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Testimony before the District of Columbia Council

Committee on Health

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Performance Oversight Hearing

Department of Health Care Finance

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Good morning Chairman Alexander and members of the Committee on Health. My name is Rebecca Brink. I am a Senior Policy Attorney at the Children's Law Center[1] (CLC) and a resident of the District. I am testifying today on behalf of CLC, the largest non-profit legal services organization in the District and the only such organization devoted to a full spectrum of children's legal services. Every year, we represent over 2,000 low-income children and families, focusing on children who have been abused and neglected and children with special health and educational needs. Almost every one of our clients is a Medicaid recipient.

I appreciate this opportunity to testify regarding the performance of the Department of the Health Care Finance (DHCF) over this past year. Over 92,000 children and youth under 21 are enrolled in the District's Medicaid program.[2] A properly functioning Medicaid system is not only vital for ensuring the health of DC's children, but it is also the backbone of our early intervention, mental health and child welfare systems -- providing the services that ensure children reach developmental milestones, aid their academic achievement and reduce their stay in foster care.

Notable Progress

Under Director Turnage's leadership, the Department has made some progress this year in some key areas. DHCF has been working with other District agencies to expand service delivery and maximize federal revenue. DHCF has made some notable progress billing for school based health services, child welfare clinic-based services, and special education transportation services. For many years these services were not able to be properly billed to Medicaid and there as much discussion about the need to create a single billing system, called an Administrative Service Organization (ASO). For years each public agency - Child and Family Services Agency (CFSA), the District of Columbia Public Schools (DCPS) and the Office of the State Superintendent of Education (OSSE) -- have had their own systems for claims submission, provider enrollment, and administrative claiming as it relates to Medicaid.[3] Not only did this deter good providers from accepting DC Medicaid, it also resulted in the District failing to maximize federal reimbursement. [4] One billing agency would help solve these problems and also allow the Council, and the public, to hold one entity firmly responsible for

ensuring the billing process runs smoothly and efficiently. After several years of delays,[5] the Department now reports the ASO is currently working CFSA, DCPS and OSSE, OSSE to process their Medicaid claims.[6] It is a positive sign that that these agencies are now billing for their services in a manner which allows the District to maximize our federal Medicaid dollars in a responsible way.

While billing practices for sister agencies have improved, CFSA is still not billing Medicaid for its Targeted Case Management Services because the State Plan Amendment that would allow this billing to occur is still under review by the Center for Medicare and Medicare Services (CMS).[7] This State Plan Amendment was submitted May 2010[8] and it is unclear why it is taking so long for it to be approved. We hope this SPA will be approved in the upcoming months and the District can also begin billing these services to Medicaid.

The Department has also made steady progress in working with OSSE to ensure its Early Intervention Program, which provides services to young children with disabilities and developmental delays, is properly utilizing Medicaid providers.[9] Although many of the services these young children require are technically part of the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit package available to children on Medicaid,[10] without the proper structure and payment mechanisms these services are not functionally available. DHCF is now working in conjunction with OSSE to strengthen this program and develop regulations for how Medicaid's fee-for-service program will pay for early intervention services.[11]

We are pleased one of the Department's initiatives (DHCF FY13 Performance Plan, Initiative 1.8) is to increase physician's awareness of the breadth of EPSDT services. The District's HealthCheck Provider Education System (http://www.dchealthcheck.net) has an increasing number of valuable tools on it for providers, including a recently expanded section on developmental and behavioral health. Early identification and treatment of mental health problems is critically important and pediatricians are ideally situated to screen children for mental health needs, provide basic mental health care and refer children to mental health clinicians when the child's condition warrants such a referral. We look forward to partnering

with the Department to ensure the pediatric community is best able to comply with EPDST's requirements to screen and treat children for behavioral health needs. This will involve providing pediatricians with tools, training and appropriate reimbursement.

Key Challenges Remain

Despite the notable progress DHCF has made there is still much work to be done to ensure that our Medicaid system is functioning optimally, particularly when it comes to children's mental health. While it is difficult to assess exactly how many children insured by Medicaid are receiving mental health services and how promptly they receive services, the measures we do have are not encouraging.[12] In the most recent year for which we have data (FY09 to FY10), there was a 16% decline in the percentage of children who received mental health treatment solely through MCOs.[13]

Given this backdrop, I will focus today on the two highest priorities for children. First, we must fix the fragmented mental health system which makes it difficult for quality community-based mental health providers to serve children and thus results in more children being removed from their families or hospitalized. Second, we must improve the system for providing oversight and accountability to the MCOs.

Make the System Attractive for High-Quality Providers

Our Medicaid funded mental health system for children remains too fragmented and difficult to navigate for both families and providers. There are three MCOs – several of which are likely to switch in May -- fee-for-service Medicaid and a separate system overseen by DMH. MCOs are responsible for providing office-based mental health services, such as counseling or family therapy. However, for children diagnosed with severe mental illness and who need more intensive in-home therapies, the responsibility for providing those intensive services shifts to the DMH and the payments shift directly to Medicaid. DMH uses a network of Core Service Agencies to provide their mental health services. To complicate matters, children who are enrolled in an MCO switch to fee-for-service Medicaid if they enter the foster care system, which makes maintaining continuity of services all the more difficult.

To be reimbursed through Medicaid for providing mental health treatment to children, providers must be credentialed with multiple entities. To treat all children within DC's Medicaid system, providers must credential separately with each of the MCOs and be licensed by DMH as a free-standing mental health clinic and as specialty provider. To offer these children a full continuum of care requires a provider to credential with at least seven and up to eleven payers.[14] On top of this, the credentials must be renewed annually.[15] Meeting these requirements is a time-consuming process and is often cited by providers as the reason they will not accept DC Medicaid. This leads to a shortage of providers, resulting in many children failing to get important mental health treatment or facing long delays that impair their health.

The credentialing process must be streamlined so that it is easier for providers to work with this host of entities and serve all children on Medicaid—who encompass the majority of DC's children. The new MCO contracts may make the credentialing process easier. The Department worked with the Department of Mental Health to include new language in the Request for Proposal (RFP) that was used to solicit bids from the MCOs regarding the MCOs responsibilities in terms of behavioral health, including requirements which should make it easier for mental health providers who are already credentialed with DMH to become part of the managed care organizations' networks.[16]

Improve Oversight and Accountability of the MCOs

Currently data on utilization and network sufficiency for children's mental health is not readily available. Without this data being available and regularly reviewed neither the Department nor the Council can ensure the MCOs are fulfilling their obligations. The RFP also sets forth many things that the MCOs may be required to track and report on – for example, that the MCO comply with all reporting requirements related to DHCF's monitoring of the child health component of the Medicaid program, called the EPSDT benefit.[17] The contracts must retain this language and MCOs must be held accountable by DHCF and this Council. The MCOs are receiving millions of taxpayer dollars and caring for some of our most vulnerable children. We urge the Council and DHCF to regularly obtain and publish detailed utilization

data from the MCOs regarding mental health services to children and to come up with an action plan on how to ensure all children receive appropriate, timely treatment.

In conclusion, we applaud DHCF for the positive steps they have taken to improve the Medicaid program and we look forward to working with them to ensure all children receive timely, high-quality care. Thank you for the opportunity to testify. I am happy to answer any questions.

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[1] Children's Law Center works to give every child in the District of Columbia a solid foundation of family, health and education. We are the largest provider of free legal services in the District and the only to focus on children. Our 80-person staff partners with local pro bono attorneys to serve more than 2,000 at-risk children each year. We use this expertise to advocate for changes in the District's laws, policies and programs. Learn more at www.childrenslawcenter.org.

[2] 92,720 totally individuals are eligible for EPSDT services. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Form 416 Annual EPSDT Participation Report, FY 2011 (most recent available).

[3] Department of Health Policy at George Washington University and Health Management Associates, Improving Medicaid: Assessment of District of Columbia Agencies' Claims Processes and Recommendations for Improvements in Efficiency and Customer Service, 3, 4 (November 21, 2008).

[4] Department of Health Policy at George Washington University and Health Management Associates, Improving Medicaid: Assessment of District of Columbia Agencies' Claims Processes and Recommendations for Improvements in Efficiency and Customer Service, (November 21, 2008).

[5] DHCF's responses to the Health Committee FY09 Oversight Question, Question 39. In 2008, DHCF said it hoped to have an ASO in place by October, 2009. In October 2009, DHCF did select a vendor but the contract was under review for many months at the Office of Contracts and Procurements.

[6] DHCF's responses to the Health Committee's FY12 Oversight Questions, Q32.

[7] DHCF's responses to the Health Committee's FY12 Oversight Questions, Q73. The State Plan Amendment is still under review by CMS. CMS recently sent DHCF a new set of questions, which DHCF and CFSA are working to respond to.

[8] DHCF's responses to the Health Committee's FY11 Oversight Questions, Q40. The State Plan Amendment (SPA) was submitted in May 2010. In November 2010, CMS transitioned the SPA to a formal Request for Additional Information (RAI) status and asked the DC government for more information. DHCF worked with CFSA to resubmit the SPA.

[9] DHCF's responses to the Health Committee's FY12 Oversight Questions, Question 58.

[10] DHCF's responses to the Health Committee's FY11 Oversight Questions, Question 55.

[11] A notice of proposed rulemaking regarding Medicaid reimbursement for early intervention services is under legal sufficiently review. DHCF's responses to the Health Committee's FY12 Oversight Questions, Question 58.

[12] District of Columbia Behavioral Health Association, *Missing Measures: Utilization & Timely Access for Child Mental Health Services* (February 26, 2013).

[13] Among beneficiaries treated solely through managed care, and not also through DMH's MHRS system, the number of children served shrank by 16% from FY2009 to FY2010. Medical Care Advisory. Committee, Behavioral Health Subcommittee, FY2011 Year-End Report & Recommendations, 3 (April 18, 2012). DMH nor DHCF have reported this data since FY2010. District of Columbia Behavioral Health Association, *Missing Measures: Utilization & Timely Access for Child Mental Health Services (February 26, 2013).*

[14] District of Columbia Behavioral Health Association, *Towards a True System of Care: Improving Children's Behavioral Health Services in the District of Columbia, Part 2 of 2* (2009).

[15] DC Behavioral Health Association, *Memo to the DC Council Committee on Health on the South Capitol Street Memorial Tragedy Act, Section 606: Credentialing of Behavioral Health Providers* (2011).

[16] Department of Health Care Finance, *Request for Proposal for Managed Care Organizations*, C.8.2.8, 89 (2012).

[17] Department of Health Care Finance, *Request for Proposal for Managed Care Organizations*, C.6.10.1.1, 70 (2012).