparent than ever.[41] Our system lacks both breadth and depth – it does not include the

full spectrum of services our children need, and for the services we do have, the capacity is insufficient to meet the need. With the pandemic continuing to drive ever-increasing behavioral health needs among children, it is more important than ever that DHCF and DBH work to build a system capable of meeting those needs. Access to quality, consistent, and timely behavioral health services is an essential component to our children's ability to fully recover from this pandemic and thrive.

Conclusion

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

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[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health and a quality education. Judges, pediatricians and families turn to us to advocate 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, we reach 1 out of every 9 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And, we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] DHCF, DC Medical Care Advisory Committee, *available at:* https://dhcf.dc.gov/page/dc-medical-care-advisory-committee.

[3] Based on December 2020 Medicaid enrollment data. DHCF, Monthly Enrollment Report – December 2020, Reflecting Period of November 2019-November 2020, *retrieved from*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MCAC%20Enrollment%20Report%20-%20December%202020.pdf

[4] Garfield, Rachel, and Priya Chidambaram, *Children's Health and Well Being During the Coronavirus Pandemic, KFF* (blog), September 24, 2020, *retrieved from:* https://www.kff.org/coronavirus-covid-19/issue-brief/childrens-health-and-well-being-during-the-coronavirus-pandemic/.

[5] *Id.*

[6] DHCF, Telemedicine, *available at:* https://dhcf.dc.gov/page/telemedicine. *See also,* MANATT, *Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19,* (February 25, 2021), *available at:* https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat#collapseNewsletter (As of December 3, only 19 states and Washington D.C. have issued telehealth guidance for Child Well-care and EPSDT visits; Washington D.C. issued guidance expanding telehealth for their Medicaid populations; Washington D.C. issued guidance to allow for a form of audio-only telehealth services). DHCF, *DC MEDICAID CODING FOR TELEMEDICINE AND*

CORONAVIRUS (COVID-19), (March 19, 2020), *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20MEDICAID%20CODING%20FOR%20TELEMEDICINE%20AND%20CORONAVIRUS%20%28COVID-19%29%20GUIDE%20FINAL%20040820_0.pdf.

[7] Hoffnung, Gabriel, et al., *Children and Telehealth in Mental Healthcare: What We Have Learned From COVID-19 and 40,000+ Sessions,* Psychiatric Research and Clinical Practice, (January 27, 2021), *retrieved from*: https://doi.org/10.1176/appi.prcp.20200035.

[8] Racine, Nicole, et al., *Telemental Health for Child Trauma Treatment during and PostCOVID-19: Limitations and Considerations*, Child Abuse & Neglect Volume 110, (December 2020), *retrieved from*: https://doi.org/10.1016/j.chiabu.2020.104698.

[9] DHCF, Medicaid Reform, *District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration, available at:* https://dhcf.dc.gov/1115-waiver-initiative.

[10] DHCF, *DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts*, (September 11, 2019), *available at:* https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts; DHCF, Transitioned Managed Care, *available at:* https://dhcf.dc.gov/page/transition-managed-care001.

[11] DHCF, Medicaid Reform, *available at:* https://dhcf.dc.gov/page/medicaid-reform.

[12] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *DC Behavioral Health Transformation*, 1, (January 6, 2021), *available at:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DHCF%20Demonstration%20STCs%20with%20Evaluation%20Design%20and%20Monitoring%20Protocol%20010621.pdf.

[13] *Id.* at 4.

[14] *Id.* at 185.

[15] DHCF, *DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts*, (September 11, 2019), *available at:* https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[16] In FFS the state pays directly for each service provided, while in a managed care program the state pays a set fee to a managed care plan for each beneficiary, and the plan pays the providers for all Medicaid services that beneficiary requires within the plan's contract with the state. Medicaid and CHIP Payment and Access Commission, *Provider payment and delivery systems*, *available at*: https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/.

[17] Judith Sandalow, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 5, 2020), *available at:* https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/FINAL%20CLC%20DHCF%20FY2019%20Oversight%20Testimony.pdf.

[18] Children's Law Center, Children's National Hospital, et. al. *Advancing Children's Behavioral Health During a Time of Transition in DC's Medicaid Program,* (February 2021), *available at:* https://www.childrenslawcenter.org/sites/default/files/AdvancingChildrensBehavioralHealthBriefFINAL.pdf.

[19] In 2019, Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, and MedStar Georgetown University Hospital/Georgetown University Medical Center collaborated and released two documents on children's behavioral health in DC. The first paper, *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System*, provided a robust background of the current local public behavioral health system landscape (*available at*:

https://www.childrenslawcenter.org/campaign/behavioral-health-district-columbia-children-youth-andtheir-families-understanding-current). The second document, *Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia*, outlined a set of guiding principles to inform future improvements to DC's public behavioral health system as it aims to deliver effective, accessible, and acceptable community-based services and supports for children, youth, and families with or at-risk for behavioral health concerns (*available at*: https://www.childrenslawcenter.org/resource/principles-and-values-guide-child-and-adolescent-publicbehavioral-health-care-system). In February 2020, Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, and MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry released a third paper, *Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program*, concentrating on the transition to a fully managed care environment for Medicaid recipients in DC and continuing our focus on uplifting children's behavioral health (*available at*: https://www.childrenslawcenter.org/sites/default/files/AddressingChildBHNeedsThroughDCMedicaidChanges_Feb2020%20FINAL.pdf). Our organizations continue to work together and are developing a forthcoming paper on broader proposed solutions to inform children's behavioral health care in DC, to be published later this year.

[20] Children and youth that qualify for Medicaid FFS include those in the custody of CFSA, as well as those committed to both CFSA and DYRS. *See* Wotring, James R., Kathryne A. O'Grady, et. al., *Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers and Recommendations*, 17, (May 2014), *retrieved from*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf.

[21] Engler, Amy D., Kwabena O. Sarpong, et. al., *A systematic review of mental health disorders of children in foster care.* Trauma, Violence, & Abuse (2020): 1524838020941197.

[22] CFSA, Preventative and Ongoing Healthcare Policy, Section III. Rationale, (Sept. 1, 2011) https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Program%20-%20Preventative%20and%20Ongoing%20Healthcare%20%28final%29%28H%29_1.pdf ("According to the American Academy of Pediatrics, children entering foster care are often in poor health and have much higher rates of serious emotional and behavioral problems….Often, barriers exist that hinder the delivery of quality healthcare to these children. Such barriers can include: information about health care services children have received and their health status before placement is often hard to obtain…complicated physical and mental health conditions in children in foster care make taking care of these children difficult").

[23] DC Gov Bulletin, *Medicaid Behavioral Health Integration Stakeholder Advisory Group – Request for Participation*, (February 3, 2021), *retrieved from:* https://content.govdelivery.com/accounts/DCWASH/bulletins/2be9728

[24] DBH&DHCF, Behavioral Health Integration Stakeholder Advisory Group, *Behavioral Health Integration: Stakeholder Advisory Group Draft Charter, available at:* https://content.govdelivery.com/attachments/DCWASH/2021/02/03/file_attachments/1680956/BH%20Integration%20Stakeholder%20Advisory%20Group%20Charter_FINAL.pdf.

[25] Sharra E. Greer Children's Law Center's Policy Director was selected to serve on the Advisory Group.

[26] Children's Law Center, *Practice Kit 8: A Guide to Medicaid for Children in DC*, May 2018. *Available at*: https://www.childrenslawcenter.org/sites/default/files/PK8_Medicaid%20for%20Children.pdf.

[27] Zorzella, Karina P. M., et. al., *The Relationships between Therapeutic Alliance and Internalizing and Externalizing Symptoms in Trauma-Focused Cognitive Behavioral Therapy*, Child Abuse & Neglect, Volume 50, 171–81, (December 2015), *available at:* https://doi.org/10.1016/j.chiabu.2015.08.002.
[28] DHCF, Medicaid Reform, *available at:* https://dhcf.dc.gov/page/medicaid-reform.
[29] Zauzmer, Julie, *Medicaid Contracts Would Shift Poor D.C. Residents' health care amid pandemic,* Washington Post, (August 27, 2020), *retrieved from:* https://www.washingtonpost.com/dc-md-va/2020/08/27/newmedicaid-contract-would-shift-poor-dc-residents-medical-care-amid-pandemic/.
[30] Zauzmer, Julie, *Judge says D.C. violated law in awarding three lucrative Medicaid contracts,* Washington Post, (December 16, 2020), *retrieved from:* https://www.washingtonpost.com/local/dc-politics/judge-says-dc-violated-law-in-awarding-three-lucrative-medicaid-contracts/2020/12/16/4000ba38-3f41-11eb-9453-fc36ba051781_story.html.
[31] DHCF, *Health Services for Children with Special Needs, Inc.,* (September 30, 2014), *available at:* https://dhcf.dc.gov/publication/health-services-children-special-needs-inc-hscsn.
[32] *Id*.
[33] After many years helping families move to HSCSN and requesting their policy, Children's Law Center staff has been advised that DHCF may be providing written guidance to us through their General Counsel. We suggest DHCF use criteria that parallel what SSA uses to determine medical eligibility since that is ultimately the question.
[34] This year Children's Law Center has had to file multiple appeals to the Office of Administrative Hearings in order for qualified clients to be enrolled.
[35] Center for Disease Control and Prevention, *Social Determinants of Health: Know What Affects Health, retrieved from:* https://www.cdc.gov/socialdeterminants/index.htm.
[36] Taylor, Lauren A., Annabel Xulin Tan, et. al., *Leveraging the Social Determinants of Health: What Works?* PLOS ONE 11, no. 8 (August 17, 2016), *retrieved from:* https://doi.org/10.1371/journal.pone.0160217.
[37] DHS FY2020 Performance Oversight Responses, response to Q12, *available at:* https://dccouncil.us/wp-content/uploads/2021/02/DHS_2021-Performance-Oversight-Pre-Hearing-Responses.pdf.
[38] Gilgore, Sara, *Mold in the walls could be triggering your child's asthma attack. Here's what a new D.C. partnership is doing about it.,* Washington Business Journal, (August 28, 2019), *retrieved from:* https://www.bizjournals.com/washington/news/2019/08/28/mold-in-the-wallscould-be-triggering-your-child-s.html?b=1566963755%5E21533096.
[39] Quantified Ventures, Health and Human Services, *Hope Has a New Home Medical Respite Program, available at:* https://www.quantifiedventures.com/hope-has-a-home-medical-respite-program.
[40] AmeriHealth Caritas, District of Columbia, *Building Community Partnerships, Bed Capacity, and Better Health Outcomes for DC's Homeless: AmeriHealth Caritas DC Breaks New Ground, available at:* https://static1.squarespace.com/static/5d5b210885b4ce0001663c25/t/5d8e76d11151cb286dca0422/1569617625523/Medical+Respite+Project+Snapshot+July+2019+vF.pdf.
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