



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 Catania and members of the Health Committee. My name is Judith Sandalow. I am the Executive Director of Children's Law Center¹ (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 those 1,200 children is a Medicaid recipient.

I am grateful for this opportunity to testify regarding the performance of the Department of the Health Care Finance (Department) over this past year. We were pleased when the Council created the Department and hoped its creation would lead to streamlined Medicaid payment procedures, ensure that the District is maximizing all possible federal funds and, ultimately, ensure that all Medicaid-eligible children receive more efficient and effective health care.

A properly functioning Medicaid system is vital for ensuring the health of DC's children, because 25 percent of residents (the highest percentage in the country) and 61 percent of children are enrolled in Medicaid.² Almost half of DC's Medicaid beneficiaries are under 18.³ Medicaid-funded services promote more than our children's physical and mental health – they are truly the backbone of our child welfare, early intervention and special education systems – providing the services that reduce children's stay in foster care and aid their academic achievement.

During the past two years, we have been encouraged by the real progress we have seen the Department make. The leadership is strong and many staff positions have been filled with well-

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, *Working Together for Health: Medicaid Annual Report FY 2008*, 2 (2008).

³ Department of Health Care Finance, *Working Together for Health: Medicaid Annual Report FY 2008*, 4 (2008).

qualified individuals. The Department has begun to promulgate regulations that have been needed for many years and has been aggressively filing important state plan amendments. The Department has also taken some very positive steps to entice more providers to become Medicaid providers such as reforming the provider payment system and raising some provider payment rates to match Medicare rates.⁴

We are also pleased the Department established the Health Care Ombudsman's office and has sought the community's involvement in developing its practices and protocols. We hope that once that Office is fully operational it will be a useful place for DC residents to get information about health insurance and resolve problems with access and coverage. In fact, we have found staff at every level of the Department to be open to community input and collaboration.

Despite the notable progress the Department has made there is still much work to be done and we are concerned that some initiatives have stalled. We urge the Department, 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 three 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 hospitalized, incarcerated and stuck in expensive, segregated special education placements. Second, developing a system for providing oversight and accountability to MCO's, whose failure to provide adequate preventive medical and mental health services has been clearly documented. Third, moving forward with the delayed Administrative Service Organization (ASO), that is essential to improving the provider pool. I also want to comment on the need, particularly in these tough budget times, for the Department to work

⁴Department of Health Care Finance, *FY09 Performance Accountability Report*, 3

with agencies, in particular the Child and Family Services Agency (CFSA), to ensure federal 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 four MCOs, fee-for-service Medicaid and a separate MHRS system. 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 Department of Mental Health (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 and is often mentioned by providers as the reason they will not accept DC Medicaid. 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 routine, preventive care.

Last year the District agencies that are collectively responsible for the children's mental health system, the Department of Mental Health (DMH), the Department of Health Care Finance, and CFSA met to discuss options to address this critical problem. One option considered was for

the District to carve-out mental health services from the MCOs and have either DMH or another entity, such as one specialty managed behavior health care organization, run the mental health services for all Medicaid beneficiaries. Last spring, the Department contracted with the 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 carve-out would be a good way to improve services. The report was originally to have been released in September. We have heard that GW completed its assessment and that the results will soon be made public. Our understanding is the report does not provide a clear solution. Whether through a carve-out or other mechanism a solution must be found. We cannot wait another year. No one agency is responsible for fixing this problem. For too long this shared responsibility has prevented the District from tackling and solving this problem. The Mayor needs 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, the Department must develop a stronger mechanism for oversight and accountability. 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;⁵ this is particularly troubling given the expansive right to services children have under federal Medicaid law.⁶

The report also found 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

⁵ Rand Corporation, Rand Health, Technical Report: Health and Health Care Among District of Columbia Youth, 112 (2009)

⁶ 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)..

diagnoses. But available evidence suggested many of these children are not receiving adequate 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.⁷ 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 the Department's oversight of HSCSN. The Department has utilization data from the MCOs regarding mental health services to children which they have offered to make public. We look forward to reviewing this data and working with the Department on improved oversight of MCOs.

To improve the quantity and quality of mental health services, the District also needs to stream line 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 or 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.⁸ Not only did this deter good providers from accepting DC Medicaid, it also resulted in the District failing to maximize federal reimbursement.⁹ 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. Last year, the Department said it hoped

⁷ Rand Corporation, Rand Health, Technical Report: Health and Health Care Among District of Columbia Youth, (2009).

⁸ 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).

⁹ 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).

to have an ASO in place by October, 2009. In October, the Department did select a vendor; however, that contract is, as of mid-February, still under review at the Office of Contracts and Procurements and there is no date set for when the ASO is expected to be up and running.¹⁰ We are pleased that the vendor has been selected, but dismayed at the slow pace of this process given that every day that the ASO is not in place the District stands to lose revenue. This contract should not be treated as routine – instead it should be given top priority and moved quickly. We urge the Council to make appropriate inquiries. Once the contract is approved, we urge the Department to make the successful transition to an ASO a high priority.

Lastly, the Department has been working with other District agencies to expand service delivery and maximize federal revenue. The Department has made some notable progress billing for school based health services. In September, the Department received approval of a state plan amendment which gives the Department 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.¹¹ The Department has also been working with Early Stages, DCPS's new program that identifies developmental delays in three to five year old children, to ensure the program receives Medicaid reimbursement for its services. This is a very positive change. Previously DC's Early Intervention program was not properly utilizing Medicaid funds.

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

¹⁰ DC Council, Committee on Health, Performance Oversight Questions to the Department of Health Care Finance, Question 39.

¹¹ Department of Health Care Finance, *FY09 Performance Accountability Report*, 6

maximize the federal dollars it can claim. We hope that federal dollars for CFSA's new in-house clinic and nurse case management will be received for FY 2010 and FY2011 and know that the Department is working to make that happen.¹² We also urge both CFSA and the Department to ensure that CFSA services that may be reimbursable by Medicaid are identified and federal reimbursement sought. In these tough times it is imperative that we maximize all possible revenue streams.

In conclusion, we applaud the Department for the positive steps they have taken to improve the Medicaid program and ensure all children receive timely, quality medical care. In the coming year we hope to see more children actually receiving services; better oversight of managed care organizations and a solution to the long-standing barriers to recruiting mental health providers; an ASO up and running; and DC agencies, including CFSA, properly billing Medicaid for all reimbursable services. We look forward to working with the Department to achieve these goals.

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

¹² In their written response to the Health Committee's oversight questions, DHCF states that they are working with CFSA to submit a State Plan Amendment for "Targeted Case Management (CFSA)" that will create a nurse care coordination program under the authority of TCM that will identify a select group of children, under the custody of CFSA, which will have a coordinated care program that encompasses medical, social and educational services. This SPA will be submitted to the Center for Medicare and Medicaid Services on by March 10, 2010. DHCF also states it is working on billing for the new in-house CFSA medical clinic. DHCF also states it is working with CFSA to identify services that CFSA funds with local dollars that may be reimbursable by Medicaid.