GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DISTRICT OF COLUMBIA MEDICAL CARE ADVISORY COMMITTEE (MCAC)

Meeting Minutes
Wednesday, May 25, 2016
1:00 pm to 2:30 pm

Attendance

Jacqueline Bowens, DC Primary Care Assn
HyeSook Chung, DC Action for Children
Ron Swanda, DC Commission on Aging
Michael Villafranca, Children's Law Center
Tim Sullivan, MedStar Family Choice
Erin Loubier, Whitman Walker Health
Thomas Duncan, Trusted Health Plan
Judith Levy, DC Coalition on Long Term Care
Michael Crawford, Unity Health Care
Claudia Schlosberg, DHCF
Carmelita White, DHCF
Justin Palmer, DCHA
Mark LeVota, DC Behavioral Health Assn
Stephanie Taylor, HSCSN
Patricia Quinn, DCPCA
Zenia Sanchez, Terris, Praylik & Millian, LLP
Ian Paregol, DC Coalition on Long Term Care
James Christian, AmeriHealth DC
Lavdena Orr, MD, AmeriHealth DC
Amy Brooks, RCM
Heather Foote
Guy Durant, Beneficiary
Lisa Fitzpatrick, MD, DHCF
DaShawn Groves, DHCF
Robert Howard, DHCF
Colleen Sonosky, DHCF
Tiffany Lee, DHCF
Heather McCabe, DHCF
Jennifer Bishop, DHCF
Alice Weiss, DHCF
Suraj Navaratne, DHCF

Participation via Conference Call:
Veronica Sharpe, DCHCA
Mark Agosto, No Wrong Door/DDS
Erin Leveton, DDS

I. Welcome, Introductions, and Approval of Minutes

Jacqueline Bowens, MCAC Interim Chair, called the meeting to order at 1:35 p.m. Introductions were made around the table. There were no meeting minutes available for committee approval at the time of the meeting but will be sent out for review and approval shortly.

II. SIM Update – Dena Hasan, Acting Director, Health Care Reform and Innovation Administration (HCRIA), DHCF

Dena Hasan briefed the MCAC members on the SIM process to date. In the beginning of 2015, CMS awarded the District of Columbia $1M through the State driven delivery process to collectively decide how we wanted to improve outcomes via care delivery reform and payment process reform.

Ms. Hasan reported that the through the stakeholder engagement process, where stakeholders were brought in via five (5) different workgroups. Some of MCAC members have participated in the work groups, and some are on the SIM Advisory Committee. Each one is dedicated to high level aspects of the District's health reform. All comments have been reviewed by DHCF, and will document the District's collective approach to health reform process and the State Health Innovation Plan (SHIP).

Ms. Hasan stated that DHCF reached out to consumers for their input as well. The consumer interview results were dedicated to patient experience, emergency department utilization, and gaps in care/services. There were five (5) key aims of DC's SHIP. These were built from a lot of stakeholder engagement and feedback.

The District's goal is to better align spending, better leverage Medicaid spending and better leverage Federal spending so that local dollars could be reallocated to the needs of beneficiaries. Also to reduce inappropriate hospital utilization, ER and hospital admissions by 10%, but the District is also looking to align with the new Health People 20/20 in which the implementation work has already begun. Additionally, the District would also like to see a reduction in health disparities. An additional area of focus for the District is to develop a collaborative and continuous health environment. Dena specified that CMS is pushing for the importance of social determinants of health and making sure that beneficiaries' total cost/services are addressed.

The District's SIM is organized by three (3) pillars and four (4) enablers. Care delivery reform, payment model reform, and community linkages are the District's three big pillars. These three can't be accomplished without our enablers. Enablers are stakeholder engagement, health information technology, workforce development, and quality improvement.

Ms. Hasan also discussed in detail the payment model – a new roadmap for transformation; additional CMS grants; SIM newsletter, SIM Website, and the SHIP development timeline. She also stated that the District is trying to share this information with as many stakeholders as possible at different sites, and to go into the community to ensure beneficiary input is part of the process.

In conclusion, she reported that the key date is June 13th for the release the SHIP report to the public for comments. The SHIP is approximately 60 pages long, so an executive summary with key bullets will also be made available for an easy read tool. All of the slide decks from the SIM workgroups are on the SIM Website, so that interested parties will be able to see and track how conversations and process have progressed over the past year. The SHIP is due to CMS by the end of July.

To see the full slide deck of the SIM Presentation, please visit DHCF's Website under the MCAC webpage – http://dhcf.dc.gov/page/dc-medical-care-advisory-committee.

Jacqueline Bowens, MCAC Interim Chair, commended Ms. Hasan, the SIM team, and others who participated thus far on the SIM for all of their hard work with the coordination, collaboration, and stakeholder engagement and outreach initiatives.

Q&A's

Ron Swanda, DC Commission on Aging, asked how the District is defining "chronic conditions". Dena Hasan stated that they reviewed claims data to see which conditions led beneficiaries to inappropriate hospital utilization. Joe Weissfeld, DHCF, stated that there are approximately fifteen (15) conditions that they have used associated with the highest cost of care, most prevalent among the population, and most amenable to care coordination. Ms. Hasan also stated that they did not

include the length of time a person had the condition. The exact list of conditions will be emailed directly to Mr. Swanda, and they are also available to the public on the SIM Website.

Jacqueline Bowens asked what the best case scenario in terms of an outcome once the SHIP is submitted to CMS the end of July. Ms. Hasan stated that submitting in July is the District's proposed plan; that we would continue to engage the work groups to specify products that we are looking to launch; timelines; building that into future budget negotiations with the City; future provider capacity initiatives; leveraging other things coming from CMS and making sure that they align with our collective vision for improved health outcomes, and; if possible, hope to receive the test phase award for up to $1M grant for the District (the grant amount depends upon the population/size of the City).

III. Proposed MCAC Bylaws – Jacqueline Bowens, MCAC Interim Chair, and Claudia Schlosberg, Senior Deputy Director/Medicaid Director, DHCF

Jacqueline Bowens commended the Bylaws Work Group for all of their hard work on revising the MCAC Bylaws. Ms. Bowens stated that she would like to personally salute Ms. Trina Dutta, DHCF, for her hard work on the Bylaws, because she did all of the hard work in terms of all of the coordination, a lot of the research, and engagement in pulling the initial draft together. She also thanked Mr. Keith Parsons of DHCF's legal team for his assistance.

As a reminder, several months ago Wayne Turnage, Director, DHCF, announced that he wanted to commission a small group to begin to review the Bylaws, make some recommendations around changes, solicit input from the members and other participants in the group, then give his final endorsement, and begin the process to adopt the Bylaws and look at new membership looking forward.

Ms. Bowens stated that the bulk of the work is almost done, but she wanted to share the proposed Bylaws to receive feedback from the committee to ensure that they are reflective of the needs we felt were the priorities for MCAC members.

HyeSook Chung, MCAC Interim Vice-Chair stated that the work group spent months reviewing and working on the Bylaws, and have contributed in a meaningful way, and she would like to ensure there is clear consensus of where the Bylaws and the direction of MCAC should go. Ms. Chung said that the work group needs to get critical feedback, but moving forward we would like to wrap this up quickly as we can plan and think about the re-composition and moving the agenda forward.

Claudia Schlosberg reported that in addition to the amount of time that this was discussed internally, the work group examined the bylaws of other states, and reviewed the DC HIE Policy Board Bylaws. The work group tried to clarify the role of MCAC as advisory engaged in policy, but in a position that makes recommendations to the leadership of DHCF. The work group also wanted to be clear about composition. One of the goals is to have more representation of beneficiaries or people representing beneficiaries involved in MCAC, and to set up a structure around committees so that MCAC becomes more of a working advisory board, more interactive.

Importantly, while there is now a very clearly defined process where members can be nominated or individuals can apply to become MCAC members. However, the agency director has the ultimate responsibility to appoint and approve members. The sub-committees importantly can include non-MCAC members as members. They will be staffed by the MCAC Advisory Committee members, but members of the public can serve on the subcommittees. Ms. Schlosberg stated that the membership will be reduced to fifteen (15), but this does not include the government/ex-officio representatives are included in this number. At least fifty-one percent (51%) of the MCAC will be

represented by beneficiaries or advocates. She said that the work-group is trying to ensure that there is diverse membership composition, and that it is reflective of whom they serve.

Ms. Schlosberg expressed that the work group would like to get the bylaws finalized, but will provide the opportunity for the MCAC to review and submit public comments. She stated that the work group would like to have the bylaws finalized by the next MCAC meeting (June 22), then open up the process for nominations or applications over the Summer, and confirm members by the October meeting.

Ms. Schlosberg and Ms. Bowens also discussed the meeting schedule options, different venues possibilities and times for meetings to ensure beneficiaries are able to attend the MCAC meetings. In addition, she stated the importance of being more visible in and accessible for beneficiaries and the community.

Ms. Schlosberg said that she would post the proposed bylaws on DHCF's website, along with the email address to submit public comments, as well as email the copy to MCAC members.

Q&A's

Ron Swanda wanted to know what is D.C. Code § 2-575(b). Ms. Bowens stated that this is the code that speaks to open meetings *(i.e.* ***DC Open Meetings Act)***.

Mr. Swanda also asked a question regarding the Article XV, Conflict Resolution. He asked why there is a dispute resolution in the proposed bylaws when the MCAC is only advisory. This reflects moving forward any scenarios that could happen, whether positive or negative, to protect the process and the purpose of the MCAC. Mr. Swanda recommended that this be limited to procedural issues. The work group agreed. And the by-laws will reflect this recommended change.

There was additional discussion regarding subcommittees, the SIM Advisory Committee, and wrapping some of the subcommittees into the MCAC.

Ms. Bowens agreed that the MCAC would get a sense of all of the different work groups and committees that we already have and consider the best compositions to help guide the work and priorities for MCAC.

IV. MCO Report – Wayne Turnage, Director, DHCF

Wayne Turnage, DHCF Director, announced that going forward Suraj Navaratne, Office of Rates and Reimbursement Analysis, DHCF, will take over the analysis and production of the MCO Report working with the data unit and policy. Suraj will issue his first report this summer on the 1st quarter of calendar year 2016. Mr. Turnage stated that he will give it a thorough review before it becomes public. He said that he will be expanding the focus to include HSCSN, in a separate document. DHCF will be doing a little more expansion work on how they are performing, to shed additional light on the care that is being managed and delivered for children with special needs.

Mr. Turnage stated that he would give a very brief summary of the end of year report for calendar year 2015. He said that he would touch on the extreme highlights as follows:

- For Medicaid membership, MedStar has experienced the highest enrollment growth (39% growth rate) since the beginning of the five-year contract period than any other plan. When Alliance members are included, the numbers do not significantly change.

- It is very clear that the health plans have sufficient revenue to cover their medical claims and administrative costs during the entirety of calendar year of 2014. None of the plans lost money, which is very good. Looking at their risk based capital profile it is the best that it's been since they started the program in 2013. All of the health plans are substantially above the 200% risk based capital requirement imposed by the Department of Insurance, Securities, and Banking (DISB).
- The doctors and their networks are tracked both primary care, primary care with pediatric specialties, and dentists. In all cases for all plans, the numbers run way past the requirements.
- The three health plans paid claims in compliance with the District's timely payment requirement. They have exceeded the standard for the entire year, which is good news.
- DHCF looked at over 4 million claims that were processed in 2015. Only 12% of those were denied, and of those that were denied, about 6% were later accepted.
- The denial rates by health plans -- the average denial rate was 12%. Trusted was nearly twice as high as the average for all plans. (AmeriHealth – 8%; MedStar – 17%; Trusted – 22%; and HSCSN – 11%)
- 12% Denied Claims - MCOs deny claims for many reasons, but the most frequent relate to service coverage and improper billing, duplicate claims, member is not eligible, and sometimes an untimely filing issue.
- Those claims that were denied, only 6% were later paid. That is down from previous reports in previous years. It was as high as 43% in the previous year.
- Summary of how 2014 compared to 2015 was slightly off because pharmacy was not included. But the denial rate went down; 2.26M in 2014, and 4.06M in 2015.
- All three health plans spent the required amount on beneficiary medical expenses, responsibly managed administrative cost, and earned profits beyond the rate assumed in the actuary's model. The requirement is 85%. Our plans easily hit that target.
- There is significant across plan variation in the Medicaid per-member, per-month medical expenses for adults and for children, but the growth rates in each plan were either modes or declined.
- MedStar has continuing challenges in its efforts to align beneficiary medical costs with their assigned risk scores. Trusted's members has the lowest risk for adults and children between the plans. AmeriHealth has the highest risk, which is to be expected. MedStar is in the red category but their cost is high for both adults and children.
- MedStar experienced more enrollment growth in FY2015 than both AmeriHealth, whose enrollment declined, and Trusted.
- MedStar's 2015 costs for three major services were also substantially higher than the other MCOs.
- MedStar's higher inpatient costs in 2015 were fueled by a much larger rate of inpatient admissions than observed for the other plans.
- Alliance medical expenses for adults spiked in two of the three health plans (12% for AmeriHealth, 10% for MedStar, and 1% for Trusted).
- When utilization for any mental health treatment is determined, the MCO total mental health penetration rate increases overall, and for both adults and children on Medicaid.
- Mental Health Utilization Trends – when compared to previous years, the growth in mental health utilization slowed in 2015. Based on what we have seen in the past, we would have guessed a 14% penetration rate for mental health services. We saw actually 12%. The rates dropped for both the psychiatric care services, and for MHRS services. Mr. Turnage stated that we will continue to identify children and adults who need mental health care, and ensure to get them into care.

- Since the 1st quarter of the managed care contract (Oct to Dec 2013), MCO spending on Medicaid-funded mental health services for both children and adults has significantly increased.
- Pay-for-Performance Plan – DHCF planned to start a program in January of 2016. However, CMS changed the way that they were reviewing contracts, and came back to inform us that none of the new rates that we were paying had been approved. DHCF's actuary submitted a certified letter in advance of us paying the rates. So the plan had to be delayed to October. In future reports, Mr. Turnage stated that he will provide information on what the thresholds are, and use something like a thermometer to show you as the fiscal year advances, how the health plans are doing with respect to the sealing that they have to adhere to.

More detailed information regarding Director Turnage's MCO Report can be found by downloading the full slide deck from DHCF's Website under the MCAC webpage – http://dhcf.dc.gov/page/dc-medical-care-advisory-committee.

Q&As

Director Turnage was asked if he could include tracking the number of pediatric mental health providers, and maybe an audit to ensure that they have access. Mr. Turnage stated that he is planning to speak with DHCF's Managed Care staff regarding ensuring that a high number of them are accepting Medicaid patients. He also stated that he would like to report on this at least twice per year. He said that he would add the mental health piece.

Mr. Guy Durant (Beneficiary), asked about a breakdown on denial rates for each health plan showing the percentage of service based denials versus denials based on prescriptions and formularies (Slide 35 & 37). Mr. Turnage stated that the codes are pretty narrow to define. He asked Mr. Durant to provide his email address so that he could have his staff provide the information requested.

Mr. Durant asked about possible inclusion of "Anti-Trust" provisions in the Health Care Provider Networks Contractual requirements to prevent predatory exclusion or exclusivity rules preventing providers from competing across networks (Slide 28). For example, privileges offered to MedStar doctors and pharmacy participants should not be removed or reduced if they also sign with AmeriHealth or Trusted for example. Mr. Turnage stated that this is a very good point, and that he will consider this issue.

Judy Levy asked if there is any age breakdown in terms of the population. Mr. Turnage stated that he would email the information regarding hospital re-admission by age to Ms. Levy.

Ron Swanda asked if CMS has posted anything to compare state performance. Mr. Turnage replied that he has not seen any good data from CMS on this information.

Mr. Durant also asked for clarity on the labeling of the chart and if it showed per capita or weighted cost differences between plans and not just total dollar spends. Since MedStar had more patients and therefore spends more total dollars, the only fair comparison would need to be based on spending per patient to track total costs. He said that he finds it hard to believe that MedStar is spending 100% more than AmeriHealth per patient on Pharmacy and 139% more than Trusted on pharmacy without looking deeper into those numbers (Slide 50). He is a MedStar beneficiary at this time and always felt that they spent less on pharmacy per patient, but maybe he's wrong about that. This slide was very important to him, and he would like to dig deeper into those numbers especially on the drug and pharmacy spending side. How much of our health care costs are increasing due to

drug costs and how much is increasing due to points of service costs increases? It's hard to tell from the slides. Mr. Turnage answered yes it is weighted.

V. Adjournment

The meeting was adjourned at 3:00 pm.

Approval of Minutes:

Jacqueline D. Bowens

Jacqueline Bowens, MCAC Interim Chair

7/28/16

Date