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Testimony before the District of Columbia Council

Committee on Health

April 19, 2012

FY13 Budget and Oversight Hearing: Department of Health Care Finance

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Good morning Chairman Catania and members of the Health Committee. My name is Judith Sandalow. I am the Executive Director of 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 more than 1,200 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 Health Care Finance (DHCF) over this past year and the Agency's FY13 budget. Over 91,000 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.

We are pleased that the Department's budget has been increased for FY13 and that there is a small increase in the Children's Health Services budget.[3] It is also encouraging to see a small increase in DHCF's local budget set aside for covering Early Intervention (Part C) services for children birth to three with developmental delays.[4]

Over the past year, DHCF has made some notable progress. Last Spring, Director Turnage created the Division of Children's Health Services and appointed a capable Associate Director, Colleen Sonosky. DHCF and the Department of Mental Health (DMH) are working together well to ensure that more services for children are billable to Medicaid. Functional Family Therapy, a new evidence-based practice, became Medicaid-reimbursable in October 2011 and the agencies are exploring how to seek Medicaid reimbursement for the other evidence-based practices (Trauma-

Focused Cognitive Behavioral Therapy, Child Parent Psychotherapy for Family Violence and Multi-Systemic Therapy for Problem Sexual Behavior).

DHCF is also working with the Office of the State Superintendent of Education's (OSSE) Early Intervention (Part C) program to improve the availability of Medicaid services to young children with disabilities and developmental delays. Although these services are technically part of the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit package available to all children on Medicaid,[5] without the proper structure and payment mechanisms these services were not actually available to all children. DHCF is now working in conjunction with OSSE to develop regulations for how Medicaid's fee-for-service program will pay for early intervention services and to enroll providers into the Medicaid system.[6]

Despite the notable progress DHCF has made, there is still much work to be done to ensure that our Medicaid system is functioning optimally. I will focus today on the two highest priorities for children: First, fixing the fragmented mental health system which makes it difficult for quality community-based mental health providers to serve children and thus has resulted in more children being removed from their families, hospitalized or incarcerated. Second, developing a system for providing oversight and accountability to the MCOs, whose failure to provide adequate preventive mental health services has been clearly documented**.**

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, fee-for-service Medicaid and a separate system overseen by DMH. MCOs are responsible for providing office-based mental health services, such as individual 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.

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 three 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.[7] On top of this, the credentials must be renewed annually.[8] 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 District should also conduct a comparability study to compare provider rates in the District to those in surrounding jurisdictions and adjust rates if necessary.

Improve Oversight and Accountability of the MCOs

The current system is not working for children and families. The District must either carve out mental health services from the MCOs completely or provide much stronger oversight of the MCOs.

One way to simplify the current system and improve children's access to care is to completely carve out mental health services from the MCOs. A carve-out is an arrangement in which mental health services are financed and administered separately from physical health services.[9] Two of the District's MCOs already carve out mental health services—Beacon Health Strategies is

the Managed Behavioral Health Care (MBHC) company for Chartered Health Plan and Optimum is the MBHC for United HealthCare Community Plan. The District's current system of several carve-outs, plus the separate DMH/MHRS system, would benefit from consolidation. The District could remove responsibility for mental health care from the MCO contracts completely and place all responsibility for mental health services either with DMH or with one specialty MBHC organization.[10]

If the solution to fix our children's mental health system includes the continued use of MCOs to provide mental health services, DHCF must develop a stronger mechanism for oversight and accountability. MCOs have an obligation to manage and provide patient care, including mental health services. Because comprehensive data is not gathered by the government and reported to the public, it is impossible to get a full understanding of how many children with mental health needs each MCO serves, what services the children receive, the size of the MCO networks and the credentials of the providers.

The statistics that are available raise significant concerns. A recent study supports the disturbing experience of parents and advocates: among children enrolled in the District's MCO for children with special health care needs, a substantial number with mental health diagnoses appear to have had no mental health treatment at all, including 74% of those with an emotional disturbance, 66% of those with pervasive developmental or adjustment disorders, 50% of those with depressive disorder, and 33% of those with an episodic mood disorder.[11]

In fiscal year 2010, the number of children receiving mental health treatment solely through the MCOs (and not also through MHRS) shrank by 16% compared to the number served in fiscal year 2009.[12] During the same period, the number of children receiving treatment solely through DMH rose by 31%.[13] Given the growth in DMH utilization numbers, the decline in MCO utilization numbers raises serious concerns.

Conclusion

In conclusion, we applaud DHCF for the positive steps they have taken to improve the Medicaid program and ensure all children receive timely, quality medical care. We look forward to seeing this good work continue. In the coming year we hope to see more children actually receiving service, a less fragmented system and better oversight of managed care organizations. We look forward to working with DHCF to achieve these goals.

Thank you again 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. As the largest nonprofit legal services provider in the District, our over 80-person staff partners with hundreds of pro bono attorneys to represent more than 1,200 at-risk children each year. Applying the knowledge gained from this direct representation, we advocate for changes in the city's laws, policies and programs. For more information, visit www.childrenslawcenter.org.

[2] 91,340 total individuals were eligible for EPSDT, the Medicaid benefit package for children under 21 in FY10, the latest year for which there is information available. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *Form CMS-416: Annual EPSDT Participation Report*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html .

[3] FY2013 DHCF Proposed Budget and Financial Plan, Preventive and Acute Care (2003), E-186

[4] FY2013 DHCF Proposed Budget and Financial Plan, Policy Initiatives, E-191. The local budget is increased by $315,000 and the corresponding change in federal Medicaid payments is an increase of $735,000.

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

[6] DHCF's responses to the Health Committee's FY11 Oversight Questions, Question 56. These new regulations only cover the approximately 10% of children in fee-for-service Medicaid program. The other 90% of children are enrolled in Managed Care Organizations (MCOs); the MCOs are supposed to already cover Early Intervention services. DHCF reports its managed care staff works with the MCOs to provide oversight and monitoring of their Early Intervention services.

[7] 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).

[8] 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).

[9] The Research and Training Center for Children's Mental Health, The University of South Florida, *Health Care Reform Tracking Project* 1 (2000).

[10] A carve-out uses "administratively or legally separate organizations to provide health care services for particular conditions, procedures, diseases or group of patients." Christine Ferguson et al., Department of Health Policy, School of Public Health & Health Services, The George Washington University, *Mental Health Carve Out Assessment* 7 (n.d.).

[11] RAND Health, *Health and Health Care Among District of Columbia Youth* 93 (2009). The study did not break down this data for children enrolled in the other Medicaid MCOs and this data does not seem to be otherwise publicly available.

[12] Behavioral Health Subcommittee, Medical Care Advisory Committee, *FY2011 Year-End Report and Recommendations* 3 (2012).

[13] *Id.*