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Committee on Health
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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 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 the Health Care Finance (DHCF) over this past year. Approximately 80,000 children 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 child welfare, mental health and early intervention systems -- providing the services that reduce children's stay in foster care and aid their academic achievement.

During the past several years, under former Director Julie Hudman, we were encouraged by the real progress we saw DHCF make. Under strong leadership and with qualified staff, DHCF began promulgating regulations that were needed for many years, filed important State Plan Amendments and communicated well with the advocate and provider community. DHCF also took some very positive steps to entice more providers to enroll with Medicaid such as reforming the provider payment system and raising payment rates to 80% of Medicare rates.[3]

We hope this strong leadership and solid work continues under the new Director, Wayne Turnage. My staff and I have met Mr. Turnage and were encouraged by his candor and willingness to work with advocates. I am concerned, however, about the 36% vacancy rate that DHCF was reporting this fall and how that is hampering the Department's ability to accomplish its work.[4] Many high level positions are now vacant and we have a very hard time getting our calls to the

Department returned; staff apologize and tell us they are just too understaffed to get us documents or answers to even basic questions. We understand that this fall the Office of City Administrator approved an exception to the hiring freeze to allow DHCF to reduce its vacancy rate to 20%.[5] We urge the Council to work with the City Administrator to allow DHCF to hire even more staff given its critically important work and the high percentage of the District's budget that the Department controls.

Despite the notable progress DHCF has made there is still much work to be done and we are concerned that some initiatives have stalled. We urge DHCF, the Mayor and the Council to treat the situation facing children using Medicaid as the crisis it is – and to make solving the problem a high priority.

I will focus today on the four 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. Third, moving forward with the Administrative Service Organization (ASO), that is essential to improving the provider pool. Fourth, working with sister agencies, in particular the Child and Family Services Agency (CFSA), to ensure federal Medicaid dollars are being maximized.

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 the Department of Mental Health (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 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. Providers must credential separately with each MCO and subcontract separately with each CSA which is a time-consuming process. To complicate matters, children who are enrolled in an MCO switch to fee-for-service Medicaid if they enter the foster care system. In order for that child to maintain continuity of services, their mental health provider must also be properly credentialed as an MHRS provider. This complicated set-up has led many providers to refuse to contract with Medicaid at all. Lawyers in our office have come across many providers who accept Maryland and Virginia Medicaid, but refuse to accept DC Medicaid because it's too burdensome. This leads to a shortage of providers, resulting in many children failing to get important medical and mental health treatment or facing long delays that impair their health. Too often children go without services or treatment until a crisis arises. Crisis care is extremely disruptive to children and families and also costs the system significantly more than less intrusive mental health care.

The District acknowledges the current system is too complex and fragmented and this is impeding access to services. There have been several projects undertaken to find solutions to this problem. In the spring of 2009, DCHF contracted with Department of Health Policy at the George Washington University to conduct an assessment of the children's behavioral health services in the DC Medicaid system and examine whether a mental health carve-out would be a good way to improve service delivery. In a carve-out model, the MCOs would no longer have responsibility for any mental health services and either DMH or another entity, such as one specialty managed behavior health care organization, would run the mental health services for all Medicaid beneficiaries. This report was just recently made public in response to this Committee's oversight questions. Unfortunately, while the report does a good job describing the current bifurcated mental health system and the problems it leads to; it does not offer any concrete solutions. The GW report calls for DHM and its sister agencies to meet and come up with a plan. The children of DC cannot

wait another year -- or two or three -- for a solution to this problem. They have waited and waited while other problems have taken priority. No one agency is responsible for fixing this problem and for too long this shared responsibility has prevented the District from tackling and solving this problem. The Mayor and the new Deputy Mayor for Human Support Services need to make this a priority and the agencies must coordinate to find a solution.

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. DMH has estimated that between 14-20% of children in the District have an emotional or behavioral disorder[6], yet the District's public mental health system (the Medicaid MCOs and DMH's provider network) is serving just slightly over 5% of children in the District.[7] A recent study by RAND Corporation found that many MCOs authorize only a limited number of mental health visits which often doesn't adequately meet a child's mental health needs;[8] this is particularly troubling given the expansive right to services children have under federal Medicaid law.[9]

The report also revealed disturbing statistics about the mental health care of children enrolled in Health Services for Children with Special Needs (HSCSN). This MCO is specifically for children who are enrolled in or eligible for Supplemental Security Income based on their medical condition. Nearly 66% of the children in HSCSN qualify based on mental health or developmental disorder diagnoses. But available evidence suggests many of these children are not receiving adequate – and sometimes not any - non-hospital behavioral health care. For example, 33% of children with episodic mood disorder, nearly 75% of children with an emotional disturbance, 66% of children with pervasive developmental or adjustment disorders and more than 50% of children with depressive disorder did not appear to have had a mental health visit (home or office based) during the year.[10] These children are in this MCO specifically because of their high medical needs, HSCSN is tasked with providing individualized care management services to its enrollees and yet

these children are still not getting proper treatment. These numbers lead us to seriously question DHCF's oversight of HSCSN and the other MCOs. We urge the Council and DHCF to 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.

To improve the quantity and quality of mental health services, the District also needs to streamline its claim systems in order to create an environment that attracts more providers. A key component for success is to create a single billing system, called an Administrative Service Organization (ASO). For years each public agency - DCPS, CFSA and DMH -- have had their own systems for claims submission, provider enrollment, and administrative claiming as it relates to Medicaid.[11] Not only did this deter good providers from accepting DC Medicaid, it also resulted in the District failing to maximize federal reimbursement. [12] 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. For several years, the projected date for when the ASO would be up and running has been repeatedly pushed back.[13] Now we understand that the ASO, Public Consulting Group, began working with DCPS, OSSE and CFSA on the first phase of the project, which involves meeting with the agencies to gather information, on October 1, 2010. Actual submissions of claims by the ASO are scheduled to begin in April (DCPS and OSSE) and May (CFSA) of 2011.[14] We urge the Council to monitor this process carefully to ensure this timeline is followed given that every day that the ASO is not in place the District stands to lose revenue.

Lastly, 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. In September 2009, DHCF received approval of a State Plan Amendment which gives DHCF authority to reimburse local educational authorities for some health and mental health

services delivered in schools, including skilled nursing services, personal care services and mental health and counseling services.[15] DHCF has also been working with the Office of the State Superintendent of Education (OSSE) to ensure its Early Intervention Program (IDEA Part C) is properly utilizing Medicaid services.[16] This is a very positive change as DC's Early Intervention program needs to reach more families, assess more children and serve them better. Connecting with Medicaid providers is an important part of its work.

Unfortunately, there is still considerable work to be done within many agencies. One agency of particular concern is CFSA. As this Committee knows well, CFSA has had many problems with its Medicaid billing in the past. We understand that it is unrealistic for CFSA to bill Medicaid for $50 million a year as it has in the past, in part due to new federal guidance. However, CFSA must maximize the federal dollars it can claim. DHCF has taken some positive steps towards this goal by submitting a Targeted Case Management State Plan Amendment (SPA) to the federal government.[17] This SPA has not yet been approved, but DHCF estimates FY11 federal reimbursement at approximately $2 million.[18] DHCF states that they are still discussing with CFSA if it's possible to bill Medicaid for any other services that CFSA provides (and previously billed for through the Medicaid Rehabilitation Option.)[19] The Sivic Solutions Group, whom CFSA has retained to help it improve its recoupment of federal revenue, completed a report in November 2010 and stated that DHCF had agreed to proceed with the Rehabilitation Option claiming, "contingent upon extensive training and QA services by CFSA, and further coordination with DMH." Sivic further stated that it would draft an appropriate state plan amendment by Nov. 5, 2010, and that a time study in congregate care facility would begin in January 2011, with claiming scheduled to begin in FY 12. Although many variables remained, Sivic estimated FY 2012 revenue of $5-$10 million.[20] The Council should seek clarity on Sivic's work and projections and DHCF's assessment of this revenue stream's feasibility.

Whether through this option or another method, we urge CFSA and DHCF to work diligently to ensure that CFSA services that may be reimbursable by Medicaid are identified and federal reimbursement sought. Especially during these tough economic times it is imperative that we maximize all possible revenue streams.

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 under the new leadership at the Department. In the coming year we hope to see more children actually receiving services; better oversight of managed care organizations; a fully functioning ASO coordinating a streamlined billing process; and DC agencies, including CFSA, properly billing Medicaid for all reimbursable services. 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 safe home, meaningful education and healthy life. As the largest nonprofit legal services provider in the District, our 70-person staff partners with hundreds of pro bono attorneys to serve 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] Department of Health Care Finance, *Monthly Enrollment Report* (January 2010). Non-SSI Children: 72,363; Specialized MA Children: 7,162.

[3] 29 DCMR 995.1

[4] DHCF's responses to the Health Committee's FY10 Oversight Questions, Question 10.

[5] Id.

[6] Christine Ferguson et al., The George Washington University, School of Public Health & Health Services, Department of Health Policy, *Mental Health Carve Out Assessment* at 2. Available in DMH's responses to the Health Committee's FY10 Oversight Questions, Question 71

[7] Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 5 at 7 (January 27, 2011).

[8] Rand Corporation, Rand Health, Technical Report: Health and Health Care Among District of Columbia Youth, 112 (2009)
[9] Early Periodic Screening, Diagnosis and Treatment (EPSDT) requires a comprehensive health care benefits package for all Medicaid-eligible children under age 21. 42 USC § 1396 (a)(43).
[10] Rand Corporation, Rand Health, Technical Report: Health and Health Care Among District of Columbia Youth, (2009).
[11] 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).
[12] 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).
[13] 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.
[14] DHCF's responses to the Health Committee's FY10 Oversight Questions, Question 42.
[15] Department of Health Care Finance, *FY09 Performance Accountability Report,* 6
[16] DHCF's responses to the Health Committee's FY10 Oversight Questions, Question 41.
[17] DHCF's responses to the Health Committee's FY10 Oversight Questions, Question 44.
[18] Id.
[19] DHCF's responses to the Health Committee's FY10 Oversight Questions, Question 41.
[20] Child and Family Services Agency, Federal Revenue Infrastructure Improvement Project, Meeting with CSSP Status Update from Sivic Solutions Group, Powerpoint Presentation at 8 (November 4, 2010)