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Performance Oversight Hearing

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Introduction

Good morning Chairman Gray and members of the Committee. My name is Sharra E. Greer. I am the Policy Director of the 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 9 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. Approximately 101,000 children and youth under 21 years of age are enrolled in the District's Medicaid program.[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. Under Director Wayne Turnage's leadership, the Department continued to make progress in the last year. More resources are being invested in children's mental health. Better information is being collected to help understand service needs and gaps in service. Changes are being made to make expansion of services to more

children with developmental delays more affordable. There is more work to be done, but strides continue to be made in the right direction.

In my testimony today, I will highlight three main areas:

1) Improved utilization of mental health services;

2) Integration of primary care with developmental and behavioral health care; and

3) Increased Medicaid funding for early intervention

Improved Utilization of Mental Health Services

Connecting children to appropriate mental health services and the lack of timely, quality and appropriate mental health services is one of the greatest barriers to success for our clients. One significant difficulty is that no one agency reports about and monitors all children receiving mental health services through DC Medicaid. Ninety percent of children on Medicaid receive their care through one of the three major MCOs - AmeriHealth DC, MedStar Family Choice, and Trusted Health Plan -- or through Health Services for Children with Special Needs (HSCSN) which serves disabled children up to age 26.[3] In addition to providing care for their beneficiaries' physical health needs, the MCOs are responsible for providing office-based mental health services. However, for children diagnosed with serious 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. 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. DHCF has made progress towards gathering data to provide this information. We do know that more children are receiving a mental health service and that spending on mental health services for children by MCOs has increased. In large part, this is due to DHCF's increased focus on MCO utilization for children's mental health in the last three and a half years. When the reporting began in FY13, DHCF described MCOs' medical spending for behavioral health services as "negligible."[4] MCOs are now spending on average $16.29 per child per month for behavioral health services.[5] This is compared to $13.86 last year and $6.25 when this number was first reported in February 2014.[6] An impressive 16% of children on Medicaid received some form of mental health service[7] -- an increase from 11% reported last year.[8]

In addition, DHCF has taken steps to increase reimbursement for services provided at school. DHCF has been working with many other agencies to clarify the scope of Medicaid reimbursement available for services provided to Medicaid-enrolled students receiving medical services at District schools, regardless of whether the child has an individualized education plan. Making this change to Medicaid's State plan

would enable DC to be reimbursed for services previously not allowable and paid out of local funds.[9] DHCF has also implemented a program where DC Medicaid providers can be reimbursed for services delivered through telemedicine.[10] While these changes affect more than just mental health, they are steps that will make it easier to bring mental health services to children and increase their utilization.

Although we are not yet serving all the children who need treatment (DBH estimates 20% of children and adolescents may have a mental health disorder that can be identified and require treatment), and there are concerns about the quality and timeliness of services, this is significant progress.[11]

Integration of Primary Care with Developmental and Behavioral Health Care

Another area where there has been continued progress is the integration of children's mental health with primary care. The Division of Children's Health Services, under the leadership of Associate Director Colleen Sonosky, has made significant steps to improve the integration of primary care with developmental and behavioral health care. Much of this work has been done with the DC Collaborative for Mental Health in Pediatric Primary Care, a public/private partnership, including: Children's Law Center, Children's National Health System, the American Academy of Pediatrics, Georgetown University, DBH, DHCF and the Department of Health.

One of the main goals of this project is to ensure that pediatricians are screening children for mental health needs using standardized screening tools. The vast majority

of pediatric practices serving children on Medicaid have now been trained on a variety of mental health topics, including how to implement the mental health screening tool adopted in DC.[12] The number of children being screened is up dramatically – from 5,020 in 2013 to 22,726 in 2015 – an increase of over 350%.[13] In addition, in 2015, DHCF implemented coding changes which required providers to bill separately for mental health screening to encourage use of the screen.[14] DHCF has created a reporting mechanism to track the adoption of the new code and receives quarterly reports from the MCOs on its use.[15] In addition to tracking whether or not the screening tool is being used, DHCF can analyze whether children have been identified as needing mental health services and then track what services the children received.[16] The utilization of the new code is still not at high enough to get a full picture of service provision or timeliness. DHCF is continuing to work on improving this data collection.

DHCF is also a key partner coordinating DC MAP (Mental Health Access in Pediatrics), a DBH-funded program to provide assistance to pediatric primary care providers who need mental health consultation for a beneficiary during a well-child visit.[17] Staffed collaboratively by a team of mental health clinicians (psychiatrists, psychologists, social workers, and a care coordinator) from Children's National Health System and MedStar Georgetown University Hospital, the DC MAP team program offers consultation and training to primary care pediatric practices to manage the

mental health concerns of children and their families.[18] Since its launch in 2015, this program has responded to hundreds of inquiries and requests for assistance.[19]

Finally, in October of 2016, in collaboration with the Department of Health and the State Early Childhood Development Coordinating Committee (SECDCC), DHCF helped to establish a new workgroup to focus on the coordination of pediatric primary care in DC. The workgroup has a special focus on integrating pediatric primary care with developmental, behavioral and oral health care.[20]

Enabling pediatricians to be part of treating and identifying mental health problems is critical, because in DC and throughout the country, there is a shortage of mental health providers, especially child psychiatrists. All of this continuing work to integrate primary care with developmental and behavioral health care will lead to early identification of problems, earlier treatment and ultimately better outcomes for children.

Increased Medicaid Funding for Early Intervention

Years of research show that a child's earliest experiences play a critical role in brain development.[21] High quality early intervention services to young children who have, or are at risk for, developmental delays have been shown to positively impact outcomes across developmental domains, including: health,[22] language and communication,[23] cognitive development,[24] and social/emotional development.[25] The majority of children receiving early intervention services catch up to peers.[26] Research

on early intervention programs shows that they produce long-lasting and substantial gains in outcomes, such as reducing the need for special education placement, preventing grade retention, increasing high school graduation rates, improving labor market outcomes, reducing social welfare program use, and reducing crime.[27] Children who do not receive the specialized support they need as infants and toddlers have a much harder time making up lost ground later.[28]

The DC Early Intervention Program (EIP), within the Office of the State Superintendent of Education (OSSE), meets the needs of DC's infants and toddlers with developmental delays by providing evaluations, individualized plans for services, and service coordination to ensure that services from a variety of funding sources, including Medicaid, are delivered timely. The *Enhanced Special Education Services Act* made more infants and toddlers eligible for early intervention so that they will receive the help they need when it will be most effective.[29] The legislation expanded eligibility to infants and toddlers if they have a 25% delay in just one developmental area.[30] This expansion will require funding. Fully utilizing Medicaid for the program would make more local dollars available to serve more children.

The District is not currently billing Medicaid for all of the services being provided, however. For the majority of DC EIP eligible children in MCOs, DC EIP has paid for some evaluations and services when MCO processes have created delays in service provision or restricted the pool of possible providers for some therapies. It is

hoped that a change in payment rates to achieve parity between OSSE and the MCOs will help correct the delays in service.[31] In addition, unlike in Maryland, service coordination is not billable to Medicaid.

Another barrier has been that OSSE, which provides many of the early intervention services, has not been able to bill Medicaid for these services. As of FY16, OSSE became a public provider enrolled in Medicaid and will be able to bill for services it provides for the small number of children on Medicaid Fee for Service.[32] In FY17, DC EIP will begin utilizing the Administrative Services Organization (ASO) for billing.[33] Full claim production for services by OSSE is expected to start this month, March 2017.[34] DHCF also executed a new MOU with OSSE in October 2016 and is working on a Data Sharing Agreement to facilitate billing for early intervention services provided to children in Fee for Service Medicaid.[35] These steps should help increase Medicaid billing for Early Intervention services. We urge DHCF and OSSE to continue to work together to maximize federal funding for this program.

Conclusion

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

[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] DHCF FY16 Performance Oversight Responses, Q39.

[3] DHCF FY15 Performance Oversight Responses, Q45.

[4] Department of Health Care Finance (February 2014), *District of Columbia's Managed Care Quarterly Performance Report: July 2013-September 2013*, p. 17.

[5] Department of Health Care Finance (October 2016), *District of Columbia's Managed Care Quarterly Performance Report: April 2016-June 2016*, p. 67. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%202nd%20Quarter%20Report%20CY2016.pdf

[6] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (Jan 2015 – June 2015), 56 (Dec 2015). http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%201st%20and%202nd%20Quarter%20Report%20CY2015.pdf. Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013), 43 (Feb 2014). http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%201st%20Quarter%20Report%20FY2014_1.pdf

[7] DHCF FY16 Performance Oversight Responses, Q39.

[8] DHCF FY15 Performance Oversight Responses, Q50.

[9] DHCF FY16 Performance Oversight Responses, Q31. This change stems from Centers for Medicaid and Medicare Services (CMS) guidance that clarified that states could use Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries when the provider did not bill the beneficiary or any other individuals for the services, or "free care". See, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[10] DHCF FY16 Performance Oversight Responses, Q33. See also, Q40(e).

[11] Department of Behavioral Health website states: "It is estimated that as many as one in five children and adolescents may have a mental health disorder that can be identified and require treatment." http://dbh.dc.gov/service/children-youth-and-family-services.

[12] DBH FY15 Performance Oversight Responses, Q43.

[13] Children's Law Center (May 2016), *Evaluating DC's Progress in Meeting Children's Mental Health Needs*. Retrieved from http://www.childrenslawcenter.org/sites/default/files/Childrens_Law_Center_MH_Update_2016.pdf.

[14] DHCF FY16 Performance Oversight Responses, Q37. On October 27, 2015, DHCF sent pediatric providers Transmittal 15-39.

[15] DHCF FY16 Performance Oversight Responses, Q37.

[16] DHCF FY16 Performance Oversight Responses, Q37.

[17] DHCF FY16 Performance Oversight Responses, Q37.

[18] See, http://www.dcmap.org/.

[19] Data from DC Collaborative for Mental Health in Pediatric Primary Care/DC-MAP dated October, 2016 on file with Children's Law Center.

[20] DHCF FY16 Performance Oversight Responses, Q37.

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[28] Robert Wood Johnson Foundation. (2008). Issue Brief. *Early childhood experiences and health*. Retrieved from http://www.commissiononhealth.org/PDF/095bea47-ae8e-4744-b054-258c9309b3d4/Issue%20Brief%201%20Jun%2008%20-%20Early%20Childhood%20Experiences%20and%20Health.pdf.
[29] See *Enhanced Special Education Services Act of 2014*, DC Code § 38-2614.
[30] See *Enhanced Special Education Services Act of 2014*, DC Code § 38-2614.
[31] DHCF FY16 Performance Oversight Responses, Q55.
[32] DHCF FY15 Performance Oversight Responses, Q48.
[33] DHCF FY16 Performance Oversight Responses, Q18.
[34] DHCF FY16 Performance Oversight Responses, Q54.
[35] DHCF FY16 Performance Oversight Responses, Q52.