Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building, Room 201
Indianapolis, IN. 46202-4800
(317) 278-9130

March 24, 2010

Mr. Stephen Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criteria #6 – Provision of Services to Children and Adolescents with Severe Emotional Disturbance

Dear Mr. Baron,

I have reviewed your letter of February 24, 2010, regarding compliance levels on Exit Criterion #6 – Provision of Services to Children and Adolescents with Severe Emotional Disturbance. Your February 24, 2010 letter, documents that DMH has (for FY 2009) achieved a penetration rate of 3.45% based on a total of 3,935 children and adolescents with SED served out of the total District census of 114,036 (ages 0-17).

I appreciate the significant improvement that DMH has made on this Exit Criterion with the inclusion of the MCO data. With the inclusion of the MCO data, DMH has now exceeded the Court-approved compliance level of 3%. Therefore, I recommend that this Exit Criterion move to inactive status.

Sincerely,

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

cc: Robert Duncan
Anthony Herman
Iris Gonzalez
Anne Sturtz

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

February 24, 2010

Dennis R. Jones, Monitor
1111 10th Street, Suite 201
Indianapolis, Indiana 46202

Re: Dixon et al. v. Fenty, et al.
CA No. 74-285 (TFH)
Evidence of Compliance with Exit Criterion #6 – Provision of Services to Children and Adolescents with Severe Emotional Disturbance

Dear Mr. Jones:

I am pleased to report that the Department of Mental Health ("DMH") has met the performance target for Exit Criterion #6 – Provision of Services to Children and Adolescents with Severe Emotional Disturbance ("SED"). Therefore, in accordance with the December 12, 2003 Consent Order Approving Agreed Exit Criteria With Measurement Methodology and Performance Levels (the "Exit Criteria Order"), DMH is formally submitting evidence that the District of Columbia has achieved compliance with Exit Criterion #6.

We request that the Dixon Court Monitor: (1) find that DMH has achieved compliance with the required performance level for Exit Criterion #6; (2) report on the performance levels for Exit Criterion #6 to the U.S. District Court as required by the Exit Criteria Order; and (3) cease active monitoring of Exit Criterion #6.

Exit Criterion # 6 Requirements

The Exit Criteria Order includes the following requirements for demonstrating compliance with the performance levels established in Exit Criterion #6:

General Methodology for Measurement: The percentage of each District subpopulation shall be measured.

Required Performance Levels: 3%.

Operational Definition: The number of enrolled children and adolescents (ages 0-17) with a primary mental health diagnosis 295-297.1, 298.9, 300.4, 309.81, 311, 312.8-9, 313.81 or 314 who received at least one provided service as a percentage of the DC population, ages 0-17.

Diagnosis: The first (or initial) DSM-IV diagnosis in the reporting period.

Age: For a person turning 18 during the reporting period, the age at first encounter during the period will be used for reporting purposes.

Enrolled: Enrolled in the Department's community services enrollment and payment system.

Served: Received a MHRS service (including an assessment service), inpatient or residential service during the period.

D.C. population: U.S. Census Bureau Estimate for the calendar year.

Target: 3% for the aggregate in one full year.

One Full Year: Means any four consecutive quarters.

Aggregate: Means cumulative performance over four consecutive quarters.

Evidence of Compliance with Measurement Methodology and Performance Level

1. **Policy and Practice Requirements**. On June 21, 2002, DMH adopted 22A DCMR Chapter 12, Priority Populations, which sets forth definitions of children and youth with severe emotional disturbance ("SED"). The Court Monitor validated that that DMH has the necessary policies in place to ensure that services are provided to children and youth beginning with his July 2006 report[1] and continuing through his January 2010 report[2].

2. **Data Collection Methods**. Historically, DMH has only submitted data to the Court Monitor about mental health services provided through DMH's MHRS program, which has resulted in significant under-reporting of the publicly funded mental health services provided to children and youth that are funded by the District.

DMH has obtained and analyzed data from the Medicaid Managed Care Organizations ("MCOs") about mental health services provided to MCO enrollees. DMH proposes to include

[1] *See* Court Monitor's July 2006 report, page 7. *Also see*, Court Monitor's January 2007 report, page 8; Court Monitor's July 2007 report, page 8; Court Monitor's January 2008 report, page 7; and Court Monitor's July 2008 report, page 10.
[2] *See*, Court Monitor's July 2010 report, pages 8 - 9.

the data about mental health services provided by the MCO's in the penetration rate reporting for FY 2009. The basis for this request is further discussed below in subsection (b).

(a) **MHRS System.** DMH developed metrics for reporting data regarding the MHRS services provided to children and youth DMH's data collection methods for Exit Criterion #6 was validated by Dr. Joan Durman, a consultant retained by the Court Monitor's Office on January 25, 2007. Dr. Durman validated a revised data collection method for Exit Criterion # 6 on April 23, 2008[3].

(b) **Medicaid Managed Care Organizations**. The District of Columbia, Department of Health Care Financing ("DHCF"), which is the state Medicaid agency, contracts with MCO's for the provision of health care services for a majority of children, adolescents and adults who are Medicaid recipients. Youth eligible for Medicaid who are also receiving Supplemental Security Income ("SSI") have the option of enrolling in a specially designed MCO.

As discussed at length in my letter of May 15, 2008 regarding Exit Criterion #17, the District requires MCO's to obtain and maintain accreditation from the National Committee for Quality Assurance ("NCQA"). NCQA accredits a variety of health plans and requires annual reporting of performance on performance measures from accredited healthcare plans. These performance measures are referred to as the Healthcare Effectiveness Data and Information Set ("HEDIS") and are used by health plans, employers and other health insurance purchasers to measure performance on various dimensions of care and service. In order to maintain accreditation and to comply with the requirements of their contracts with the District, the Medicaid MCOs are required to report HEDIS data to DHCF.

On January 2, 2009, DMH and DHCF finalized a memorandum of understanding addressing the MCO contract obligations to DHCF and DMH for oversight of mental health services provided by the MCOs. Among other things, the MOU provides that DHCF will make HEDIS encounter data regarding mental health services provided to MCO recipients available to DMH. The MCOs are an integral part of the District's public health system and the MOU with DHCF regarding the MCO's clearly establishes DMH authority, provider oversight and the justification for inclusion of MCO enrolled consumers in the penetration rate calculation for Exit Criteria #5 - #8[4].

DMH has revised its metric for reporting on Exit Criterion #6 to include MCO data effective February 23, 2010. A copy of the approved data collection metric for Exit Criterion #6 is attached and marked as ***Exhibit A***.

3. **Performance Levels**. DMH has collected data regarding publicly funded mental health services provided in FY 2009 using the approved *Dixon* data reporting metric for Exit Criterion #6.

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[3] The revised metric included some changes in SQL statements used to extract data from eCura.

[4] Although DMH has already achieved compliance with Exit Criterion #8, DMH has also developed a metric for reporting MCO data regarding services provided to adults with SMI, which was also validated by Dr. Durman.

The data for Exit Criterion #6 is as follows:

EXIT CRITERION #6 SERVICES TO CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCES PERFORMANCE TARGET: 3%	
CHILDREN & YOUTH WITH SED SERVED ONLY THROUGH MHRS PROGRAM[5]	2,201
CHILDREN & YOUTH WITH SED SERVED BY MEDICAID MCO's ONLY[6]	1,019
CHILDREN & YOUTH WITH SED SERVED BY BOTH MCO's & MHRS PROGRAM[7]	715
UNDUPLICATED COMBINED TOTAL OF CHILDREN & YOUTH WITH SED RECEIVING MENTAL HEALTH SERVICES	3,935
CHILD CENSUS[8]	114,036
PENETRATION RATE	**3.45%**

Conclusion.

DMH has met and exceeded the performance target for Exit Criterion #6 for FY 2009. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has met the required performance level for Exit Criterion #6; (2) report on the performance levels for Exit Criterion #6 to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #6.

If you have any questions or wish to discuss this matter further, please feel free to call me.

Sincerely,

Stephen T. Baron
Director

Attachment

Cc: Anthony Herman, Counsel to the Dixon Plaintiffs
Grace Graham, Counsel for the District of Columbia

[5] Based upon claims submitted for processing for MHRS services provided in FY 2009 as of January 29, 2010.
[6] Based upon encounter data submitted by the MCOs to DHCF for services provided in FY 2009 as of February 1, 2010.
[7] Based upon an analysis of the MHRS claims submitted for processing as of January 29, 2010 and the encounter data submitted by the MCO's as of February 1, 2010 for services rendered in FY 2009.
[8] Based upon U.S. Census Bureau Estimate of the Population by Selected Age Groups for the United State and States and Puerto Rico: July 1, 2009. ***See www.census.gov/popest/states/asrh***.

EXHIBIT A

PENETRATION RATES: CHILDREN WITH SED METRIC 6

Demonstrated provision of service to children with serious emotional disturbance

DATA METHODS	
Operational Definition	The number of enrolled children and adolescents (ages 0-17) with a primary mental health diagnosis of 295-297.1, 298.9, 300.4, 309.81, 311, 312.8-9, 313.81 or 314 who received at least one provided service as a percentage of the DC population, ages 0-17. Services may be provided directly by the Department of Mental Health (DMH), through agencies under contract to DMH or through a Medicaid Managed Care Organization (MCO) funded by the District of Columbia to provide these services.
Target	3% in the aggregate for one full year
Method	For directly provided services: ▪ Using e-Cura, select all paid claims for the reporting period. Paid claims have an enrollment date, date of service received, and a mental health diagnosis. ▪ Select persons ages 0 through 17 years. Include persons who turned 18 during the reporting period, if they were age 17 at the time of the first encounter. ▪ Select the first or initial DSM-IV diagnosis that matches one of the following diagnoses: 295-297.1, 298.9, 300.4, 309.81, 311, 312.8-9, 313.81 or 314. For example, if the report covers April 1, 2005 through March 31, 2006, then: ▪ Select all paid claims (where a warrant has been approved) for the period April 1, 2005 through March 31, 2006: o Date From BETWEEN 04-01-2005(First date of reporting period) AND o 03-31-2006(Last date of this reporting period). ▪ Select all paid claims during this period where the -adjudicated amount is greater than $0 o Adjudicated amount GT 0. ▪ Select persons whose ages 0 -17 years – age is calculated as on the earliest service date in the fiscal year. ▪ Select if DSM IV diagnoses: 295-297.1, 298.9, 300.4, 309.81, 311, 312.8-9, 313.81 or 314. For MCO services: ▪ Using data provided by the MCOs, follow the procedure outlines above. Combine data from e-Cura and the MCOs, using the automated procedure noted below.

	The formula used to calculate this metric for the above example is shown in this SQL statement: CREATE TABLE dbo.FY08Patient (PATIENT_ID int NOT NULL, LAST_NAME char(30) NOT NULL, FIRST_NAME char(30) NOT NULL, BIRTHDATE datetime NULL, SEX char(1) NOT NULL, SS_NUMBER char(11) NOT NULL, EarlySvc datetime NULL, Adjud_Dollars money NULL, AGE int NULL, INSUR_NUM char(8) NULL, unique_ident char(15) NULL, SMISED char(3) NULL) INSERT INTO FY08Patient (PATIENT_ID, LAST_NAME, FIRST_NAME, BIRTHDATE, SEX, SS_NUMBER, EarlySvc, Adjud_Dollars) SELECT t.PATIENT_ID, pt.LAST_NAME, pt.FIRST_NAME, pt.BIRTHDATE, pt.SEX, pt.SS_NUMBER, MIN(D.DATE_FROM) as EarlySvc, SUM(A.Adjud_Doll) as Adjud_Dollars FROM sdmhdc14.cc3.dbo.ClaimDet D INNER JOIN sdmhdc14.cc3.dbo.ClaimAdj A ON D.ClaimMst_I = A.ClaimMst_I INNER JOIN sdmhdc14.cc3.dbo.ClaimMst M ON A.ClaimMst_I = M.ClaimMst_I INNER JOIN sdmhdc14.cc3.dbo.TREAT t ON M.Bill_Numbr = T.Bill_Numbr INNER JOIN sdmhdc14.cc3.dbo.PATIENT pt ON t.patient_id = pt.patient_id WHERE A.STAT_ID = 1 AND D.DATE_FROM Between '10/01/2007' and '09/30/2008' AND A.Adjud_Doll > 0 GROUP BY t.PATIENT_ID, pt.LAST_NAME, pt.FIRST_NAME, pt.BIRTHDATE, pt.SEX, pt.SS_NUMBER HAVING SUM(A.Adjud_Doll) > 0 UPDATE FY08Patient SET AGE = CASE WHEN DATEPART(DY, BirthDate) < DATEPART(DY, EarlySvc) THEN DATEDIFF(YEAR, BirthDate, EarlySvc) ELSE DATEDIFF(YEAR, BirthDate, EarlySvc) - 1 END UPDATE f

```
SET f.INSUR_NUM = i.INSUR_NUM
FROM FY08Patient f
    INNER JOIN sdmhdc14.cc3.dbo.INSUSPAN i
    ON f.patient_id = i.patient_id
WHERE LEN(i.INSUR_NUM) = 8
AND   i.INSUR_NUM  like '7%'
AND   i.PHEAD_ID = 31
AND   DATEDIFF(DD, Date_From, Date_To) > 0

CREATE TABLE SMIDX
(Axis_ID INT NOT NULL,
 Axis    VARCHAR(6) NOT NULL)

INSERT INTO SMIDX
SELECT Axis_ID, Axis
FROM   sdmhdc14.cc3.dbo.Axis
WHERE  Axis BETWEEN '295' AND '297.1'
or    AXIS in ('298.9','300.4', '309.81')
or    AXIS like '311%'

CREATE TABLE SEDDX
(Axis_ID INT NOT NULL,
 Axis    VARCHAR(6) NOT NULL)
INSERT INTO SEDDX
SELECT Axis_ID, Axis
FROM   sdmhdc14.cc3.dbo.Axis
WHERE  Axis BETWEEN '295' AND '297.1'
OR     Axis IN ('298.9','300.4', '309.81','313.81')
OR     Axis LIKE '311%'
OR     Axis LIKE '312.[8-9]%'
OR     Axis LIKE '314%'

SELECT DISTINCT t.Patient_ID
INTO  FY08SMIPatient
FROM   sdmhdc14.cc3.dbo.ClaimDet D
      INNER JOIN sdmhdc14.cc3.dbo.ClaimAdj A
                              ON D.ClaimMst_I =  A.ClaimMst_I
      INNER JOIN sdmhdc14.cc3.dbo.ClaimMst M
            ON A.ClaimMst_I =  M.ClaimMst_I
      INNER JOIN sdmhdc14.cc3.dbo.TREAT t
            ON  M.Bill_Numbr = T.Bill_Numbr
      INNER JOIN SMIDX S
            ON D.Prin_Diag = S.Axis_ID
WHERE A.STAT_ID = 1
AND   D.DATE_FROM Between '10/01/2007' and '09/30/2008'
AND A.Adjud_Doll > 0

UPDATE F
SET    F.SMISED = 'SMI'
FROM   FY08Patient f
      INNER JOIN FY08SMIPatient S
            ON F.Patient_ID = S.PAtient_ID
WHERE  F.AGE > 17

SELECT DISTINCT t.Patient_ID
INTO  FY08SEDPatient
FROM   sdmhdc14.cc3.dbo.ClaimDet D
```

```
    INNER JOIN sdmhdc14.cc3.dbo.ClaimAdj A
                        ON D.ClaimMst_I =  A.ClaimMst_I
    INNER JOIN sdmhdc14.cc3.dbo.ClaimMst M
        ON A.ClaimMst_I =  M.ClaimMst_I
    INNER JOIN sdmhdc14.cc3.dbo.TREAT t
        ON  M.Bill_Numbr = T.Bill_Numbr
    INNER JOIN SEDDX S
        ON D.Prin_Diag = S.Axis_ID
WHERE A.STAT_ID = 1
AND   D.DATE_FROM Between '10/01/2007' and '09/30/2008'
AND A.Adjud_Doll > 0

UPDATE F
SET   F.SMISED = 'SED'
FROM   FY08Patient f
    INNER JOIN FY08SEDPatient S
        ON F.Patient_ID = S.PAtient_ID
WHERE  F.AGE BETWEEN 0 AND 17

UPDATE MCO
SET sa =  'y'
WHERE (diagnosiscode1 like '303%'
or diagnosiscode1 like '304%'
or diagnosiscode1 like '305%')
AND SourceFile = '2008Access'

SELECT DISTINCT MedicaidID, BirthDate
INTO #NO_DOB
FROM MCO
WHERE sa IS NULL
AND ProcedureCode BETWEEN '90801' AND '90899'
AND SourceFile = '2008Access'
AND BirthDate IS NULL

UPDATE n
SET n.BirthDate = m.BirthDate
FROM #NO_DOB n INNER JOIN
   MCO m ON n.MedicaidID = m.MedicaidID
WHERE m.BirthDate IS NOT NULL

UPDATE m
SET m.BirthDate = n.BirthDate
FROM  MCO m INNER JOIN
    #NO_DOB n  ON m.MedicaidID = n.MedicaidID
WHERE m.BirthDate IS NULL

UPDATE MCO
SET age = CASE WHEN DATEPART(DY, BirthDate) < DATEPART(DY,
ServiceBeginDate)
        THEN DATEDIFF(YEAR, BirthDate, ServiceBeginDate)
        ELSE DATEDIFF(YEAR, BirthDate, ServiceBeginDate) - 1 END
WHERE sa IS NULL
AND ProcedureCode BETWEEN '90801' AND '90899'
AND SourceFile = '2008Access'
UPDATE m
SET m.eCura = 'y'
FROM MCO m,
```

```
    FY08Patient f
WHERE m.MedicaidID = f.INSUR_NUM
AND m.SourceFile = '2008Access'
AND ProcedureCode BETWEEN '90801' AND '90899'
AND sa IS NULL

SELECT MedicaidID, MIN(age) as age
INTO #MCO
FROM MCO
WHERE SourceFile = '2008Access'
AND ProcedureCode BETWEEN '90801' AND '90899'
AND sa IS NULL
GROUP BY MedicaidID

UPDATE m
SET m.age =  o.age
FROM MCO m,
   #MCO o
WHERE m.MedicaidID = o.MedicaidID
AND SourceFile = '2008Access'
AND ProcedureCode BETWEEN '90801' AND '90899'
AND sa IS NULL

UPDATE MCO
SET   DXCode = CASE  WHEN LEN(DiagnosisCode1) > 3
            THEN SUBSTRING(DiagnosisCode1, 1, 3) + '.' +
SUBSTRING(DiagnosisCode1, 4, 3)
            ELSE DiagnosisCode1 END

UPDATE MCO
SET   SMISED =  'SED'
WHERE  (DXCode between '295' and '297.1'
or    DXCode in ('298.9','300.4', '309.81','313.81')
or    DXCode like '311%'
or    DXCode like '312.[8-9]%'
or    DXCode like '314%')
AND   ISNULL(Age,0) BETWEEN 0 AND 17
AND SourceFile = '2008Access'
AND sa IS NULL
AND ProcedureCode BETWEEN '90801' AND '90899'

UPDATE MCO
SET   SMISED = 'SMI'
WHERE  (DXCode between '295' and '297.1'
or    DXCode in ('298.9','300.4', '309.81')
or    DXCode like '311%')
AND   Age > 17
AND SourceFile = '2008Access'
AND sa IS NULL
AND ProcedureCode BETWEEN '90801' AND '90899'

SELECT DISTINCT MedicaidID
INTO #FY08_MCO_SMI
FROM MCO
WHERE SMISED = 'SMI'
AND sa IS NULL
AND SourceFile = '2008Access'
```

	AND ProcedureCode BETWEEN '90801' AND '90899' UPDATE M SET SMISED = 'SMI' FROM MCO M, #FY08_MCO_SMI F WHERE M.MedicaidID = F.MedicaidID AND sa IS NULL AND SourceFile = '2008Access' AND ProcedureCode BETWEEN '90801' AND '90899' SELECT DISTINCT MedicaidID INTO #FY08_MCO_SED FROM MCO WHERE SMISED = 'SED' AND sa IS NULL AND SourceFile = '2008Access' AND ProcedureCode BETWEEN '90801' AND '90899' UPDATE M SET SMISED = 'SED' FROM MCO M, #FY08_MCO_SED F WHERE M.MedicaidID = F.MedicaidID AND sa IS NULL AND SourceFile = '2008Access' AND ProcedureCode BETWEEN '90801' AND '90899' SELECT PATIENT_ID, LAST_NAME, FIRST_NAME, BIRTHDATE, SEX, SS_NUMBER, AGE, INSUR_NUM, SMISED, 'eCura' as 'Source' INTO Complete_FY08 FROM FY08Patient INSERT INTO Complete_FY08 SELECT DISTINCT 1111, ISNULL(LastName, 'UNKNOWN'), ISNULL(FirstName, 'UNKNOWN'), BirthDate, Gender, ISNULL(SSN, 'UNKNOWN'), age, MedicaidID, SMISED, 'MCO' FROM MCO WHERE eCura IS NULL AND SourceFile = '2008Access' AND sa IS NULL AND ProcedureCode BETWEEN '90801' AND '90899' /*Exit Criterion 6 */ SELECT COUNT(DISTINCT CASE WHEN Source = 'MCO' THEN INSUR_NUM ELSE PATIENT_ID END) AS SED_Children_Served FROM Complete_FY08 WHERE age BETWEEN 0 AND 17 AND SMISED = 'SED'
Sources	eCura: CLAIM, CLAIM_DETAIL, and PATIENT. US Census Population Estimate for the calendar year 2004. MCOs collect consumer data and record these data in their own data systems. A file similar to the one generated from e-Cura is produced

	from the MCO data system and sent to DMH. The e-Cura data file is matched with the MCO data file to produce a consolidated file of unduplicated consumers.
Collection Process	Data are collected as a part of the care delivery system in the District of Columbia that is identical to medical care delivery in the private sector. A Provider, after providing an authorized service, sends in a claim for payment. This claim is adjudicated, approved for payment, (i.e., warranted), and added to the database of other paid claims.
Training	All providers are required to attend Provider Connect training prior to using the system. Provider Connect is a web tool that provides eCura functionality over the internet. Provider claim files are independently tested multiple times to insure that they meet HIPAA and data quality requirements prior to going live.
Dictionary	▪ Date From– Date service began ▪ INSUR_NUM – Medicaid ID ▪ STAT_ID – Claim Status ▪ sa – Substance Abuse ▪ SMI – Severely Mentally Ill ▪ SED – Severe Emotional Disturbance ▪ Adjudicated Amount – Adjudicated amount on claims submitted ▪ DX Code – DSM IV Dx
User Manual	Internal Operations Manual, Internal User Manual, and Provider User Manual exist and are used to submit and process claims.
Quality Assurance	Claims are submitted as accurately as possible. However, when errors are encountered, claims are denied. Providers have the option of resubmitting the claims depending on the type of denials. Basically, errors are corrected in both side of the house.
PROCESS VALIDATION	
Persons Validating	DMH Information Technology Services staff
Date	March 1, 2006
Type	Review of data source, data tables, data fields
Process	Review SQL select statements for verification of extract logic and formula.
Results	Metrics were found to be accurately produced.
Validation Confirmation	Joan Durman, Ph.D., January 25, 2007; revised April 23, 2008 (new SQL statements added); revised February 23, 2010 (MCO data added).