The Next Chapter in Kids Medicaid Coverage:
Improving Care Delivery for Children and
Leveraging the Medicaid Benefit for
Children & Adolescents

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Agenda

- Medicaid in the District of Columbia
- Children’s Health Coverage in DC
- Medicaid Service Delivery in DC
- Sustaining EPSDT in Post Health Reform Environment
- Improving Data Collection and Reporting on Children’s Health
- Integrating Primary Care with Developmental, Behavioral and Oral Health
- DC Collaborative for Mental Health in Pediatric Primary Care
- Partnering with MCOs to train Providers to improve children’s health service delivery
- DC Managed Care Quarterly Performance Report
Medicaid In the District Of Columbia

- DC offers robust, comprehensive benefit package

- District’s program costs ~$2.7 billion, 70% from federal funds

- Department of Health Care Finance is the State Medicaid Agency
  - CHIP is a Medicaid expansion in DC
  - Also administers two locally funded programs: the Health Care Safety Net Alliance and the Immigrant Children’s Program

- Eligibility determinations for assistance programs done by Economic Security Administration (ESA) in Dep’t of Human Services (DHS)

- Approximately 1 out of every 3 District residents receives health care through the Medicaid and Alliance programs (~237,000 participants)
Children’s Health Coverage in DC

- **Insurance Coverage & Medicaid/CHIP Participation**
  - *Low Numbers of Uninsured:* Only 3% of DC children lack health care coverage; enrollment of children in Medicaid/CHIP increased by 13% from 2008-2010.
  - *High Participation Rate in Public Insurance:* In FY11, about 95% of eligible children were enrolled in Medicaid/CHIP according to Urban Institute figures.

- **Medicaid/CHIP Enrollment Overview**
  - FY13 CMS 416: 97,000 children were enrolled in D.C. Medicaid at some point during year and approximately 6500 of those were “CHIP” children
  - About 70% of the District’s children are enrolled in Medicaid/CHIP
  - Over 40% of D.C. Medicaid enrollees are children

- **Service Delivery for Pediatric Care under Medicaid**
  - All beneficiaries under 21 receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services benefit through Managed Care or Fee-for-Service
Medicaid Service Delivery in DC

DC Medicaid’s Two Service Delivery Systems:

- Managed Care [approximately 90% of Medicaid children]
  - AmeriHealth DC
  - MedStarFamily Choice
  - Trusted Health Plan
  - Health Services for Children with Special Needs (for disabled children up to age 26)

- Fee-for-Service [approximately 10% of Medicaid children]
  - Children with Disabilities not residing in an institution
  - Children residing in LTC facilities
  - DYRS-linked children
  - Children under custody of Child & Family Services Agency (foster care, adopted)

- Provider Types Serving Children in the District of Columbia
  - FQHCs (e.g., Unity, Mary’s Center)
  - Facility-Based (e.g., Children’s Hospital, Georgetown)
  - Provider Practice Groups
Sustaining EPSDT in Post Health Reform Era: The Medicaid benefit for Children

- An access component consisting of informing and referral; transportation and scheduling; and assistance obtaining necessary health, nutritional, educational, and social services

- Provision for periodic and as-needed well-defined screenings
  - Assessments of physical, developmental, behavioral & oral health in well-child visits
  - Health education and counseling to parents
  - Assistance in understanding developmental phases of child’s life
  - Information about benefits of healthy lifestyles and practices

- Follow-up and Tracking of Diagnostic and Treatment services necessary to correct or ameliorate any health concerns, EPSDT requires the coverage of services needed to diagnose and treat the concerns.
Improving Data Collection & Reporting on Children’s Health

- Meeting Coverage Goals: Crossing the Finish Line for Children’s Health Coverage
- Utilization of Services: Improving Numbers and Documenting Service Delivery
  - Documenting Well-Child Visits and Referrals
  - Defining and Quantifying the “T” in EPSDT
- Quality of Care: Selecting Core Measures
  - Use of HEDIS: Core Measures & Measurement Development
- Outcomes
  - Defining Outcome Measures to Tell Story of Children’s Health Well-being in Your State
- Communicating Goals with Key Stakeholders in Defining and Monitoring Child Health in Your State:
  - PolicyMakers (Executive and Legislative branches)
  - MCO & Provider Groups
  - Other Child-Serving Agencies Coordinating with the Medicaid Agency
  - Families Served by Medicaid Program
DHCF changed billing requirements and rates for EPSDT/well-child visits as of 10/1/14 with instructions to use Preventive Visit CPT codes and specific codes for screenings (e.g., 96110 for developmental).

Billing Changes Established to Help DHCF and MCOs:
- Confirm that all components of a well-child visit were performed;
- Detail need for diagnostic or treatment services; and
- Establish accountability for linking and tracking children in need of EPSDT services to the appropriate providers.
Integrating Primary Care with Developmental, Behavioral & Oral Health

- Documentation on Well-Child Visits will Help Related Initiatives for Children in DC
  - DC Pediatric Oral Health Coalition & Fluoride Varnish implementation
  - DC Collaborative for Mental Health in Pediatric Primary Care (Partnership with Children’s National Health System (CN), Georgetown, Dept. of Behavioral Health (DBH), DHCF and Children’s Law Center)
  - Help Me Grow (Department of Health)
  - Mayoral Initiatives: Raise DC & Early Success Council (includes goals related to measuring developmental screens)
DC Collaborative for Mental Health in Pediatric Primary Care

- Multi-faceted project since 2012 (provider, advocacy and government agency partnership) involving the following:
  - Surveys of Providers: Primary Care and Mental Health in 2014
  - Mental health screening tools recommendations to DHCF for pediatric primary care providers (to be included in DHCF’s EPSDT Billing Manual)
  - Develop electronic tool-kits for pediatric practices
  - Every major provider group participated in Children’s National Quality Improvement Learning Collaborative to train pediatricians on mental health screening and referrals (Phase 2 of Collaborative continuing in 2015)
  - Beginning in FY15: Child Behavioral Health Access program for pediatric primary care practices to have direct linkages to psychiatric consults (drawn from Massachusetts Psych Access Project)
Partnering with MCOs to Improve Service Delivery of EPSDT through Provider Education

- Primary Care Provider Education
  - HealthCheck Training & Resource Center: [http://www.dchealthcheck.net/index.html](http://www.dchealthcheck.net/index.html)
  - Materials on Medicaid’s EPSDT Benefit for DC Providers, Government Agencies and Families
  - EPSDT training (for 5 CMEs paid by MCOs every two years) and Fluoride Varnish Training for PCPs to serve children 0-3
  - Based on Bright Futures Guidelines with latest materials and guidance documents from CMS, HRSA, and national organizations
  - Compliance of training monitored by DHCF and MCOs
DC Managed Care Quarterly Performance Review

- MCO Performance Review is conducted quarterly by DHCF and shared with stakeholders for feedback and future action.

- Areas addressed in Performance Review:
  - What is the financial health of the MCOs including the risk profile of the plans? Are plan revenues sufficient to cover claims and operating cost?
  - What is the demonstrated ability of the MCOs to meet the administrative requirements for plan management—claims processing, development of encounter systems, and establishing an effective care management program?
  - What are the trends in MCO medical spending across the various health care service categories?
  - What are the observed trends in the rate at which Medicaid beneficiaries use the emergency room for low acuity or non-emergency health problems? What proportion of these visits should the health plans be reasonably expected to prevent?
  - What proportion of inpatient hospital admissions for Medicaid beneficiaries were avoidable? What proportion of these admissions should the health plans have been reasonably expected to prevent?
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