DISABILITY RIGHTS DC
at University Legal Services

Written Testimony of Disability Rights DC at University Legal Services

Before the Council of the District of Columbia
Committee on Health

Fiscal Year 2017 Agency Performance Oversight Hearings
Department of Behavioral Health

Good morning, Chairperson Gray and Committee Members. Thank you for this opportunity to testify. My name is Lyndsay Niles. I am a Staff Attorney at Disability Rights DC at University Legal Services ("DRDC"), the designated protection and advocacy program for people with disabilities in the District of Columbia. Under our federal mandate, DRDC advocates on behalf of hundreds of D.C. residents with mental illness each year, including children and youth with serious emotional disturbance who need intensive community-based services and intensive care coordination to remain in their homes and communities and avoid institutionalization.

My testimony will focus on DRDC's concerns regarding the following issues: (1) inadequate provider capacity to meet the high demand for behavioral health services for children and youth, (2) the state of high fidelity wraparound in D.C., (3) the lack of continuity of care for consumers in institutions, and (4) issues with DBH's process of developing medical necessity criteria.

Shortage of DBH Providers

We know the demand for behavioral health treatment for children and youth is high. In fiscal year 2016, 101,359 children and youth under 21 were enrolled in the District's Medicaid

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Program.[1] Approximately 20% of children (or more than 20,000 children on DC Medicaid) have a diagnosable mental health disorder.[2] And it is estimated that 10% of children (or more than 10,000 children on DC Medicaid) experience serious mental health challenges that are severe enough to impair how they function at home, in school or in the community.[3] Yet by DBH's most recent count, only 4,567 children (ages 0-17) received at least one mental health service in fiscal year 2016 from the public mental health system.[4] Based on this data, over 5,000 Medicaid-eligible children who need intensive mental health services are likely not receiving them.

We appreciate DBH's willingness to meet with DRDC monthly to collaborate regarding systemic problems children and families face within the mental health system. Because the unmet need for children and youth with behavioral health needs is significant, an adequate number of providers to meet the level of need is essential to help ensure positive outcomes. Unfortunately, there is an inadequate number of providers to meet the level of need for Medicaid-eligible children with significant mental health needs in the District's behavioral health system.[5] In addition, a number of Core Service Agencies (CSAs) and specialty providers of

[1] DHCF FY16-17 Performance Oversight Responses, Q39.
[2] President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, available at http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html; The Georgetown University 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," 13 (May 2014), available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf.
[3] *Id.*
[4] Department of Behavioral Health, "Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)," January 15, 2017, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202017_0.pdf.
[5] The Georgetown University 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,

intensive, in-home services for youth have either closed their doors or reduced the quantity of their service array in fiscal year 2017.

Multiple behavioral health providers for youth have ceased providing services in the past eight months. In June 2017, Youth Villages, the only specialty provider in DC for multi-systemic therapy ("MST")[6], closed. Before this Council, then District Manager for Youth Villages testified that it closed because of the longstanding rate structure issues with DBH.[7] In fiscal year 2016, 156 children and youth (0-17) were receiving MST.[8] Recently, providers reported at the DBH Children's Roundtable Meeting that several provider agencies are reluctant to become an MST provider because they have concerns that MST is not financially viable in DC because DBH does not fund MST through provider contracts. In September 2017, Family Matters of Greater Washington ("Family Matters"), a CSA, community-based intervention

Barriers, and Recommendations," 36 (May 2014), available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf; DC Action for Children, D.C. Kids Count Data Snapshot, "Children's Mental Health in D.C.: The Mismatch Between Need and Treatment," 2 (May 2012), available at https://www.dcactionforchildren.org/sites/default/files/Snapshot-MentalHealth%20FINAL.pdf.

[6] MST is an evidence-based, intensive family-and community-based treatment program for youth with behavior-related challenges or a history of juvenile justice involvement that focuses on all environments that impact the at risk youth – their homes and families, schools and teachers, neighborhoods and friends. MST is considered a community-based Intervention (CBI) Level I service that is provided by a DBH certified CBI Level I provider. DBH Policy 340.9, *Community Based Intervention (CBI) Services for Children and Youth*, at Exhibit 1-5a, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL148.pdf; MST Services, available at http://www.mstservices.com/.

[7] Testimony of Joe Goldsmith to the D.C. Council Committee on Health (June 5, 2017).

[8] Department of Behavioral Health, "Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)," January 15, 2017, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202017_0.pdf.

("CBI")[9] provider, and "Child Choice Provider" [10] for CFSA youth, closed similarly due to financial instability over the last four years.[11] On August 18, 2017, DBH notified Mental Health Rehabilitation Services ("MHRS") providers of the closure and that approximately 150 children and youth needed to transition from Family Matters to a new provider.[12] On August 25, 2017, DRDC attended Family Matters' Consumer Form, and an administrator at Family Matters reported that DBH billing limitations made it difficult to bill enough to sustain the work. The administrator also noted that this is a specific barrier in the District and is not an issue at Family Matters' Maryland office.

Thus far in fiscal year 2018, there is no evidence that provider capacity is improving. In November 2017, First Home Care, a CSA, CBI provider, and "Child Choice Provider", also abruptly closed due to financial problems. Although First Home Care completed a novation to their non-profit arm Foundations for Home and Community ("Foundations") to operate as a CSA, Foundations currently does not have the staff capacity to accept intakes for CBI, including the Functional Family Therapy ("FFT")[13] level of CBI. Before the novation, DYRS and CFSA

[9] CBI is defined as "[t]ime-limited, intensive mental health services delivered to children and youth ages six (6) through twenty-one (21) and intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. CBI is primarily focused on the development of consumer skills to promote behavior change in the child or youth's natural environment and empower the child or youth to cope with his or her emotional disturbance." D.C. Mun. Regs. tit. 22A § 3422.1; DBH Policy 340.9, *Community Based Intervention (CBI) Services for Children and Youth*, at 1.

[10] "Child Choice Provider" is defined as "a Mental Health Rehabilitation Service (MHRS) Core Service Agency (CSA) with a demonstrated ability to provide quality, evidence-based, innovative services and intervention to meet the most complex and changing needs of children, youth, and their families in the District, particularly those who have histories of abuse or neglect." D.C. Mun. Regs. tit. 22A § 3599.

[11] Family Matters provided a letter to consumers and providers at the Consumer Forum announcing the closure. *Letter from Tonya Jackson Smallwood to Family Matters Consumers* (on file with DRDC) ("The decision was made in late July due to financial strains we have been experiencing over the past four years.").

[12] Email from DBH to MHRS Providers, August 18, 2017 (on file with DRDC).

[13] FFT is an outcome-driven, evidence-based prevention/intervention program integrating clinical theory, home engagement, and sustaining strategies for at-risk youth who have a documented history of moderate to serious behavioral challenges which impair functioning in at least one area, such as the school or home. FFT is considered a community-based Intervention (CBI) Level IV service that is provided by a DBH certified CBI Level IV provider.

transitioned approximately 150 youth to other providers to help prevent gaps in services.[14] Foundations reported in December 2017 that approximately 240 children transitioned to Foundations, but others were referred elsewhere.[15]

These gaps negatively affect youth in crisis. One of those youth referred out by Foundations is a DRDC client who was transitioning from a Psychiatric Residential Treatment Facility ("PRTF") who was receiving CBI services from First Home Care prior to placement in the PRTF. In December 2017, the child's mother, who did not receive any discharge planning assistance from First Home Care, attempted to enroll her child at Foundations but was told that it was not accepting intakes because it did not yet have a clinical psychiatrist on staff. The parent enrolled her child with another CBI provider, however, the new provider has failed to provide timely, quality services. Specifically, the parent reports the CBI worker has failed, without explanation, to show up for two scheduled appointments in the home this month. Not only does this example highlight the gaps in care and lack of continuity of care, but also the lack of consumer choice[16] and the unnecessary loss of a familiar provider that the family had a trusting relationship with.

On February 8, 2018, DBH notified DRDC that Contemporary Family Services ("CFS"), one of the largest CSAs and a CBI provider, will cease operating as a MHRS provider as of April 8, 2018. DBH expects about 300 children and youth[17] will need to transition to other providers. DBH has not informed stakeholders and the community about why CFS will be closing as a

D.C. Mun. Regs. tit. 22A § 3599; DBH Policy 340.9, *Community Based Intervention (CBI) Services for Children and Youth*, at Exhibit 1-5a.

[14] Email from DBH to DRDC, November 9, 2017 (on file with DRDC).

[15] Foundations reported these enrollment numbers at the December 4, 2017 DBH Children's Roundtable Meeting.

[16] D.C. law gives consumers the right to have free choice in choosing their mental health provider. *See* D.C. Code § 7-1131.03.

[17] 1,600 adults will also need to transition to other providers.

provider in April. Similar to the prior abrupt provider closures, we are also concerned that the official closure date does not comply with DBH's provider closure policy because it is less than 90 days from the date of notification and is not enough time to ensure a smooth transition for CFS consumers to a provider of their choice.[18]

We urge the Council to investigate these provider closures, how DBH has handled the situation, and the impact of the closure on consumer outcomes and the capacity among the provider network to meet the behavioral health treatment demand. We also urge the Council to investigate whether these closings due to financial instability are related to low reimbursement rates, billing limitations, under-utilization of specialty services, or otherwise related to lack of incentives for qualified providers and mental health professionals to stay in the District. We also ask the Council to adopt the recommendations in Finding Eighteen of the Office of the District of Columbia Auditor (ODCA) report on the DC DBH and DC Justice System that 1) DBH develop more robust performance measures for CSAs and strengthen its oversight of them to ensure that they meet the performance measures and are financially stable and 2) that the Council provide more direct oversight of DBH's management of CSAs and other DBH-certified providers by, for example, scrutinizing the methodologies DBH uses to assess their performance, reviewing DBH's overall capability for supervising the performance and financial stability of its providers, and holding DBH accountable for its failure to identify and effectively respond to poor performance by CSAs and low consumer satisfaction.[19] Adoption of these recommendations will assist not only justice-involved consumers but all mental health consumers in ensuring that

[18] DBH Policy 115.7, *Provider Closure*, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/115.7%20TL-313.pdf.
[19] Office of the District of Columbia Auditor, "The D.C. Department of Behavioral Health and the D.C. Justice System", at Finding Eighteen (February 2018).

DBH provides adequate oversight of CSAs and adequate performance measures to ensure that CSAs are financially stable and providing quality services.

High Fidelity Wraparound Program

Intensive community-based services, directed and supervised by a child and family team whose work is facilitated through intensive care coordination, is also necessary to effectively support children and youth with significant emotional disabilities in their homes. This facilitation process or High Fidelity Wraparound ("wraparound") is an evidence-based practice that uses a specific process of individualized care planning for youth with complex needs and their families. It has proven to be an effective approach in many jurisdictions and the District, particularly with youth involved in multiple public care systems and/or youth at risk of or returning from placement in residential treatment, PRTFs, psychiatric hospitals, and other out of home placements. However, to be truly effective, wraparound needs to be expanded to a permanent, fully-funded program with capabilities to meet the needs of all eligible District youth. Unfortunately, wraparound is not reimbursable through MHRS and DBH only funds wraparound through local dollars to a small handful of youth, and its full potential has not been utilized. Only one Care Management Entity, MBI, provides intensive care coordination consistent with a "wraparound" approach directed by a child and family team. Only 94 children and youth[20], out of the hundreds or potentially thousands who need it, currently can receive wraparound from MBI. As of February 2018, of those 94 slots only 23 children and youth are assigned to the "wraparound" program.[21]

[20] 276 children and youth received wraparound services in fiscal year 2016. DBH FY16-17 Performance Oversight Responses, Q35, Q36.
[21] MBI reported these enrollment numbers at the February 2, 2018 DBH Children's Roundtable Meeting.

DBH has previously stated in prior oversight responses its commitment to working with DHCF and the MCOs to further examine the possibility of the wraparound program becoming Medicaid reimbursable. However, because of DBH's recent decision to significantly reduce the number of wraparound slots despite the high demand for intensive care coordination, we are concerned the District is moving backwards, creating barriers to accessing coordinated mental health services. We hope that City Council, in its oversight capacity, will monitor DBH's efforts to ensure that all eligible District youth can access high fidelity wraparound supports and that the 94 slots currently available are fully utilized.[22]

Lack of Continuity of Care for Consumers in Institutions

In fiscal year 2017, DBH instituted new medical necessity criteria which severely restricts discharge planning services and supports provided by CSAs to DBH consumers in institutional settings, including Saint Elizabeths Hospital, jails, prisons, and halfway houses though an MHRS Bulletin.[23] The bulletin states that DBH consumers can only receive discharge planning services from their CSAs within 30 days of discharge from Saint Elizabeths Hospital and within 60 days of discharge from the DC Jail. Last year, DRDC testified about the harmful impact of this proposal which has now become DBH practice. In our experience working with consumers in Saint Elizabeths Hospital and the D.C. Jail it takes more than 30 or 60 days to assist consumers with discharge planning which involves putting crucial services into place prior to discharge such as, applying for housing, benefits, and coordinating services in the community. DBH's bulletin is also contrary to its own continuity of care practice guidelines for adult mental

[22] Because of the high demand for wraparound, we recommend that DBH evaluate why the 94 slots are under-utilized and determine whether DBH needs more robust outreach and technical assistance to community providers, psychiatric hospitals, PRTF providers, stakeholders, and families.
[23] MHRS Bulletin No. 111 dated February 22, 2017.

health providers which require CSAs to meet with consumers at Saint Elizabeths Hospital at least monthly, attend all treatment team meetings and develop discharge planning with the consumer and staff.[24]

For consumers at Saint Elizabeths Hospital, DBH contends that the social workers employed there can effectively assume the responsibilities of CSAs and assist consumers with the discharge planning process. This position, however, neglects the importance of continuity of care for consumers in institutions, consumers maintaining and building trust and relationships with their providers in the community for a successful transition to the community, and the role of CSAs in gradually introducing consumers back to the community after long periods of institutionalization. Further, the DC Auditor's report illustrates that Saint Elizabeths Hospital social work staff assuming the discharge planning and transitional services workload of CSAs comes at the expense of clinical treatment at the Hospital since social workers are no longer involved in providing clinical interventions to consumers.[25]

We urge DBH to rescind the MHRS Bulletin as it conflicts with DBH policy and with DC law which requires DBH to make any changes to medical necessity criteria through the rule-making process as discussed in more detail below. In addition, we ask DBH and the Council to adopt the Auditor's report recommendation in Finding Twenty that 1) "DBH immediately increase the amount of time for which CSAs may bill for discharge planning from inpatient care or incarceration. These increases should reflect the realities involved with discharge planning in the District and 2) that, even when increased, discharge billing restrictions be considered for

[24] DBH Policy 200.2B, *Continuity of Care Practice Guidelines for Adult Mental Health Providers*, at 11–12, available at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL178.pdf.
[25] Office of the District of Columbia Auditor, "The D.C. Department of Behavioral Health and the D.C. Justice System", at Finding Twenty (February 2018).

extension on a case-by-case basis to ensure that individuals with more complicated situations are eligible for the same quality of discharge planning as other consumers."[26]

Medical Necessity Criteria

In fiscal year 2017, DBH also announced plans to develop medical necessity criteria for behavioral health services including community support, day treatment and crisis bed services. Stakeholders shared several concerns about DBH's process of developing the criteria including the lack of meaningful stakeholder engagement in developing the criteria, whether the criteria was developed based on evidence-based and best practices, and whether DBH would follow the proper process and issue the criteria through the rulemaking process. In December 2017, the Council addressed the concerns of stakeholders and passed the Medical Necessity Review Criteria Emergency Amendment Act of 2017 which requires changes to medical necessity be through rule-making. However, in a forum about medical necessity criteria in December, after the Council passed the act, DBH focused their discussion on the system procurement process for a system that will manage medical necessity criteria, as opposed to ensuring that the criteria is first developed and finalized through the rule-making process. Additionally, DBH must develop regulations to require written and timely notice regarding a denial or change in services, appeal rights to challenge medical necessity decisions, and the right to receive benefits pending appeal.[27]

Further, DRDC and other stakeholders are concerned that implementation of medical necessity criteria may result in the termination of mental health services including community support services for many consumers and that consumers who do not qualify for community

[26] *Id.*
[27] D.C. Code § 4-205.55.

support will have little to no options for receiving other mental health services. DBH needs to ensure that it has a proper array of services across all levels of care prior to proposing medical necessity criteria. Currently, DBH does not offer a lower level of care than community support. Therefore, consumers who are denied community support services have little to no options for receiving other mental health services. Although DBH is taking steps to address this by starting the process of transferring regulation of Free Standing Mental Health Clinics from the Department of Health Care Finance to DBH's array of services, the process will be lengthy. Further, DBH should ensure that it also offers robust peer support services and explores other supports that it can offer to ensure that consumers have access to a broad spectrum of mental health services.

Thank you for the opportunity to testify. I am happy to answer any questions.