DISTRICT OF COLUMBIA
BEHAVIORAL HEALTH ASSOCIATION

Committee of the Whole

Hearing on B19-0211
South Capitol Street Tragedy Memorial Act

June 2, 2011

Testimony of
Shannon Hall, Executive Director
D.C. Behavioral Health Association

Good morning, Chairman Brown and members of the Committee of the Whole. I am Shannon Hall, Executive Director of the D.C. Behavioral Health Association. Since 1974, the D.C. Behavioral Health Association has sought to improve the quality of community-based behavioral health services, and increase access to those services for the District's low-income population. Every year, our thirty-four member organizations help over 20,000 D.C. residents find recovery, resiliency and support through community-based behavioral health services.[1]

Nationally, 13.5% of low-income children need mental health treatment.[2] Despite having one of the highest child insurance rates in the country,[3] the D.C. Medicaid program provided outpatient mental health treatment to approximately 6.5% of its child beneficiaries in FY2010.[4] This suggests that at least half of the children *who are covered by Medicaid* do not receive the mental health treatment they need. The 5,600 D.C. children who go without needed treatment may drive avoidable, negative outcomes; they are up to five times more likely to be suspended, expelled or truant than their peers.[5] Truancy, in turn, feeds into juvenile delinquency.[6] We can improve outcomes for these children by ensuring that their needs are identified, and that they are linked to treatment.

Thus, I want to begin by commending so many members of this Council for co-sponsoring this bill. The legislation eschews easy answers in favor of asking that the city better deploys its resources to address children's behavioral health needs. In particular, we are very pleased that Title VI of the bill attempts to tackle low-cost, high-value barriers to a better delivery system.

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[1] Our members are: Affordable Behavior Consultants; Anchor Mental Health Services (a division of Catholic Charities); API Associates; Capital Community Services; Careco Mental Health Services; Community Connections; Cornerstone; Deaf-REACH; Family Matters; Family Preservation Services; First Home Care; Green Door; the Healthy Families Thriving Communities Collaborative Council; Hillcrest Children's Center; La Clinica del Pueblo; Latin American Youth Center; Lifestride; Mary's Center; Maya Angelou Public Charter School; Metro TeenAIDS; McClendon Center; Open Arms Housing; Pathways to Housing; Positive Nature; Progressive Life Center; Psychiatric Center Chartered; Psychiatric Institute of Washington; Sasha Bruce Youthworks; the Student Support Center; So Others Might Eat; Washington Hospital Center's Behavioral Health Services; the Wendt Center for Loss and Healing; Woodley House; and Youth Villages.
[2] Urban Institute, "Access to Children's Mental Health Services under Medicaid," p. 5 (August 2004).
[3] Dept. of Health Care Finance, "Health Insurance Coverage in the District of Columbia," p. 7 (April 2010).
[4] Denny Jones, Dixon Court Monitor, Letter to Dept. of Mental Health, p. 3 (Dec. 2, 2010).
[5] National Center for Children in Poverty, "Children's Mental Health: Facts for Policy-Makers" (2006), *available at*: http://nccp.org/publications/pub_687.html.
[6] *See, e.g.,* Colorado Foundation for Families and Children, "Youth Out of School: Linking Absence to Delinquency" (Sept. 2002).

I. Closing the Loop from Referral to Linkage (Sections 401 and 603)

Today's legislation highlights the need for child-serving agencies to improve their behavioral health response. Because of the nature of mental illness and substance abuse, referrals alone may be insufficient to ensure that needed treatment is obtained, which is why we are pleased with the bill's attention to reporting requirements.

All too often, families referred for office-based mental health treatment may not engage in services. In Detroit, for example, only 13% of referred families engaged in mental health treatment.[7] In D.C., few agencies monitor the gap between referral and actual service delivery. APRA is the only agency offering public data on this topic. Its FY10 oversight responses indicate that D.C. agencies referred 564 youth to ASTEP providers for treatment,[8] but providers only treated 300 youth.[9] This data suggests that 47% of referred youth do not engage in treatment.

The legislation promises to improve care coordination by requiring some agencies to improve their reporting on whether children and families actually receive the services for which they are referred. This knowledge will help the referring agencies to craft better interventions. Section 401(b)(4)(A)(iv) requires improved reporting from schools, while section 603(f) requires reporting from DYRS. We encourage you to add similar language to section 602, governing CFSA's referral obligations.

II. Enhancing Collaborative Treatment Solutions: Collateral Contacts (Section 604)

Strong care coordination is critical to closing the gap between referral and actual linkage to treatment. Enhanced reimbursement for care coordination, through collateral contacts, will strengthen providers' ability to do the outreach necessary to engage families in treatment. Collateral contacts may also allow providers to improve integrated solutions to children's behavioral health needs by providing a mechanism to collaborate with professionals outside of the mental health arena.

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[7] Atkins et al, "School-Based Mental Health Services for Children Living in High Poverty Urban Communities," *Administration and Policy in Mental Health and Mental Health Services Research*, 33, 146-159 (2006).
[8] D.C. Council, Committee on Health, "FY2010 Oversight Responses from Department of Health, Addiction Prevention and Recovery Administration," at Q31 (Feb. 2010).
[9] *Id.* at Q4.

III. Streamlined Credentialing of Behavioral Health Providers (Section 606)

Timely access to treatment is also critical to ensuring that families follow up on referrals. Timely access to treatment is dependant on two key factors: streamlined access across benefits, and adequate provider networks. We are very pleased that Section 606 of the bill encourages the Department of Health Care Finance to take steps to streamline the credentialing process. This is a critically important method of improving access to treatment. However, we recommend strengthen Section 606 to build upon and improve existing practice. Briefly, we recommend that the section be amended to more narrowly address streamlining in three ways:

- Modify managed care contracts to reflect Medicare credentialing policy, making payors retroactively responsible for all claims with dates-of-service on or after the date that the provider first submits a credentialing application;
- Require DHCF to monitor managed care contractors for timely processing of credentialing applications;
- Pursue voluntary deemed status accreditation across MHRS and MCO networks.

We explain the problem and offer constructive suggestions to strengthen Section 606 below.

A. Streamlined Access Improves Access to Treatment

Although D.C. Medicaid covers a broad range of mental health services for children, the fragmented structure prevents easy access to treatment: two benefit plans are fractured across six insurers, and none of the insurers offers a comprehensive array of covered Medicaid benefits. Thus, in order to offer a continuum of children's behavioral health services, a provider must credential and contract with up to 10 separate payors. The median DCBHA member credentials with 4-5 payors, while the median non-member contracts with 1-2 payors. The multiplicity of payors diverts resources from treatment to administration, introduces delays to accessing treatment, and disrupts continuity-of-care for children.

When processes are streamlined, providers save money that they can re-direct toward treatment. Thus, for example, when Georgia standardized 29 separate process flows into one standardized process for accessing treatment, the wait time for treatment was cut in half. Similar studies across multiple states have found that streamlined access achieves valuable gains in reduced administrative burdens.

B. Current Managed Care Credentialing Processes

Section 606 requires DHCF to create a single form to credential behavioral health providers under MHRS and Medicaid behavioral health programs. DCHF's managed care organizations already use a single form to credential providers – known as the Council for Affordable Quality Healthcare's universal provider database (CAQH). The managed care organizations have 180 days to process a credentialing application, and they are only responsible to pay for services delivered after the application is accepted.

Each managed care organization interprets and applies the CAQH differently. United, for example, will credential providers as clinics – thereby allowing easy substitution of individual practitioners, as needed due to staff turnover. Beacon, by contrast, uses CAQH to credential individual practitioners, and then it independently verifies all information reported in the CAQH database; our members report that the verification process leads to significant credentialing delays and greater administrative burdens. Thus, although all managed care organizations currently use the same credentialing forms, their nuanced interpretations of their obligations can translate into dramatically disparate outcomes, when viewed from providers' lens.

C. Three Recommendations for Streamlined Credentialing

We believe that the objective of Section 606 could be strengthened in by requiring the Department of Health Care Finance to report more specifically on three measures:

1. Adopt a Medicare standard of retroactive payment for MCO contracts.

To correctly align incentives, DHCF should consider modifying its MCO contracts to reflect a credentialing policy similar to Medicare's. Once Medicare has accepted a provider's application, Medicare will reimburse all of a provider's claims retroactive to dates-of-service on or after the date that the credentialing application is submitted. We believe that a similar policy for the District's managed care organizations will minimize incentives to delay credentialing of providers.[10]

[10] U.S. Government Accountability Office, "Medicaid Managed Care: CMS's Oversight of States' Rate-Setting Needs Improvement" at p. 2 (Aug. 2010) ("capitation payments, which are made prospectively to health plans to provide or arrange for services for Medicaid enrollees, can create an incentive to underserve or deny access to needed care"), *available at*: http://www.gao.gov/new.items/d10810.pdf.

2. Report MCO timeliness in processing applications

As noted above, although the MCOs all use one database for credentialing providers, they apply different verification standards for the submitted information. For some MCOs, the verification requirements far exceed their contractual obligations,[11] which reportedly lead to significant delays. The Departments of Health Care Finance and Mental Health already have an MOU in place which is supposed to require the managed care organizations to include core service agencies within their provider networks, and provide notification and oversight when the MCOs' fail to credential providers.[12] We recommend that Section 606 be amended to require DHCF to report on the outcome of this MOU by evaluating the extent to which DMH providers are paneled with each of the MCOs, and the number of outstanding or pending applications.

3. Pursue voluntary deemed status accreditation

Deemed status is when a licensing body recognizes a provider's national accreditation and allows the accredited organization to provide proof of accreditation in lieu of undergoing certain parts of the licensing process. It reduces administrative costs for states and providers, which is why it is currently used by 25 states for a wide range of human and health services.

Deemed status accreditation is already used in D.C. for residential treatment facilities, inpatient psychiatric facilities, inpatient substance abuse treatment, and tiered reimbursement from the Early Care and Education Administration.[13] Thus, allowing community-based providers to use deemed certification status would bring them on an equitable level with many of the city's inpatient services. There are 41 D.C. providers who are nationally accredited for behavioral health services by these bodies, including at least 25% of MHRS core service agencies.

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[11] The MCO contracts' current credentialing requirements states, "These [credentialing] policies and procedures shall, at a minimum, comply with NCQA or JCAHO standards. Contractor shall re-credential Providers at least every two (2) years, or if Contractor is NCQA accredited, Contractor shall re-credential based on NCQA requirements."

[12] Dept. of Health Care Finance and Dept. of Mental Health, "Memorandum of Understanding for Implementation of DHCF's Solicitation DCHC-2007-R-5050" (Jan. 2010).

[13] http://www.jointcommission.org/state_recognition/state_recognition_details.aspx?ps=100&s=DC&b=41.

We recommend that Council consider amending Section 606 to require DHCF to report on the viability of voluntary deemed status accreditation for outpatient mental health clinics.

IV. Timely Access to Treatment

> *"Primary care physicians ... reported significant challenges finding specialty care for patients enrolled in Medicaid, including notably limited options for Medicaid patients with mental health problems. District residents pointed to substantial gaps in the availability of outpatient specialty care, and District parents reported that getting behavioral health care for their children was a daunting problem."*
> *-- RAND Corporation, 'Behavioral Health in the District of Columbia' (2010).*[14]

Timely access to treatment is also critical element to ensuring that families follow up on referrals. Timely access to treatment is dependant on two key factors: streamlined access across benefits, and adequate provider networks. Although this legislation addresses streamlined credentialing, it is silent on the adequacy of the Medicaid mental health provider network. This is a problem that cannot be ignored.

In the past three years, eight studies have indicated that the D.C. Medicaid program has an insufficient number of licensed mental health practitioners.[15] Because provider participation in Medicaid has a direct, positive correlation to reimbursement rates,[16] this suggests that prior reimbursement rates were insufficient to retain the needed number of licensed professionals. Recent rate cuts may exacerbate the problem.

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[14] C.R. Greznenz, RAND Corporation, "Behavioral Health in the District of Columbia," p. 1 (2010).
[15] D.C. Child and Family Services Agency, "A Mental Health Needs Assessment of Children in Foster Care" (2007); D.C. Primary Care Association, "Slipping Through the Cracks," p. 11 (2007); Dept. of Mental Health, "Recommendations for the Governance of the D.C. Community Services Agency," p. 9 (Sept. 2008); KPMG, "Report on Governance Options for the D.C. Community Services Agency," p. 41 (Sept. 2008); A. Chandra, RAND Corporation, "Health and Health Care Among District of Columbia Youth," p. 21, 77, 92 (2009) (one child psychiatrist east of the River; mental health conditions accounted for 14% of hospital inpatient stays for school-age D.C. youth); C.R. Greznenz, RAND Corporation, "Behavioral Health in the District of Columbia," pp. vi, 1, 11 (2010); N. Lurie, "Assessing Health and Health Care in the District of Columbia," p. 199 (2008) (mapped mental health professional shortage areas); Christine Ferguson, Geo. Wash. Univ. Dept. of Health Policy, "Mental Health Carve Out Assessment" at p. 10 (2010).
[16] *See, e.g.,* National Academy for State Health Policy, "The Effects of Medicaid Reimbursement Rates on Access to Dental Care" (2008); S. Hamid Fakhraei, "Payments for physician services: an analysis of Maryland Medicaid reimbursement rates," Int. J. Healthcare Technology and Management, Vol. 7, Nos. 1/2, p. 129 (2006); Missouri Foundation for Health, "Medicaid Rates and Provider Participation" (2008); American Academy of Pediatrics, "Data Raise Concerns About Medicaid Access," *AAP News,* Vol. 18, No. 4, p. 143 (2001).

While we strongly support this legislation's objective of better screening and referral of children, that investment could be wasted if we do not simultaneously take steps to improve the adequacy of city's Medicaid mental health network. This outcome cannot be achieved through streamlining credentialing alone, although that is an important first step.

V. Conclusion

We believe that the South Capitol Street Tragedy Memorial Act of 2011 recognizes that an effective public health response to youth violence requires the cooperation and expertise of all of the city's child-serving agencies. Achieving this outcome will require many of the investments identified in the Act, as well as investments to improve timely access to children's treatment. Thus, we recommend that Council consider the following three suggestions:

- Amend Section 602, which governs CFSA's screening and referral obligations, to include monitoring whether referral resulted in linkage for treatment.
- Amend Section 606 to require DHCF reporting on: (1) making managed care organizations responsible for paying all claims for provider services delivered on or after the date that the provider submits a credentialing requirement; (2) implementation of the DMH-DHCF MOU by evaluating extent of paneling of MHRS providers with MCOs; and (3) reporting on viability of deemed status accreditation for outpatient mental health clinics.
- Improve Medicaid reimbursement rates for mental health services for children, particularly in areas of documented inadequacy like psychiatrists and licensed mental health professionals.

In this budget climate, it's tough to prioritize making investments. Investing in meeting children's need for behavioral health services is worth prioritizing because it pays off. According to DMH's latest service reviews, the overwhelming majority of children in treatment showed gains in responsible social behavior and improved meaningful relationships. Providers working with highest-need children can demonstrate long-term gains in school engagement and avoiding law enforcement contact – outcomes achieved with only six months of treatment. Deploying behavioral health treatment to children in need is good for children and good for D.C. taxpayers.

Thank you for your attention today, and I am happy to answer any questions.