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Committee on Health
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Good morning Chairman Gray and members of the Committee. My name is Judith Sandalow. I am the Executive 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. Nearly all of our clients are Medicaid beneficiaries.

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. In DC, one in two children is covered by Medicaid – over 101,000 in FY2018.[2] The public health care landscape in the District of Columbia is rapidly evolving. As DC advances practice, policy, and system changes to improve the physical and emotional well-being of its residents, it is imperative that these changes meet the behavioral health needs of DC's children, adolescents and families in order to allow them to thrive.[3] My testimony today will focus on anticipated changes to DC's Medicaid program and provides recommendations for how to take the opportunity these changes offer to better serve children's behavioral health needs. [4]

Background

In DC, children with behavioral health conditions often struggle to access the quality public behavioral health services they need in a timely manner. Year after year,

Children's Law Center has testified that many of the children we work with – children in the foster care system or receiving special education services – only need our services because their mental health needs have gone unaddressed.[5] Many of these children have faced multiple adverse childhood experiences and have resulting complex trauma that makes them more vulnerable to experiencing adverse medical and behavioral outcomes. These children need access to high quality services to achieve stability.

All children deserve to have comprehensive, accessible, and high-quality health care. Federal Medicaid law recognizes the unique needs of children by requiring the delivery of comprehensive pediatric health care services to all Medicaid-enrolled children and youth under the age of 21 through provisions in the law known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).[6] With a particular focus on prevention and early detection as well as a broad mandate related to treatment, the objective – and legal requirement – is for children to get the healthcare, including behavioral health care, they need when they need it: the right child at the right time in the right setting.[7]

On September 11, 2019, DHCF announced plans to move towards a fully managed Medicaid program over the next five years.[8] This shift will involve transitioning individuals currently in Medicaid's Fee-for-Service (FFS) program to the Medicaid managed care program.[9] 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. Approximately 90% of children served by Medicaid in DC are currently enrolled in managed care organizations (MCOs), and 10% are enrolled in FFS.[10]

While DHCF has not yet provided details on the transition for children and youth currently served by FFS, we view this 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.[11] We have identified three broad areas of opportunity where DHCF's work can strengthen DC's public behavioral health system for children, youth, and families: access and care coordination; network adequacy; and effective services. We urge DHCF and this Committee to consider the specific recommendations detailed below during the implementation of the transition to a fully managed Medicaid program.

Access and Care Coordination

Children and families seeking public behavioral health services in DC are struggling to access the right services at the right time and often find it difficult to coordinate care across different providers and services. For example, although families seeking help can be connected with a Core Service Agency (CSA) that provides an array

of clinical services by calling the Department of Behavioral Health's Access HelpLine, in FY2019, it took an average of 22 days for a child enrolled with a CSA to receive a diagnostic assessment – only the first step towards treatment if indicated.[12] For children needing an initial appointment for medication management with a psychiatrist, it took an average of 76 days to see a psychiatrist.[13] This amount of delay to receive critical services is severely detrimental to the health and well-being of the children involved, and impedes their ability to recover quickly and fully.[14] When the initiation of necessary treatment takes this long, equating to almost 12 weeks of the school year, it can severely impact educational outcomes as well.

In a fully managed care environment, it is hoped that the MCOs will do a better job of connecting families with the services they need quickly. However, simply transitioning to an MCO does not guarantee care coordination will lead to better access to care or outcomes for children seeking public behavioral health services. To encourage a transition that leads to better outcomes for children and their families in implementation, DHCF should consider the following recommendations:

Revise DC Code and Regulations to Support Implementation

DHCF needs to collaborate with its partner agencies across the District government to conduct a thorough analysis of all relevant DC laws and regulations through the lens of supporting the implementation of a fully managed Medicaid program. Certain parts of the existing DC code and regulations that did not anticipate a

fully managed care environment may undermine the transition. For example, DC Department of Behavioral Health (DBH)'s regulations are framed from the perspective of DBH as an integrated regulator and payor. Even if DBH continues to be a payor for some services, these regulations need to be reframed for a fully managed care environment with MCOs playing a greater role in care coordination and linkages and also, possibly, paying for more care. Certain sections of the Mental Health Information Act limit health information exchange and data sharing – an example of DC code that will need to be revisited in light of the transition.[15] It is essential that all relevant DC laws and regulations support smooth transitions between forms of care and providers for children, without interruptions of care or confusion over billing.

Ensure Uniform and Clinically Appropriate Coverage

In order to ensure that children and families can access the services they need regardless of the MCO in which they are enrolled, DHCF should require all MCOs to base level of care determinations on publicly available, evidence-based standards, independent from business considerations and consistent with generally accepted standards of care. DHCF should also develop MCO quality standards in order to ensure equity in care coordination across MCOs and seamless transitions between plans for beneficiaries. In addition, medical necessity determinations, prior authorization decisions, and decisions regarding denials, grievances, and appeals regarding care for children should be made by individuals with clinical expertise specific to children,

stratified by age, as well as experience treating the relevant disease or condition. The credential of any clinician denying care should be at least equal to the credential of the recommending clinician and based on relevant clinical experience.

Network Adequacy

There is a scarcity of behavioral health care providers that are able to provide services for children and youth in DC, particularly for very young children (under 5 years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays.[16] The behavioral health needs of children and youth are distinct from those of adults. Treatment plans and services must be age-appropriate – what works for adults does not necessarily work for children. Accordingly, providers for children and youth require specific evidence-based training and experience in order to serve this specific population.[17] Currently, the shortage of child-serving providers in DC results in long wait times for initial appointments and significant delays in obtaining treatment for urgent conditions.[18] To ensure there is an adequate network of child-serving providers, DHCF should consider the following recommendations:

Provide Technical Assistance and Onboarding Support to Providers Entering the Managed Care Market

DHCF needs to identify child-serving providers with limited or no experience in the managed care market and provide them with technical assistance and onboarding support during the shift to a fully managed care Medicaid program. As part of this effort, DHCF should provide guidance on how to prepare for the shift and share

timelines for implementation targeted by specific beneficiary groups. Providers that serve children and youth (a specialized population) will need focused support to ensure they are able to successfully transition to a fully managed care environment, so that the already short supply of child-serving providers is not further reduced and can offer continuous care in a managed care environment.

Require Universal Contracting for Critical Providers

Our experience with other types of government transitions suggests that there is a significant risk that the transition, by itself, will lead to a reduction in an already limited market. To prevent this from occurring, MCOs should be required to contract with any critical child-serving provider licensed and willing to accept their contract terms. Critical providers for children include DBH-certified Mental Health Rehabilitation Services (MHRS) providers, Adolescent Community Reinforcement Approach (ACRA) providers, Adolescent Substance Abuse Treatment (ASTEP) providers, Federally Qualified Health Centers (FQHCs), and Psychiatric Residential Treatment Facilities (PRTFs), and hospitals. MCOs should be required to offer at least an initial contract to all other child-serving providers, to ensure there is an adequate network for children immediately following the transition. MCOs can then phase in and progressively increase quality standards for providers with DBH and DHCF input and with a view as to whether such standards (element to be measured or rate of expected improvement) would be too disruptive to the network's ability to address

beneficiary needs. Changes to payment terms should also be phased in gradually, with initial payment rates at least matching the Medicaid fee-for-service fee schedule for provider organizations not prepared to move more quickly to value-based payments.

Require Coverage and Payment for All Medicaid-Covered Services Offered by Providers in MCO Networks

DHCF should require that all MCO contracts provide coverage and payment for all Medicaid-covered services offered by providers within their network, as long as the provider is appropriately licensed or certified to provide that service.[19] A network of community providers and hospitals, including psychologists and other licensed behavioral health care professionals employed by those entities, also provide crucial services and encompass a safety net for care in DC. This support should improve the availability of behavioral health services across all levels of care, by ensuring appropriate levels of compensation for all providers.[20] DHCF should also pay particular attention to network adequacy for children and ensure there are a sufficient number of providers available through each MCO.

Mandate Uniform Credentialing Requirements for all MCOs

To make it easier for child-serving providers to join MCO networks, DHCF should require uniform credentialing requirements for all MCOs. As part of this requirement, all MCOs should be required to accept DBH certification as meeting MCO standards, and credential DBH-certified behavioral health provider organizations and Federally Qualified Health Centers (FQHCs) at the organizational level (rather than at

the individual staff level). Whether or not MCOs are required to credential at the organization or individual level, DHCF should require electronic exchange of provider organization staff records using standardized processes, forms, and formats to be adopted by all MCOs. Taking these steps will reduce barriers to joining the MCO networks and support the building of an adequate network of child-serving providers.

Enable Providers to Assign Duties and Responsibilities.

DHCF must ensure that providers are able to assign their rights and obligations under provider participation agreements in the event of mergers, acquisitions, or other types of corporate restructuring. These types of activities are commonplace in the health care delivery system and are often necessary business decisions. Prohibitions on assignment negatively impact children and youth's access to services because they usually result in providers being automatically terminated following a merger, acquisition, or legal restructuring. This in turn often leads to treatment disruptions and problems with continuity of care. Accordingly, MCOs should honor the transfer of a provider's rights and obligations to a new legal entity when the only change is to corporate identity (and not the individuals providing services).

Effective Services

While timely access to services is necessary, it is not sufficient. The services children and families receive must be high-quality, evidence-based, and effective. When treating children and youth's behavioral health needs, there should be an

expectation that services will result in improvement and full recovery in many cases. DHCF should consider the following recommendations to hold MCOs accountable for ensuring the services provided to children, youth, and their families are high-quality, evidence-based, effective, and meet expected outcomes.

Encourage Move Towards Value-Based Purchasing

DHCF is taking steps to move towards value-based purchasing (VBP), and this should include VBP for children's behavioral health. This means that payments to providers will be linked to meeting evidence-based definitions of and expectations for successful treatment. For children with behavioral health needs, there are better defined and supported timelines for interventions to be delivered and take effect (as compared with adults). When properly treated, children are generally expected to improve and often can recover in episode-based care and may avoid relapse or deterioration (whereas adult treatment is more often focused on managing chronic conditions). VBP is one way in which MCOs can promote the delivery of effective behavioral health services to children.

Improve Understanding of Beneficiary Experience

DHCF and the MCOs should jointly develop an enhanced understanding of "beneficiary experience" that encompasses family-reported and youth-reported information in order to gain insight into the experience that children and youth are having. This will require improvements regarding measurement of the child, youth

and family experience, and data collection methods. DHCF should require MCOs regularly report on results of enrollee surveys and measures based on key dimensions of the beneficiary experience, with a specific view to whether the needs of children, youth, and families are being adequately served. These data, specific to children and families, could be incorporated into already-existing reports on beneficiary experience required by DHCF.

Require Uniform Standards for Data Collection

DHCF should require MCOs to adopt uniform standards for data requests and provide a standard format and process of data collection to be used by all MCOs and providers. The data reported by MCOs should include metrics specifically targeting children, youth, and families, including dollars per child spent on behavioral health services and service utilization rates for children. Public reporting about collected metrics should be frequent enough – perhaps quarterly – for DHCF, MCOs, provider organizations, and members of the public to call for a change of course if performance appears to be falling short. Clear, comprehensive, and uniform data reporting is essential to holding both MCOs and providers accountable for providing quality behavioral health care services to children and youth.

Conclusion

When facing behavioral health problems, early intervention and effective treatment are essential to reducing symptoms, improving independent function without

psychosocial supports and improving children's wellness. To do this successfully, DHCF must ensure children, youth, and families have access to the services they need when they need them. Accordingly, DHCF should take the opportunities provided by the planned transition to a fully managed Medicaid program to address existing challenges to delivering high quality behavioral health care services to children, youth, and their families.

Thank you for the opportunity to testify. I look forward to answering any questions you 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] Department of Health Care Finance, *FY2018 Performance Oversight Responses*, response to Q31. *Retrieved from*: https://dccouncil.us/wp-content/uploads/2019/04/dhcf.pdf.

[3] 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-and-their-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-public-behavioral-health-care-system). This past month, 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/resource/Addressing-Children-Behavioral-Health-Needs-Through-Changes-to-DC-Medicaid-Program). My testimony today largely follows this paper. Moving forward in 2020, our organizations will 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.

[4] We use the term "behavioral health" to refer to emotional and mental health as well as substance use and addiction. This term encompasses a continuum of promotion, prevention, early intervention, treatment and recovery support services. We also acknowledge that learning, intellectual, or developmental disabilities may impact individuals' abilities to function at school, at home, and in the community, and these complex issues often drive families to seek behavioral health assessment and ongoing treatment.

[5] Sharra E. Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (Jan. 31, 2020), a*vailable at:* https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/Children%27s%20Law%20Center%202020%20Performance%20Oversight%20Testimony%20for%20DBH%20-%20SG%20testimony%20v2.pdf; Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (Nov. 20, 2019), *available at*: https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/FINAL%20Children%27s%20Law%20Center%20Testimony%20for%20Nov.%2020%202019%20DBH%20Oversight%20Hearing.pdf; Sharra E. Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (Feb. 23, 2018), *available at:* https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/Childrens%20Law%20Center%20DHCF%20Final.pdf; Sharra E. Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (Feb. 23, 2017), a*vailable at:* https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/CLC%20Testimony%20--%20Department%20of%20Behavioral%20Health%202017%20Oversight.pdf; Sharra E. Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health and Human Services, (Feb. 4, 2016) *available at:* https://www.childrenslawcenter.org/sites/default/files/attachments/testimonies/CLC%20Testimony%20--%20Department%20of%20Behavioral%20Health%202016%20Oversight.pdf.

[6] Centers for Medicare and Medicaid Services, *Early and Periodic Screening, Diagnostic and Treatment*. *Available at:* https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

[7] Manatt Health, *Keeping Medicaid's Promise: Strengthening Access to Services for Children with Special Healthcare Needs*, Oct. 2019. *Available at*: https://www.manatt.com/Manatt/media/Documents/FINAL-Keeping-Medicaid_s-Promise-Issue-Brief-10-01-19.pdf.

[8] Department of Health Care Finance, *DHCF Announces Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts*, Sept. 11, 2019. *Available at*: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[9] 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/.

[10] 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.
[11] It is crucial that DC pays particular attention during this transition to the thousands of children who have moved through the child welfare system in the District, who historically have been placed in the FFS program. These children often encounter further barriers to effective treatment and recovery due to lack of care coordination and wraparound support as they transition between homes, caregivers, providers, and services. *See* National Technical Assistance Center for Children's Mental Health, *Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers and Recommendations,* May 2014, "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," *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf; *and* Child and Family Services Agency, Preventative and Ongoing Healthcare Policy (Sept. 1, 2011) "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," *available at:* 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.
[12] Department of Behavioral Health, *FY2019 Performance Oversight Responses*, responses to Q19. *Available at*: https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf. Mental Health Rehabilitation Services (MHRS) regulations governing certification standards for Core Service Agencies (CSAs) require that CSAs provide consumers with an intake appointment within seven business days of the initial referral. §22-A D.C.M.R. §3411.5(f).
[13] Department of Behavioral Health, *FY2019 Performance Oversight Responses*, response to Q44. *Available at*: https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf.
[14] Centers for Disease Control and Prevention, *Therapy to Improve Children's Mental Health*, (Sept. 26, 2019) *Available at*: https://www.cdc.gov/childrensmentalhealth/parent-behavior-therapy.html. "Mental, emotional, and behavioral disorders in childhood can cause long-term problems that may affect the health and well-being of children, families, and communities. Treating a child's mental health problems as soon as possible can help children reduce problems at home, in school, and in forming friendships. It can also help with healthy development into adulthood."
[15] D.C. Code § 7-1203 (2001).
[16] DC Health Matters Collaborative, *Community Health Needs Assessment*, June 2019, "Specifically, participants perceived a shortage of psychiatrists (particularly pediatric psychiatrists), child psychologists, drug and alcohol abuse counselors, and fully licensed therapists." *Available at:* http://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf.
[17] U.S. Department of Health and Human Services, *Mental Health: A Report from the Surgeon General,* p.123, 1999, "...it is important to underscore the often heard admonition that 'children are not little adults.' Even more than is true for adults, children must be seen in the context of their social environments, that is family, peer group, and their larger physical and cultural surroundings." *Available at:* https://archive.org/stream/mentalhealthrepo00unit/mentalhealthrepo00unit_djvu.txt.
[18] WAMU, *D.C. Lacks Mental Health Providers, Especially for Youth,* June 25, 2019, "[Director of the Child Health Data Lab at Children's National Health System] Chaya Merrill says there are long wait times to

see the few trained mental health providers that specialize in youth." *Available at:* https://wamu.org/story/19/07/25/d-c-lacks-mental-health-providers-especially-for-youth/.

[19] For children, any medically necessary services should be covered under Medicaid because of EPSDT. Children's behavioral health needs are different from those of adults and require broader coverage accordingly. Compensating for these needed services will help support network adequacy for children.

[20] National Council for Behavioral Health, *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, Oct. 10, 2018, "There must also be a better understanding of the real cost of delivering mental health care and related reimbursement rates, which typically cover only a small portion of care. This is critical to help attract new providers into the field and more must be done to train and retain providers to help ensure people can get help when they need it." *Available at:* https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/.