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Testimony Before the District of Columbia Council
Committee on Health and Human Services
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Performance Oversight Hearing

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Introduction

Good morning Chairman Alexander and members of the Committee. My name is Rebecca Brink. I am a Senior Policy Attorney at 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 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 8 children in DC's poorest neighborhoods – more than 5,000 children and families each year. Almost every one of our clients is a Medicaid beneficiary.

I appreciate this opportunity to testify regarding the performance of the Department of the Health Care Finance (DHCF) over this past year. As you know, DHCF is the Medicaid agency for the District. Over 98,000 children and youth under 21 years of age were enrolled in the District's Medicaid program in FY14.[2] A properly functioning Medicaid system is not only vital for ensuring the physical and mental health of DC's children, but it is also the backbone of our early intervention and child welfare systems -- providing the services that ensure children reach developmental milestones, aid their academic achievement and reduce their stay in foster care. While the District's Medicaid program is improving, there remains a great deal of work to be done to ensure all our children have access to easily accessible, timely services that support their health and development.

Under Director Wayne Turnage's leadership, the Department has made impressive progress this year in some key areas and, under the direction of Lisa Truitt the Health Care Delivery Management Administration is poised to do important work this year, particularly around improving quality outcomes.[3] Her team has shown the ability to delve deep, identify barriers and come up with strategies for improvement. We look forward to working with them this year to improve care for children.

In my testimony today, I will highlight three main areas where we see a great deal of progress and, at the same time, the need and opportunity to keep the momentum going in order to improve the health of the District's children:

1) The increased oversight of the MCOs;
2) Improving children's utilization of mental health services and having accurate data by which to measure progress;
3) Improving the integration of children's health.

Increased Oversight of the MCOs

MCO Spending on Behavioral Health Services has Improved and More Children Are Receiving Services

In FY2014, DHCF initiated a comprehensive review process to assess and evaluate the performance of the MCOs. Over the last year, DHCF has released quarterly performance reports of the MCOs to address issues including the MCOs' financial health, their ability to meet the administrative requirements for plan

management, each plans' medical and mental health spending across various health service categories, whether members are accessing primary care and care coordination, and to what extent members are using emergency rooms for non-emergency purposes.[4] This level of oversight and transparency has been a welcome improvement and led to some important changes.

Last year, DHCF categorized the MCOs' medical spending for behavioral health services as "negligible."[5] But, over the course of the year, with increased pressure from DHCF to increase their spending in this area, the plans have done so. The *End of the Year Performance Report* (released in February 2015 and covering the time period of July 2013-June 2014) shows that the MCOs are spending an average of $10.94 per child per month on behavioral health services. [6] When this number was first reported in February 2014 it was only $6.25.[7]

Of course, while an increase in the amount of money the plans are spending on mental health is a great sign, what we really want to see is that more children are receiving services and, ultimately, that these children's health is improving. Early reports are showing that more MCO member have received mental health services in recent months which is a very encouraging sign.[8] We congratulate DHCF and the MCOs for the progress they have made so far and look forward to working with them to continue to delve into this data more fully in coming months.

Care Management is Still Lacking

None of the three health plans have established robust case management or care coordination systems. Per the contract, each MCO is required to have "intensive care coordination services for enrollees with multiple, complex or intensive health care problems that require frequent and sustained attention."[9] None of the MCO has enrolled more than five percent of their membership into a program of case management.[10] We are pleased that DHCF is putting such an emphasis on improving case management. The Division of Quality and Health Outcomes plans to implement a comprehensive case management program for the MCOs that aims not only to increase the number of beneficiaries receiving the service, but also to improve the quality. The program will include education and training for case managers, consistent standards of service and performance outcomes.[11]

For years Children's Law Center clients have struggled due to lack of meaningful case management at the MCOs. For parents of children with intense health needs, and especially those trying to navigate the complex mental health system, it is often impossible to obtain proper treatment without assistance. We look forward to working with DHCF and the MCOs on this new, improved case management system.

Improving Children's Utilization of Mental Health Services and Ensuring Accurate Data by Which to Measure Progress

Ninety percent of children on Medicaid receive their care through one of the three major MCOs - AmeriHealth DC, MedStarFamily Choice, and Trusted Health Plan -- or through Health Services for Children with Special Needs (HSCSN) which serves disabled children up to age 26.[12] In addition to providing care for their beneficiaries' physical health needs, the MCOs are also responsible for providing office-based mental health services. 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 Department of Behavioral Health's (DBH) provider network and the payments shift directly to DHCF. Unfortunately, even though both the MCOs and DBH have been providing mental health care to the same group of children and families for many years, there has been insufficient coordination between them. This has resulted in many complications for providers and, ultimately, made it difficult for children and families to obtain services.

The complexity of the system also makes it quite difficult to get a comprehensive and clear picture of what mental health services children are receiving. As I mentioned at the oversight hearing for DBH, that Department only reports on the number of children being served through its Mental Health Rehabilitation Services (MHRS) system; DBH doesn't report any data or outcomes about the children who receive

services through a Medicaid managed care organization (MCO). DHCF has increased its efforts to offer a more robust picture of what mental health services various groups of children are receiving. But, the data both agencies currently report leaves us with a complicated and, at times, contradictory, understanding of how many children are receiving what services. One example:

- DBH reports that during FY14 5,009 children (age 0-20) received a service through MHRS.[13]
- DHCF reports 8,156 children (age 0-20) received a service from MHRS during FY14.[14]

We applaud DHCF for producing all of these reports. But we encourage them to work with DBH to ensure these reports are consistent with each other, and more easily understandable to a wider audience.

Integration of Primary Care with Developmental, Behavioral and Oral Health Care

Another area where we see much progress is in the Department's initiative regarding improving the integration of children's health. The Children's Division, under the leadership of Associate Director Colleen Sonosky, has set forth an improved plan for integration of primary care with developmental, behavioral and oral health care. Through the DC Collaborative for Mental Health in Pediatric Primary Care, a public/private partnership including Children's Law Center, Children's National Health System, American Academy of Pediatrics, Georgetown University, DBH, DHCF

and the Department of Health, we have been working along with DHCF on the behavioral health aspect of this integration project. One of the main goals of this project is to ensure that pediatricians are screening children for mental health needs using standardized screening tools. DHCF staff has been part of an interdisciplinary group that selected appropriate screening tools and established an Improvement Learning Collaborative to train pediatricians on how to properly implement the mental health screenings. Through the leadership of Children's National, almost 150 pediatricians and their staff (representing 75% of children on Medicaid) participated in a nine-month learning collaborative where they learned about a variety of mental health topics and how to implement the new screening tools.[15] Round two of the learning collaborative is now underway. Pediatricians are now well-prepared to ensure children's mental health issues are detected as early as possible.

On October 1, 2014 DHCF implemented new rates and billing requirements associated with well-child visits.[16] Per the Early and Periodic Screening, Diagnostic and Treatment (EPDST) benefit and the District's periodicity schedule, children receive many different services during a well-child visit. The District's former billing practices didn't allow DHCF to confirm that all the components of the well-child visit were performed. With the new billing requirements in place, DHCF will be able to better confirm what services children are receiving and track how many children are receiving various components of a well-child visit (e.g., a mental health screen). These new rate

and billing requirements are a great step forward in ensuring that all children receive the appropriate screenings. Of course, screening is just a first step; ultimately, we also need to ensure that once a child screens positive for having a mental health problem, he or she is easily connected to appropriate follow-up treatment. There remains much work to be done in fully implementing these requirements and we look forward to partnering with DHCF in this work.

Conclusion

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 easily accessible, 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 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 be the voice for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 8 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] Data analysis by John Wedeles, Acting Director, Division of Analytics and Policy Research, Department of Health Care Finance (February 2015). Total number of Medicaid beneficiaries for FY14 aged 0-20 is 98,476. Chart on file with CLC.

[3] Department of Health Care Finance FY14 Oversight Responses, Question 24. Health Care Delivery Management Administration, Objective 2, Initiative 2.1.

[4] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014) (Feb 2015).

[5] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013), 17 (Feb 2014).

[6] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014), 51 (Feb 2015).
[7] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013), 43 (Feb 2014).
[8] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014), 48-50 (Feb 2015).
[9] Managed Care Organization Contract C.1.3.31, 6 (2013).
[10] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014), 20 (Feb 2015).
[11] Department of Health Care Finance FY14 Oversight Responses, Question 24. Health Care Delivery Management Administration, Objective 2, Initiative 2.2.
[12] Colleen Sonosky, Division of Children's Health Services, Department of Health Care Finance, Integrating EPSDT/Primary Care with Developmental, Behavioral and Oral Health Care, Presentation to the HHS Monthly Cluster Meeting (Jan. 30, 2014).
[13] Department of Behavioral Heath FY14-15 Oversight Responses, Question 84.
[14] Department of Health Care Finance FY14 Oversight Responses, Question 54.
[15] Department of Behavioral Health FY14-15 Oversight Responses, Question 45.
[16] Department of Health Care Finance FY14 Oversight Responses, Question 50, Attachment 1.