

GOVERNMENT OF THE DISTRICT OF COLUMBIA



Department of Health Care Finance

FY 2012 Oversight Hearing

Testimony of

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Department of Health Care Finance

Before the

Council of the District of Columbia

Committee on Health

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John A. Wilson Building

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Introduction

Good morning Chairwoman Alexander and members of the Committee on Health. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and it is my pleasure today to provide a status report on the activities of DHCF over the past year. To ensure that we respond comprehensively to any questions raised during this hearing, I am joined by key DHCF staff members from across the department.

Madam Chairwoman, allow me to start by congratulating you on your leadership of the Committee on Health. I, along with my staff, look forward to working with you on the very important health care issues faced by this Committee.

I must also commend your staff for their quick grasp of some of the critical health care issues affecting the District, as well as their willingness to meet with my staff to discuss in detail some of the problems and challenges we have already faced in your tenure thus far.

Finally, I would like to acknowledge the guidance and support provided by the Office of the Deputy Mayor for Health and Human Services. Many of the beneficiaries of the programs we administer are served by various systems, and they are supported best when these systems work together. Under the guidance and urging of Deputy Mayor Otero, we have worked across agencies to coordinate,

collaborate, and otherwise leverage the resources we have to improve the lives of the people served by the District's public health insurance programs.

My testimony today provides a broad overview of the major issues we faced in FY2012 and a balance sheet, if you will, summarizing the progress made in response to those challenges. In addition, I would like to briefly update the Committee on the next steps we plan to implement for some of the major projects in the agency.

Mission and Priorities of DHCF

DHCF was established as a cabinet-level agency on October 1, 2008 to operate the District's Medicaid and Alliance programs with the fundamental mission to improve the health outcomes of low-income residents of the District. We attempt to accomplish this by providing access to comprehensive health care services through both the Medicaid and Alliance programs.

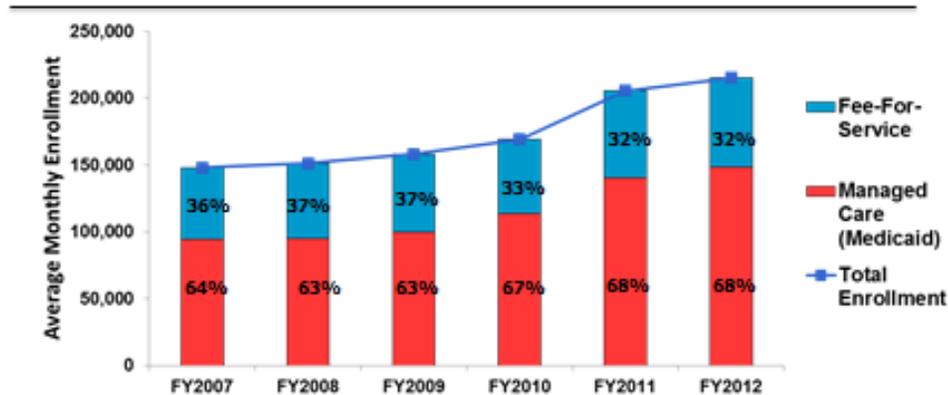
The annual program and administrative cost to implement these health insurance programs is nearly \$2.5 billion. DHCF funds the programs' provider payments, administrative overhead, and vendor contracts through a combination of local dollars, dedicated tax revenue, special purpose and federal funds.

The work of the agency is guided by the four major priorities we established in support of the agency's broadly defined mission. These priorities -- improve patient outcomes, strengthen DHCF's program integrity operations, resolve

Medicaid billing issues with our partner agencies, and successfully implement health care reform -- are unchanged from the first day of the Gray Administration and provide a valuable roadmap to guide the work of agency staff.

In many ways, the work at DHCF is driven by the bifurcated structure of the health care insurance programs we implement. As shown in the graph below, DHCF has moved a large portion of its Medicaid beneficiaries into a system of managed care. Today, nearly seven out of every 10 Medicaid recipients -- and all Alliance beneficiaries -- have their health care services managed by one of three health plans.

**District of Columbia Medicaid Managed Care Enrollment Trends,
FY2007 – FY2012**



While the health plans that we hire to manage beneficiary care handle all patient care coordination and claims processing, DHCF staff must secure a sufficient number of managed care companies to operate the program. Once the plans become a part of Medicaid, we must negotiate rates that are actuarially sound and within the parameters established by the Mayor's budget, develop the contract and performance requirements against which the health plans are evaluated, provide proper oversight of plan activities, and mediate disputes between the plans, their providers, and the beneficiaries. As will be highlighted later in my testimony, DHCF has been forced to address a number of problems in many of these areas over the past 12 months.

The remaining Medicaid beneficiaries receive their care in what we refer to as our fee-for-service environment. These members include children who are in the custody and care of District government, senior citizens, persons with disabilities, and individuals who receive long-term care services to assist them with the basic activities of daily living.

Administratively, DHCF staff must implement a host of activities in support of our fee-for-service program. Notably, we must design reimbursement systems, negotiate payment rates, and complete audits for some of the providers who deliver the care. This provider list includes hospitals, clinics, primary and specialty care physicians, nursing homes, public providers, and community-based care programs.

It is more than a delicate balance to establish payment rates that ensure providers are sufficiently reimbursed to deliver quality care, while adhering to the Mayor's demand that we be good, fiscally responsible stewards of the taxpayers' dollars.

In this context, we must also ensure that the actual payments we process through our Medicaid Management Information System (MMIS) are for allowable services delivered to eligible beneficiaries by certified Medicaid providers. We understand that the most significant threat to large publicly-financed health care programs is waste, fraud, and abuse. We are also aware that on a per-recipient basis, DC's health care expenditures are substantially higher than the levels observed in neighboring jurisdictions of Virginia and Maryland, and are among the most expensive in the United States. DHCF must work diligently to minimize both provider and beneficiary fraud which can inappropriately inflate expenditures for Medicaid and the Alliance program.

As result, each year within DHCF, we discuss and evaluate our agency efforts to enhance program integrity, in part, by better designing and managing the agency's system for editing and verifying claims before they are paid by our MMIS. As will be highlighted later in this testimony, more work is needed in this area.

The final priority area for DHCF is health care reform. The ambitious goals of the health care reform law offer great opportunities for the District while posing

tremendous challenges. There are numerous federal requirements associated with the federal law which we are working to implement. The federal government has established a focus on controlling the incidence of hospital acquired infections, building recovery audit programs in the States, and creating electronic health records to improve the efficiency and effectiveness of patient care. We must attend to these new requirements.

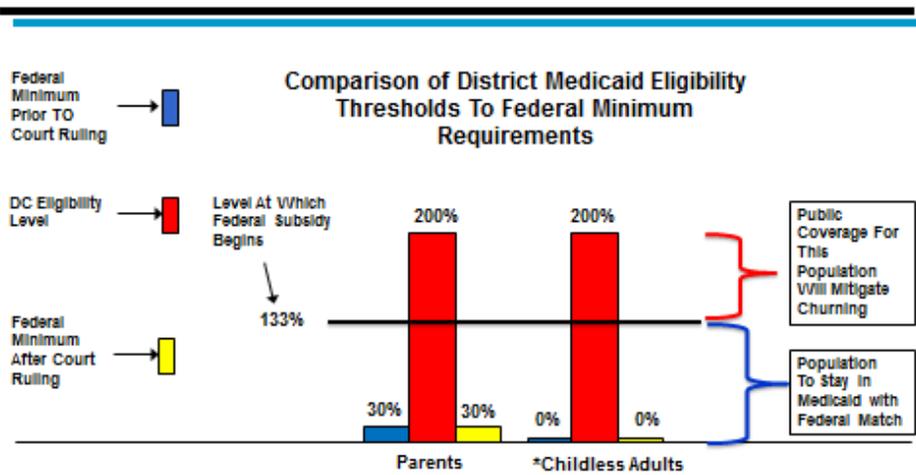
However, the responsibility for perhaps the most daunting challenge of the new law -- building the District's insurance exchange -- is now the exclusive purview of the recently established independent Authority and its eleven-member Board on which I serve. While we have passed the baton for this work to the Authority, it will be very important that DHCF work collaboratively with the Board and its very capable Executive Director, Mila Kofman, to ensure that the Medicaid program is properly integrated into the Exchange.

Our goal is to align Medicaid with the health plans that will be on the Exchange to promote seamless movement for the beneficiaries when a change in coverage is needed. Such an approach will help us avoid chronic problems with Medicaid "churning" -- best described as the involuntary and repeated movement of members between public health plan coverage, private insurance plans, or possibly no coverage due to income fluctuations.

Churning can add significantly to the administrative cost of implementing health insurance programs but can also have more serious consequences for beneficiaries. Most significantly, the frictional movement into and out of health care coverage threatens the consistency of patient care and has the potential to result in adverse health outcomes.

There are strategies that can be employed to reduce churning and Medicaid eligibility expansion is one such approach. As the graphic below indicates, the District has already taken steps to expand coverage for its Medicaid population up to 200 percent of the federal poverty level, thus reducing the number of persons who will lose Medicaid coverage due to modest income growth.

The District's Medicaid Expansion Will Reduce Movement On And Off Of The Program For Beneficiaries In The Lower Income Brackets



*A subset of the Alliance population will be eligible for coverage under the Affordable Care Act

The challenge for DHCF and the Authority will be to take advantage of this expansion by properly aligning the District's Medicaid health plans on the Exchange to ensure seamless coordination. This will require transitioning 150,000 of our beneficiaries to a new income methodology based upon Modified Adjusted Gross Income (MAGI). As a part of this process, we will streamline and automate Medicaid eligibility determinations and renewals and align these processes with those for cost sharing and premium tax assistance programs on the Exchange.

Status of Major Projects at DHCF

At this time, Madam Chairwoman, I would like to provide a brief overview of the status of our major projects in FY2012, outline the progress we have made as of this Hearing, and talk briefly about the next steps we plan to implement in the coming fiscal year.

Our projects range from plans to establish our new managed care program, implement payment reform for the hospitals, establish a program to improve our long-term care services, grow public provider Medicaid claims, and rethink our approaches to mitigating fraud.

For details, I refer you to the status report outlined in the table on pages 10 through 14 which addresses a range of projects cutting across DHCF's four major priorities.

Agency Challenge	Status In FY2012	Most Recent Progress	Next Steps
<p>Reform managed care program.</p> <p><i>Agency Priority - Improve patient outcomes through strong Managed Care Program</i></p>	<ul style="list-style-type: none"> • Program lacking 3rd health plan • Entered into 5th and final year of MCO contracts • Drafted RFP for new MCO contract <ul style="list-style-type: none"> ➢ Current contracts heavily emphasize process measures rather than patient outcomes • Largest MCO entered receivership due to financial problems 	<ul style="list-style-type: none"> • Added a 3rd health plan to the MCO program by awarding contract to MedStar Family Choice Plan in July 2012 • In November 2012, finalized and issued RFP with the goal of establishing three health plans to manage the Medicaid and Alliance programs for the next four years. • RFP strengthened expectations regarding patient outcomes, including care coordination, case management, and network adequacy • Plan to send three contracts to Council by March 27th for the new five-year program 	<ul style="list-style-type: none"> • Seek approval from Council for new MCO contracts • Complete transition of any new MCO plans by start of the new contract year • Following the selection of the MCOs, begin discussions around additional contract criteria that will be put in place to ensure increased access for special populations, enhanced care coordination, improved patient outcomes, and greater accountability by the health plans
<p>Payment Reform for Hospitals.</p> <p><i>Agency Priority - Improve program integrity by redesigning hospital payment rates</i></p>	<ul style="list-style-type: none"> • Hospital DRG payment methodology not in compliance with federal regulations <ul style="list-style-type: none"> • Hospital overpayments totaled nearly \$126 million • Hospital reporting for Disproportionate Share Hospital funding not in compliance with federal regulations resulting in overpayments for some hospitals • Hospital outpatient reimbursement methodology is antiquated and only covers 47 percent of hospital Medicaid outpatient cost 	<ul style="list-style-type: none"> • Redesigned the hospital DRG system to conform with federal payment rules and saved \$126 million (\$38 million local) • Redesigned the data collection tool used by hospitals to report uncompensated care and reallocated Disproportionate Share Hospital funding based on more accurate reporting • Developed a work plan to shift hospitals to the ICD-10-CM system used to classify and code all diagnoses • Developed a work plan to update the grouper used to calculate in-patient payment rates, modernize the hospital outpatient payment methodology, and develop new payment methods for non-DRG hospitals 	<ul style="list-style-type: none"> • Implement the work plan to complete ICD-10-CM conversion and update the outpatient payment methodology

Agency Challenge	Status In FY2012	Most Recent Progress	Next Steps
<p>Reform the personal care program.</p> <p><i>Agency Priority - Enhance program integrity by modifying the rules around the delivery of personal care and developing an enhanced system of monitoring</i></p>	<ul style="list-style-type: none"> Implemented new rule for personal care aides to improve program integrity safeguards Determined additional revisions to personal care aide policy needed to further strengthen the program Issued RFP for ASO long term care services project 	<ul style="list-style-type: none"> 2nd personal care aide rule is in draft and will establish conflict-free assessment; rescind 10% rule related to staffing agencies; and clarify level of need requirements An assessment tool that allows DHCF to more accurately match service hours to patient care needs is under development. Vendors submitted proposals for ASO long-term care services project 	<ul style="list-style-type: none"> Publish and implement 2nd PCA rule Award contract to vendor for ASO long-term care services project in April 2013 Implement ASO project by end of FY2013 Design and implement new Quality Improvement System (QIS) for overseeing vendor and service providers.
<p>Redesign the ICF/DD rate methodology.</p> <p><i>Agency Priority - Improve patient outcomes by developing a rate model that promotes quality care at the lowest possible cost to the District Medicaid program</i></p>	<ul style="list-style-type: none"> Designed a rate model that is based on individual client needs and supports six patient acuity levels Model has six cost center components and does not overpay on capital Model contains stringent patient care requirements and is designed to reduce funding for administrative expenses if providers under spend on patient care Model received approval from all stakeholders and the opposition to the provider tax has been dropped Model supports the District's living wage requirements 	<ul style="list-style-type: none"> Developed and submitted Medicaid State Plan Amendment to CMS on June 22, 2012 seeking approval of new methodology CMS approved SPA on January 25, 2013, effective retroactively to October 1, 2012 Established new rates by individual provider Acuity levels redone under new model for all current ICF individuals Providers informed of new acuity levels for each individual in their program 	<ul style="list-style-type: none"> Implement State Plan Amendment Institute weekly implementation calls with providers Begin paying new rates for dates of services March 1, 2013 Begin retroactive payments (October 2012 – February 28, 2013) to providers on April 1

Agency Challenge	Status In FY2012	Most Recent Progress	Next Steps
<p>Update ID/DD Waiver</p> <p><i>Agency Priority - Improve patient outcomes by renewing the District's waiver program for persons with intellectual and developmental disabilities</i></p>	<ul style="list-style-type: none"> • Work on developing new waiver as the federal authorization for the program was due to expire in FY2013 <ul style="list-style-type: none"> ➢ \$65 million in federal funding at risk • Existing waiver had unnecessary services which reduced the cost effectiveness of the program 	<ul style="list-style-type: none"> • Renewal waiver submitted to CMS in time and approved on October 25, 2012, one month before the authorization expired • New waiver funds a wide range of services but also eliminates others • New waiver monitoring and oversight work plan drafted • Electronic system for monitoring under agency development 	<ul style="list-style-type: none"> • Finalize work plan and electronic database for continued monitoring and oversight of the waiver
<p>Redesign Day Treatment Services</p> <p><i>Agency Priority - Enhance program integrity by modifying the rules around the delivery of day treatment services to ensure federal compliance</i></p>	<ul style="list-style-type: none"> • CMS informed DHCF that it has been providing day treatment services without proper authorization for more than 20 years <ul style="list-style-type: none"> ➢ Failure to address the problem would expose the District to significant federal disallowances • Enrollment of new day treatment providers halted February 2012 	<ul style="list-style-type: none"> • Formed a multi-agency task force with sister agencies and providers to redesign the program • Ongoing monthly meetings with stakeholders to work through problems • Identified beneficiaries who are impacted <ul style="list-style-type: none"> ➢ Developed and began implementation of plan to transition beneficiaries from Day Treatment to allowable services • Enrollment of new participants halted January 2013 • Started work on 1915(i) State Plan program for elderly and frail adults to replace existing design 	<ul style="list-style-type: none"> • Submit 1915(i) State Plan Amendment to CMS to bring program into compliance in 2013 • Redesign eligibility criteria as a part of a comprehensive restructuring of the District's entire long-term care program • Revise level of care for nursing facilities

Agency Challenge	Status In FY2012	Most Recent Progress	Next Steps
<p>Enhance Medicaid public provider billing.</p> <p><i>Agency Priority - Enhance program integrity by improving the accuracy of public provider billing</i></p>	<ul style="list-style-type: none"> Four agencies -- CFSA, DCPS, OSSE, and Charter Schools -- with the most potential for receiving significant public funds were either not claiming at all or being reimbursed for a limited range of services 	<ul style="list-style-type: none"> DCPS and OSSE established their own billing systems and have been successfully linked to the ASO claims adjudication system. Claims submission went live during the 1st week in April 2012 For CFSA, claiming continues for clinic services DHCF staff is working closely with CFSA to implement the required State Plan Amendment to allow the agency to bill for Targeted Case Management. Scheduled approval is prior to end of FY2013 	<ul style="list-style-type: none"> Work with DCPS and OSSE to increase the claims volume now that the billing system is operational Upon approval of the State Plan Amendment for Targeted Case Management, DHCF and CFSA will work with CMS to seek approval of a plan to allow for the reimbursement of rehabilitation services Track progress on the State Plan Amendment to allow OSSE to bill for services provided in non-public schools Bring FEMS into the ASO process and revisit the rates paid for ambulance services to increase revenue for the District
<p>Implement Health Care Reform.</p> <p><i>Agency Priority – Successfully implement health care reform in the District.</i></p>	<ul style="list-style-type: none"> RFP released for Recovery Audit Contractor (RAC) CMS approved State Plan Amendment for Hospital Acquired Conditions on July 26, 2012 Progress significantly delayed on Health Information Exchange (HIE) and Electronic Health Records (EHRs) Submitted Level II Establishment Grant to build out the Health Benefits Exchange (HBX) Submitted successful application for a Health Homes Planning Grant to create an integrated health care system for Medicaid eligible individuals with chronic illness Submitted successful application for a Medicaid Emergency Psychiatric Demonstration (MEPD) 	<ul style="list-style-type: none"> RAC contract awarded to vendor Implemented Direct Secure Messaging (Direct) in November 2012, allowing health care providers and professionals to electronically share patient health information Re-issued solicitation for vendor to implement EHR project Selected vendor -- Xerox -- for EHR project Awarded \$73 million Level II Establishment Grant to implement the HBX Designed and implemented the MEPD demonstration, effective July 1, 2012 Established policy framework and drafting state plan amendments related to streamlining eligibility and adopting the MAGI methodology 	<ul style="list-style-type: none"> RAC vendor begins analysis and audit of provider claims Expand number of subscribers to Direct Roll out EHR's project in May 2013 Implement increase in rates for primary care services, as mandated by the ACA Implement streamlined eligibility processes and the MAGI income methodology on October 1, 2013 Develop health home option for Medicaid

Agency Challenge	Status In FY2012	Most Recent Progress	Next Steps
<p>Program Integrity</p> <p><i>Agency Priority - Enhance program integrity by establishing the necessary system edits in MMIS to minimize improper payments and reduce Medicaid disallowed costs</i></p>	<ul style="list-style-type: none"> • The agency received MMIS federal certification just prior to the established deadline in October 2011 • Internal Steering Committee established to systematically assess existing gaps in edit protocols and develop solutions but work has moved slowly • Edits added to safeguard a number of benefits – dental, personal care, ID/DD and EPD Waiver services 	<ul style="list-style-type: none"> • Agency meeting with vendors to discuss cutting edge technology for reducing improper payment 	<ul style="list-style-type: none"> • Increase pace and volume of work for Steering Committee to identify additional gaps in the DHCF’s edits protocols • Explore whether to establish a prospective payment edit system to stop improper payments before they are processed by MMIS

Conclusion

Madam Chairwoman, as this status report reveals, we have accomplished much over the past year but face many challenges ahead. The evolution of our managed care program, plans for hospital payment reform, the redesign and effective management of the District’s long-term care services, the progress of our fraud mitigation strategies, and DHCF’s ambitious plan to develop the appropriate linkages to the District’s efforts to stand up an insurance exchange are all projects that demand great effort and warrant the close scrutiny of this Committee.

As always, under the guidance of Mayor Vincent Gray and the general direction of Deputy Mayor Otero, we will aggressively tackle these issues and vigilantly monitor the agency’s progress. In the course of our efforts, we look

forward to open dialogue with the Committee on Health as well as opportunities to work with you and your staff in the coming months.

This concludes my presentation and my staff and I are happy to address your questions as well as those of other Committee members.