Testimony for the DHCF Oversight and Budget Hearing

April 19, 2012

I would like to thank Chairperson Catania for convening these hearings, as well as the members of the Committee on Human Services and members of the City Council.

I am Monica Hutchins-Thomas, a social worker with the Medical House Call Program (MHCP). The MHCP is based at MedStar Health's Washington Hospital Center and has been providing case management services under the EPD Waiver for nearly ten years. We have provided case management to over 340 waiver beneficiaries during this time. The MHCP currently has five social workers who provide case management to 99 active Waiver beneficiaries and we have added a total of 30 patients to the EPD Waiver waitlist.

I would like to first acknowledge the strengths and recent improvements in the Medicaid Waiver program. Department of Health Care Finance is much more expeditious in processing the EPD Waiver prior authorizations which allows providers to bill for services rendered to beneficiaries in a timely fashion. Although some agencies still have a back log, DHCF's "EPD Waiver Overhaul Plan" is working with providers on an individual basis to rectify these remaining billing issues. Additionally, the use of Delmarva to review clinical data and issue authorizations has worked very well over the last few years. Delmarva is efficient, offers feedback to agencies and responds quickly to written and verbal communication.

Despite some of the above improvements, there continue to be areas of concern for both beneficiaries and providers regarding the current administration of the EPD Waiver program. Specific areas of concern include: implementation of a 30-day discharge rule, the waitlist, communication from DHCF, and change requests.

New 30 day rule –DHCF has implemented a new rule that a waiver client in a Sub acute rehabilitation (SAR) facility (or any institution) for 30 days, must be discharged from the EPD waiver program. The new rule essentially relegates people who need more than 30 days of rehabilitation services to permanent placement in a nursing home. This completely contradicts the purpose of the waiver which is to provide the least restrictive setting for the recipient. Clients have pursued the Medicaid waiver services because they have a preference for remaining in their homes. If a client's rehabilitation at a facility lasts more than 30 days, the new rule effectively bars them from having the choice to return home because now the waiting list is so long. Once discharged from the Medicaid waiver program, it would take months, if not years, to rise to the top of the list again. Additionally, by defaulting to nursing home placement for this person, the city's cost of care for that client has greatly increased.

Medicare guidelines allow for up to 100 days of rehabilitation services in a SAR if the beneficiary requires the continuation of therapy services. We recommend that the DHCF consider a longer period, perhaps 90 days, before discharging someone from the EPD waiver. This is particularly important for continuity of care now that a waiting list for services has been implemented.

Waiting List: In the summer of 2011, DC's EPD waiver reached its cap of 3940 recipients. The provider community has great concerns about the lack of transparency in the way the waiting list is being managed.

a. Only the first 500 people have received letters stating what their number on the waiting list is and the additional people have not been assigned a number, so they are unclear on their status.
b. We are frankly worried that people are getting lost. This concern came from an incident that happened at the start of the waiting list. Our agency made 23 referrals to the waiver waitlist and when we called to confirm the status of these referrals, 10 of those people were not on the list at all. Despite having time stamped emails, DHCF was not able to get the people back on the waiting list at the point at which the initial referrals were made, thus the clients have been "bumped down" the list, making the possibility of getting this precious service more remote. If nearly half of the names added by our program were missing, it begs the question of how many more individuals have been dropped from the waitlist.
c. Since that time, DHCF has instituted a rule that providers cannot call DHCF to check on the status of their clients on the waiting list – only the client or caregiver can call. If a case manager made the initial referral, the client gave permission to the provider to represent them. In the waiver system, the case manager serves as the gate keeper and ushers the client's application through the process. Many individuals who are in need of waiver services are vulnerable and have limited abilities to navigate a complex system such as DHCF and the referral process. We are concerned that by blocking providers from being able to advocate on their clients' behalf, they will be lost in what is often a cumbersome system. Continued case management involvement would also help to ensure that recipients do not get bumped off the list once they rise to the top of the waiting list. Currently the process as described by DHCF is as follows:
    a. a letter goes out and client has five days to respond
    b. second letter is sent out by DHCF if the recipient does not respond
    c. after 15 business days, DHCF calls client or personal representative
    d. If no answer, then DHCF closes the slot and goes to the next person.

If an agency is also notified in the process, the client is unlikely to lose their spot due to inattention. Many of the people who need EPD services are very ill, or suffer from dementia or have completely overwhelmed caregivers who may not pay attention to a mailing. Clients also bounce back and forth from hospital to rehab, etc and may have had to pursue other care options while they wait for the EPD services. The involvement of an agency will help inform DHCF where the client is and increase the chances of the client being able to access this needed service and preserve their slot.

d. Recommendations: If a client contacts an agency to find out information about the waiver and asks the agency to represent them, this should satisfy the "choice of provider" requirement of the program. This way, the agency could remain involved and advocate on the client's behalf, and from a business standpoint, be able to measure their future business prospects.

Communication – since the start of Mayor Gray's administration, there have been quite a few changes in the administration of the EPD waiver program. To the credit of the DHCF staff, there have been regular monthly meetings, but communication has often been confusing with contradictory information given at different meetings. For clarity, we respectfully suggest that each meeting be recorded and minutes distributed the following week so that all participants receive a consistent message. Additionally, this would allow clear, consistent information to be disseminated to those who were not able to attend a particular meeting.

The provider community would also like to reiterate a continuing concern about communication by DHCF staff. We understand the heavy volume of requests the department receives, but we hope to see a cultural change occur. There are several staff members who are responsive, but from surveying the provider community, emails and phone calls are routinely ignored by DHCF staff. This is a huge barrier to resolving beneficiary's problems and providing needed services to the DC community of elders and those with physical disabilities.

Change Requests: Another significant concern is the processing of change requests. Change requests are sometimes required for waiver beneficiaries who have experienced a significant functional decline usually due to an acute medical event such as stroke, cancer or fall. In these situations, case managers request a change to increase hours of Personal Care Aide assistance so that the beneficiary can remain in his home. This process requires the case manager to submit a change request to DHCF for prior authorization to initiate the additional services. At

the time of request, the beneficiary often requires an increase in services in an expedited fashion in order to receive needed care and to ensure their safety in the community.

DHCF has provided conflicting information regarding how to complete the change request forms and the information that needs to be included. In some cases, the change request approval was delayed nearly two weeks due to a back and forth dialogue between our staff and DHCF despite multiple attempts to follow DHCF's recommendations. The information required by DHCF has changed, yet no formal training, transmittal or guidelines have been provided. A training has been promised for months, but to date, none has been forth coming. The lack of clarity has resulted in continuing delays in processing change requests. For beneficiaries, this delay can potentially make the difference between staying in the community or needing institutionalization.