GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2019-20
Performance Oversight Hearing

Testimony of
Wayne Turnage
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent C. Gray, Chairperson

March 5, 2020
10:00 A.M.
Room 412
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

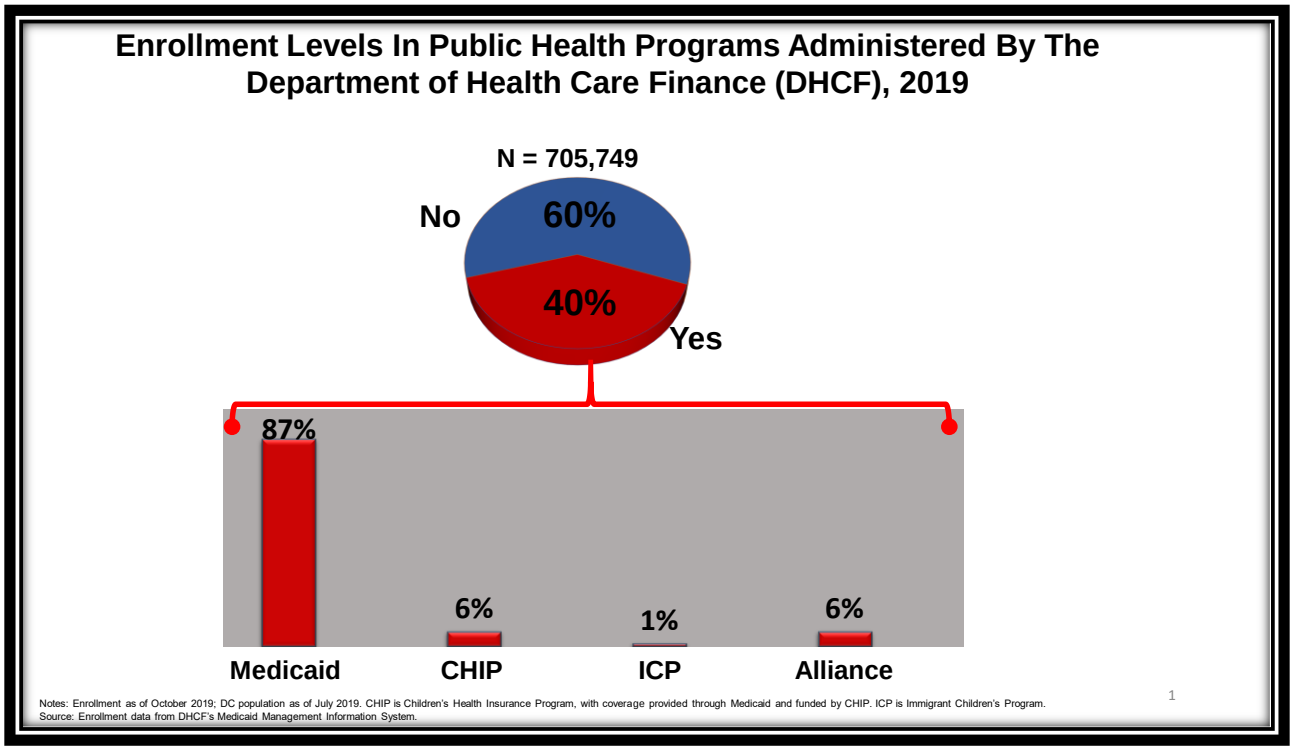
Good morning, Chairman Gray and members of the Committee on Health. My name is Wayne Turnage, and I am the Director of the Department of Health Care Finance (DHCF). Thank you for inviting me to testify on behalf of the Bowser Administration to discuss the activities and accomplishments of DHCF in Fiscal Year 2019 (FY2019), through the first quarter of Fiscal Year 2020 (FY2020). My testimony today will summarize the major activities of DHCF over the past 16 months. My goal is to offer insight into the rapid pace of change at DHCF and the nature and purpose of activities we have pursued to ensure that we provide continued access to a full range of health care services for District residents who rely upon the Medicaid and Alliance programs.

I have been serving in a dual role for more than one year now—a job that requires balancing the responsibilities of the Director of DHCF with those associated with the role of Deputy Mayor for Health and Human Services (DMHHS). There are not sufficient words to describe the enormous support that I have received from my executive management team at DHCF, as well as the very capable staff in the office of DMHHS. In both agencies we continue to work closely with the Office of the City Administrator (OCA) and the Executive Office of the Mayor (EOM), advancing the policies and programs that promote access to quality health care across all neighborhoods of the District of Columbia.

Agency Mission

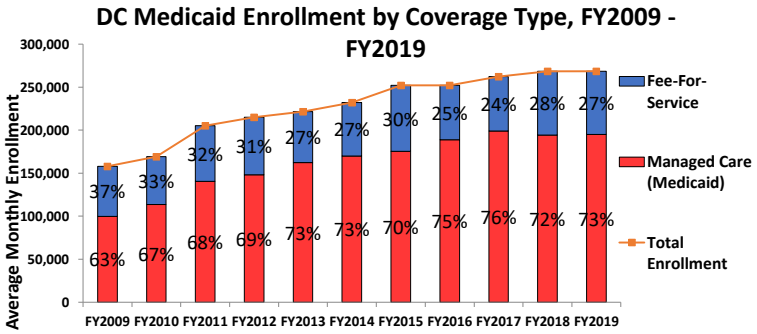
The mission of DHCF since its formation in October 2008 is unchanged—improve health outcomes by funding access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia. We do this through the administration of two primary insurance programs: (1) Medicaid (including coverage funded by Children's Health Insurance Program (CHIP) dollars), and (2) Alliance (along with the Immigrant Children's Program (ICP)) (see graph below). As of October 2019, we fully financed the healthcare cost for more than

282,200 individuals. As shown below, this represents 40 percent of all District residents, 87 percent of whom are enrolled in non-CHIP Medicaid, with the remaining 13 percent receiving benefits from either CHIP-funded Medicaid (six percent), Alliance (six percent), and ICP (one percent).



As we have shown in the past, DHCF operates a bifurcated program in which nearly three-quarters of our members receive care through the Medicaid managed care programs, while the remaining members receive care through the District's fee-for-service (FFS) Medicaid program. Since 2009, DHCF has increased the proportion of its Medicaid enrollees in managed care by 16 percent, from 63 to 73 percent (see graph on next page). With our planned Medicaid reform activities, we fully anticipate that within the next five years, at least 95 percent of program enrollees will receive care through one of our managed care plans.

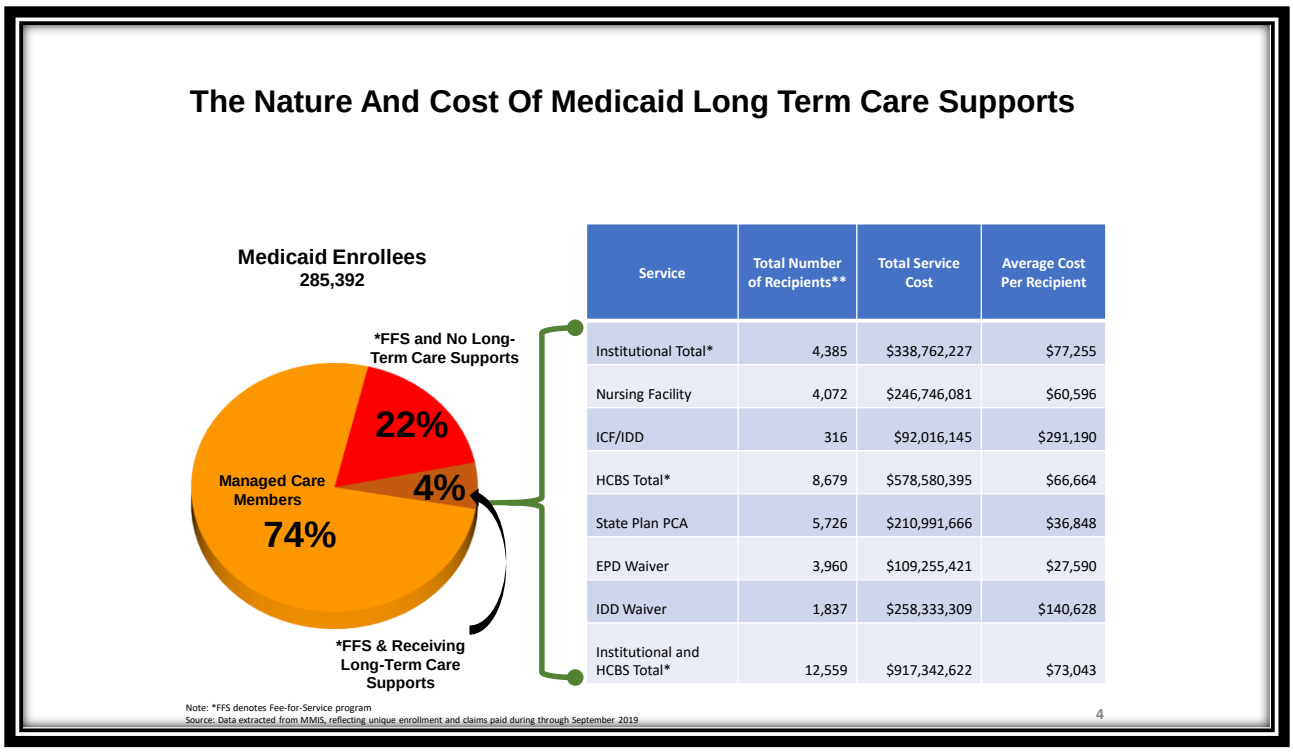
Nearly Three-Fourths of Medicaid Enrollees Are In The Managed Care Program But Plans Are To Grow This Number To Near 100 Percent



Source: DC Medicaid Management Information System (MMIS) beneficiary data extracted February 2020.

Outside of managed care, and as a part of its FFS program, DHCF funds a series of long-term care services and supports for some of the District's most vulnerable residents. As with other state Medicaid programs, the District provides long-term care services in institutional and home- and community-based settings, which accounts for nearly one-third of the dollars we spend on Medicaid. These funds are used to purchase nursing home services for persons who need this level of institutional care, a full range of home and community-based services for members who require assistance to live in the community, and a mix of support services that are delivered in both institutional and community-based programs for persons with profound intellectual, developmental, or physical disabilities.

The number of beneficiaries and the associated per-member cost for each of the programs in FY2019 are shown in the table on the next page. When considering both home and community-based services and institutional care, the District's Medicaid program spends more than $900 million on the health care and support services for just over 12,500 enrollees.



Focus of DHCF's FY2019 Oversight Activities

Mr. Chairman, the next part of my testimony today offers a high-level summary of the major projects of focus during the oversight period, the work we undertook to advance these programs, and the significant progress we have made during the review period. Chairman Gray, while DHCF staff performed work on a number of priority projects over the past 16 months, my testimony focuses on only a few major initiatives designed to help us achieve Medicaid reform and to strengthen the way we deliver health care in the District.

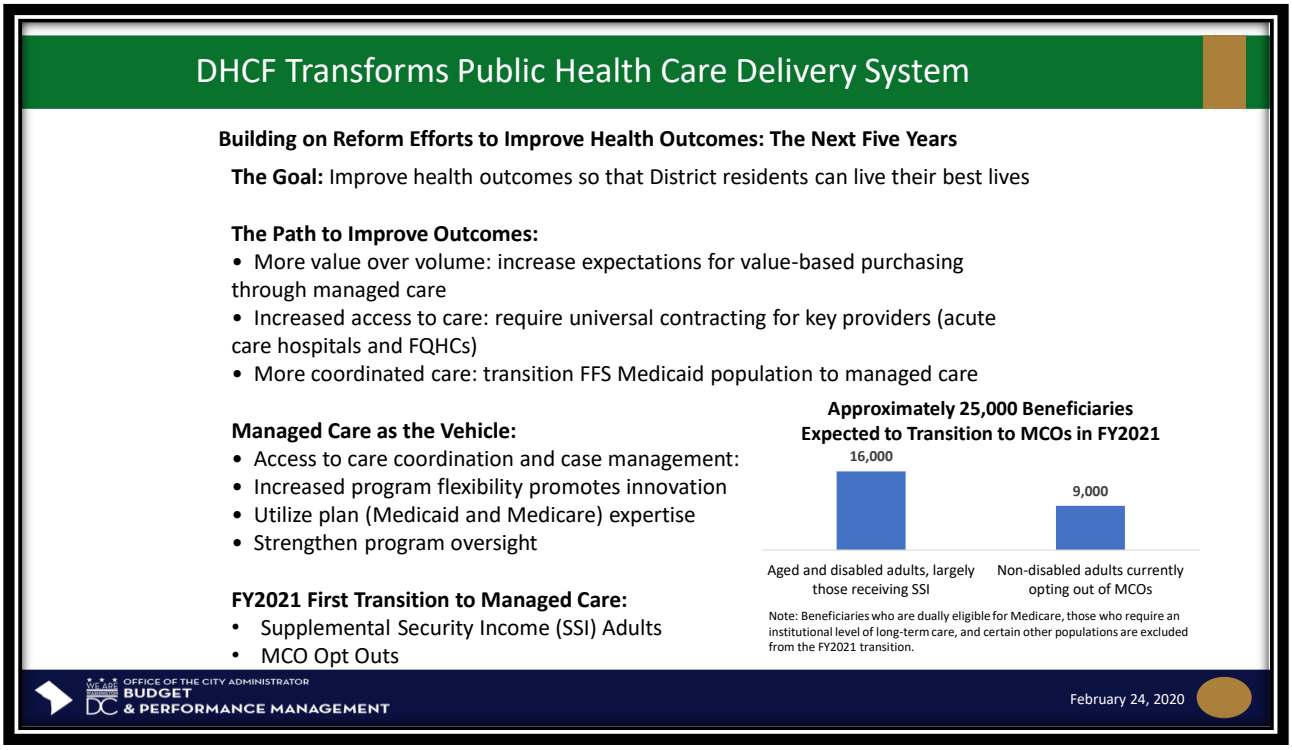
Over the past several years, the District of Columbia has made significant improvements in providing healthcare coverage to District residents. DC's uninsured rate of 3.2 percent is second lowest in the country. As noted earlier, through the Alliance and Medicaid programs, we provide healthcare coverage to over 40 percent of District residents. Despite high levels of healthcare coverage, significant challenges remain, especially as it relates to care delivery and health outcomes for many enrollees who are not in the managed care program. Accordingly, over the

next five years, DHCF is undertaking an ambitious plan to transform the Medicaid delivery system to improve health outcomes by:

- *Transition FFS to Managed Care.* To improve the level of care coordination for some of Medicaid's chronically ill enrollees, we have begun the process of moving 25,000 fee-for-services beneficiaries into our managed care program, and convert the managed care program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.
- *Launch PACE*. DHCF will launch the PACE program in late 2020 to provide elderly individuals with access to highly coordinated, community-based care in Ward 7 and 8, and a benefit package that is broader than those in the typical Medicaid program.
- *Implement Section 1115 BH Waiver*. By successfully pursuing a Section 1115 federal Medicaid Waiver, we expanded the range of behavioral health services available to persons struggling with severe mental illness, serious emotional disturbance or substance use disorders.
- *Re-procurement of Managed Care Contracts*. Although there were 4 remaining option years on the agency's $1 billion managed care contracts, significant planned changes to the program, and problems with the uneven distribution of high cost members across the agency's three health plans required DHCF to cancel the option years and work with the Office of Contracts and Procurement to establish a new procurement. The Request for Proposal (RFP) has been significantly modified to expand care coordination, increase value-based payments, and mandate universal contracting – changes that are designed to correct problems that rendered the program unmanageable.
- *Improvements in Long-Term Care*. The staff in DHCF's long-term care administration have systematically tackled a number of programmatic and policy changes to marry technology to business practices, in the process advancing the program's operational efficiency, effectiveness and integrity, and quality of care. The volume of this change has been significant, allowing the long-term care system as a whole to become streamlined, high-functioning, more accountable, and heavily data-driven.
- *Building A Successful Health Information Exchange (HIE).* For several years, DHCF has worked to establish a system that allows users access to patient clinical data in real time through an interoperable HIE. These data could then be used to promote better health outcomes and generate cost savings across the entire network of health care providers. After many challenges, staff in the innovation administration have constructed a system that significantly increased the number of users for the HIE network, while connecting providers for almost two-thirds of Medicaid enrollees to an alert system which notifies them when their patients receive 911 and or hospital emergency care.

Transition FFS to Managed Care. As a central feature of Medicaid reform, DHCF aims to convert our managed care program into an accountable, person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health. Initially,

DHCF expects to transition about 25,000 individuals currently in the Medicaid FFS program to the Medicaid managed care program, effective October 1, 2020. This managed care expansion population primarily consists of aged, blind, and/or disabled individuals who have not previously been required to enroll with a Medicaid health plan to receive their care. More specifically, this population represents those who are receiving Social Security Income (SSI), but who are not eligible for long-term care services and supports nor enrolled in Medicare (see information below).



Health care costs for individuals with FFS coverage are typically four-to-five times greater than persons in managed care as they tend to experience substantially higher rates of emergency room use, hospital admissions, and inpatient stays. Today, these beneficiaries must manage their health care needs without assistance or care coordination. By joining the managed care program, this population will receive access to much needed care coordinators who will:

- Work with members to develop a care plan to make sure they receive the care they need;
- Help schedule appointments with providers;

- Review doctor instructions with members;
- Help with managing medications and slow the rate of unnecessary emergency room visits;
- Follow up after a hospitalization or emergency room visit;
- Assist with other issues that impact well-being, like housing, and employment; and
- Connect individuals to legal help, food security, transportation, and childcare.

Although the full FFS population will not transition to the traditional managed care program in 2020, DHCF has been focused throughout the prior and current fiscal year on other opportunities to better integrate care for the remaining FFS beneficiaries. Specifically, individuals who are dually eligible for both Medicaid and Medicare will have the option to enroll in a Highly Integrated Dual Eligible Special Needs Plan (D-SNP), effective January 1, 2021. This new program will promote Medicare-Medicaid alignment and integration of services. D-SNP health plans will be responsible for providing all Medicare benefits as well as the same Medicaid benefits provided by MCOs. In addition, D-SNPs will be responsible for all long-term care services and supports.

Launch PACE. Continuing our previous early reform efforts, DHCF plans to launch the PACE program in late 2020. PACE is a nationally-recognized, alternative model of care that integrates Medicare and Medicaid benefits for eligible beneficiaries. Under this model, beneficiaries are eligible for a broader array of benefits than is typically available under either the Medicaid or Medicare programs, and their care is managed by a comprehensive, inter-disciplinary team of clinical professionals working to deliver high-quality and highly coordinated care at a community-based site. To be eligible for PACE, individuals must be 55 years or older, meet the nursing facility level of care criteria, and reside in the proposed PACE service area, which will be limited to District Wards 7 and 8.

DHCF recently published its final rules in January 2020 and received approval from the Centers for Medicare and Medicaid Services (CMS) to modify the state plan to include PACE in February 2020. Next, the agency will select a PACE provider through a competitive RFP, after which, the chosen vendor must proceed through the PACE provider application process for CMS. Once approval is obtained, DHCF and CMS will sign a three-way PACE program agreement with the provider and prepare to launch the program in late 2020.

Implement the 1115 Behavioral Health Waiver. A large part of our agency's Medicaid reform focuses on behavioral health. On November 6, 2019, CMS approved the District's Medicaid Section 1115 Behavioral Health Transformation Demonstration Waiver with an effective date of January 1, 2020. The District was the first in the nation to receive federal approval for this waiver. Among other features, the waiver allows the District's Medicaid program to pay for short-term stays for services provided to adults with serious mental illness (SMI) or substance use disorders (SUD) who are residing in an institution for mental disease (IMD). This includes the Psychiatric Institute of Washington (PIW), St. Elizabeth's Hospital, as well as community-based residential SUD providers.

Additionally, the waiver will add new community-based services designed to improve behavioral health treatment capacity and strengthen transitions from emergency, inpatient, and residential treatment to the community. This comprehensive design furthers the District's goals of:

1. Covering a broader continuum of Medicaid behavioral health treatment services for individuals with SMI/SED or SUD;
2. Advancing the goals of the District's Opioid Strategic Plan by improving outcomes for individuals with Opioid Use Disorder and other SUDs; and
3. Supporting Medicaid's movement towards more integrated medical and behavioral health care to better coordinate prevention and treatment.

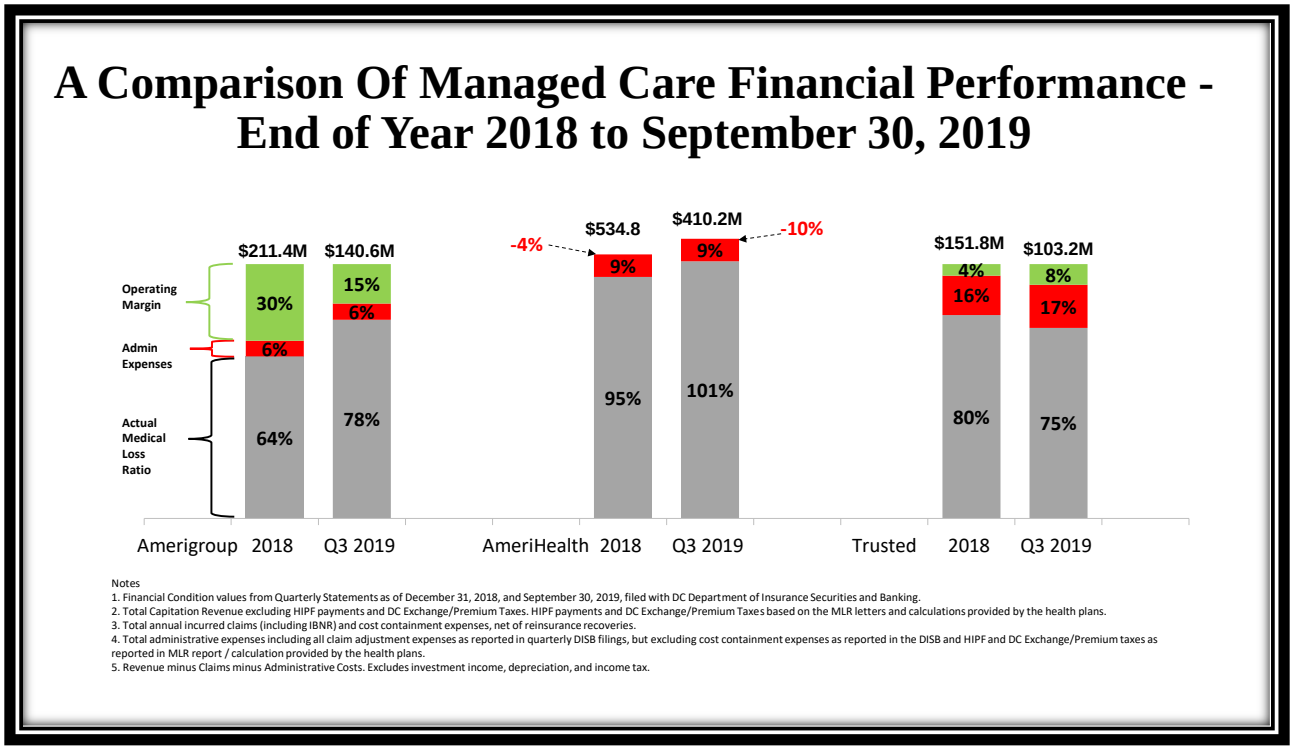
DHCF, in collaboration with DBH, has already made significant progress in implementing the new services included in the waiver. On January 1, 2020, we launched coverage for IMD services for non-elderly adults, eliminated the $1 co-pay for prescriptions associated with medication-assisted treatment (MAT), initiated psychosocial rehabilitation (clubhouse), provided recovery support services, as well as significantly enhanced the number of psychologists, licensed clinical social workers, and Medicaid providers that will be available for the program. Later this spring, DHCF will add the additional benefits of supported employment for both the SMI and SUD population and those in Trauma-Targeted Care. We will conclude the service expansion this summer by extending benefits for transition planning services and crisis stabilization.

Strengthening DHCF's Medicaid Managed Care Program. In May 2019, DHCF awarded its Medicaid managed care contracts to three health plans:(1) Amerigroup DC, (2) AmeriHealth Caritas DC, and (3) Trusted Health Plan. These new awards replaced the emergency contracts that were established to ensure service delivery while an earlier protest of that award was adjudicated by the Contract Appeals Board.

During the period of emergency contracts (October 2018 through April 2019), each managed care organization (MCO) was reimbursed using the same capitation rates as certified by the District's actuary according to federal regulations. However, over time, the patient risk level of the plans dramatically shifted creating significant losses for one plan, while unjustly enriching two others. By 2019, the District's largest health plan was on pace to lose between $40 to $50 million. In response, DHCF reinstated the risk-adjusted rate model in May 2019, effectively dampening AmeriHealth's losses through September 2019 from $6 to $2 million per month. This reduced the projected loss for AmeriHealth by more than $20 million for FY2019, while significantly slowing the margin growth for one of the other two plans. When the health plans'

financials are compared to 2018, prior to the rate adjustment, with the financial information through a 9-month period for 2019, these impacts are revealed.

As shown in the graph below, AmeriHealth's operating loss was capped at 10 percent through the first three quarters of 2019. Though this was higher than their four percent loss from 2018, without the adjustment to the rates, the plan's losses would have been considerably greater.



Meanwhile, Amerigroup, with three months remaining in the year, saw its margins reduced, but still reported a three-quarter profit of more than $20 million. This means, in part, that the level of adverse selection in the program was so severe, that the risk-adjusted process was not fully sufficient to correct the program. While some of the differences in financial performances reflect differences in contract prices across health plans, our concerns about the stability of the MCOs was not fully obviated by the risk adjustment.

During this same time period, DHCF was making plans to move FFS members to managed care as earlier described. Because these members would bring to the managed care program a

medical profile that reflected a level of complexity beyond those observed for legacy managed care members, we concluded that the program would have to be re-procured, allowing for the development of material contract changes and an equal redistribution of plan members.

Considering each of these factors, DHCF, in collaboration with the Office of Contracting and Procurement, issued an RFP on January 10, 2020 for the solicitation of new health plans. To ensure that we effectively addressed adverse selection present in the existing program, the RFP indicates that we will be implementing universal contracting which requires all District hospitals, large provider groups, and federally-qualified health centers (FQHCs) that contract with the Medicaid FFS program to also execute binding provider agreements with all contracted MCOs. The implementation of universal contracting is a critical change for the program as it provides common access to District health care providers for all Medicaid beneficiaries, thereby eliminating the need for enrollees to select the plans with the most robust hospital network, and effectively guarding against future problems of adverse selection that have destabilized this $1 billion program.

Although the procurement is not yet complete, evidence from the bidder's conference suggest that these changes have attracted the interest of health plans with significant expertise and proven success in organizing care for not only traditional managed care populations, but also adults with special health care needs and individuals with complex conditions. Thus, when universal contracting provisions are combined with an increased focus on value-based purchasing, more expansive coordination requirements, and a reestablishment of performance incentives, we believe the health plans that are ultimately selected for the next contract, will return the program to the strong foundation it once enjoyed.

Improvements in Long-Term Care (LTC). Over the past 16 months, DHCF's Long Term Care Administration (LTCA) adopted several major programmatic and policy changes, while effecting critical changes to organizational culture through systems modernization and transformation. These changes have been instrumental in advancing program efficiency, effectiveness, integrity, and quality of care. Meanwhile, the volume of change has been significant, allowing the administration and the long-term care system as a whole to be streamlined, high-functioning, more accountable, and heavily data-driven.

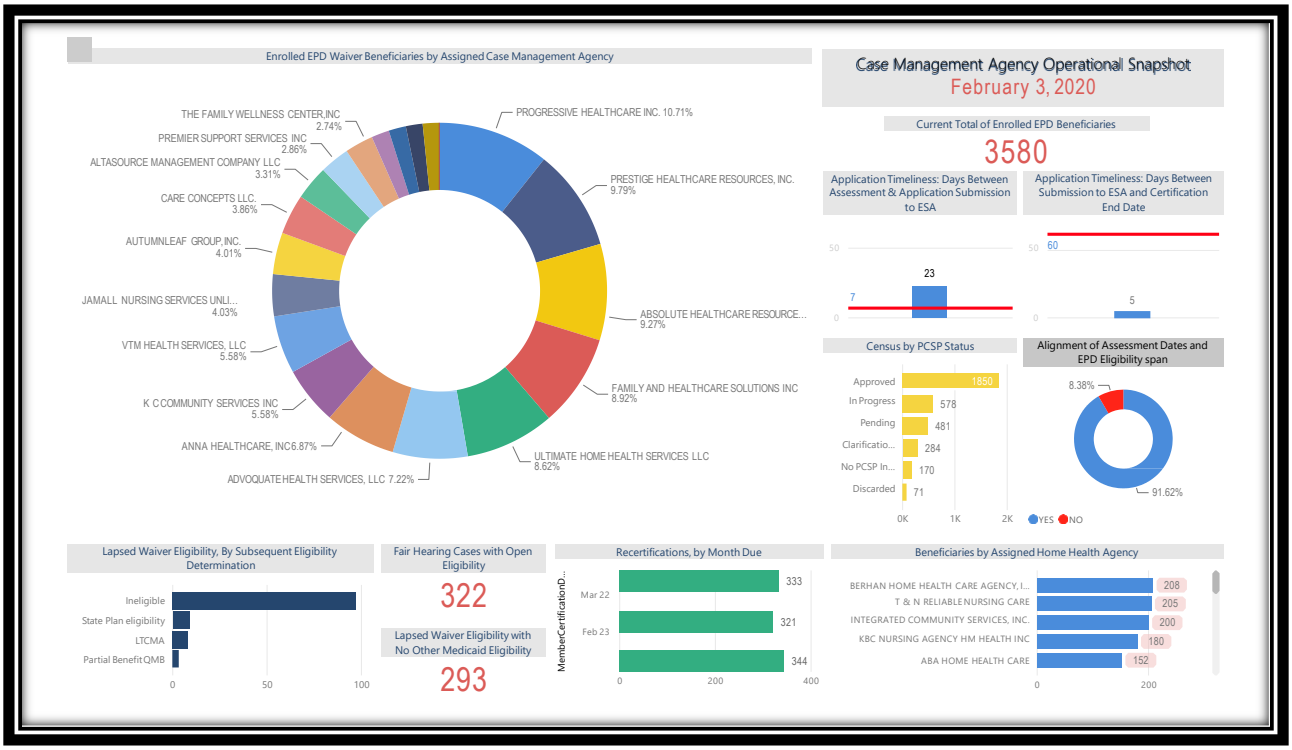
Most notably, LTCA moved its entire system away from a financially conflicted assessment and case management process by implementing independent assessments using a widely validated and comprehensive instrument. In addition, LTCA has established an agile, cloud-based, and secure clinical case management system. These changes offer a number of benefits, including more broadly shared electronic records for all long-term services and supports, vastly increased data management and analytic capacity, and greater agency control over workflows and information. These changes also occurred in concert with implementation of enhanced provider monitoring processes and routinely scheduled engagements with hospital and nursing facility providers for the first time in years.

These system transformations demand on-the-fly analyses and daily monitoring of implementation activities. To accommodate the new demands, the LTCA has exponentially enhanced its capabilities in this regard, thanks to a strong collaboration with our powerful Data Warehouse and the agency's information technology staff, all supported by a robust investment of time from LTCA management.

Most impressive has been the enthusiastic adoption of both the technology and new business processes by the staff. LTCA was actually the first administration in the agency to partner

with the Data Warehouse team, developing an agile solution to replace what was once an entirely paper-based process. The old process—manually tracking eligibility redeterminations for a small number of enrollees—was time consuming and took staff members an entire week to complete. It is now managed in minutes, freeing staff for other tasks. And with the implementation of our case management system, DC Care Connect, and other tools like a SharePoint-based form allowing long-term care providers to submit problem cases, LTCA efficiently draws data from a range of sources, including assessment and care planning data, eligibility records, claims, authorizations, fair hearings, and more, to aid in case processing.

The administration now uses these data to track operations on a weekly basis and produces information for the provider community, advocates, and other stakeholders on a routine basis through a dashboard, frequently providing enhanced context that corrects common misunderstandings of the program (see example below).



This dashboard gives LTCA staff virtual real time reports on the number of enrolled beneficiaries by the assigned case management and home health agencies. It reports application processing timeliness statistics, recertification dates, lapsed eligibility cases, and Fair Hearing cases where the beneficiary has open eligibility. In short, this team has learned its way around a brand-new case management system, assessment tool, and associated reporting mechanisms, as well as developed technical skills working with sophisticated data management tools. This is one of the most effective marriages of business processes, technology, and staff that I have witnessed.

Expanding Health Information Exchange (HIE) Capabilities. Finally, allow me to discuss our advancements in HIE. In FY19, DHCF published a new State Medicaid Health IT Plan—a CMS requirement designed to outline the District's priorities for health IT and HIE. The report identified significant challenges resulting from a disconnected system of care and outlined a set of priorities based on extensive stakeholder feedback, including the prior testimony and priorities of various stakeholders, with input from both the DC Hospital Association, and the DC Primary Care Association, among many others.

The District's State Medicaid Health IT Plan proposed four uses of health IT, in which the District planned to invest using CMS funding:

1. Supporting transitions of care;
2. Collecting and making effective use of social determinants of health data;
3. Providing analytics for population health; and,
4. Leveraging HIE for public health.

Notably, the focus of the work is not the technology itself, but how the technology can be used to support providers, patients, and payers to improve care and outcomes. So, to effectuate this plan, DHCF competitively awarded Chesapeake Regional Information System for our Patients (CRISP), a set of grants to establish and maintain core HIE capabilities for all Medicaid providers. CRISP DC is a local, wholly owned subsidiary of CRISP that manages services and local

governance in the District. CRISP DC's Board, as well as the CRISP DC clinical committee are led by District experts well-known to the Committee on Health.

The ongoing maintenance and operational costs for CRISP DC are funded by local health plans and hospitals. To build on this momentum, DHCF is supporting the development of additional HIE services such as secure messaging, and screening and referral for social needs such as food and housing insecurity. We are also providing additional technical assistance through our grantee, Enlightened Inc.

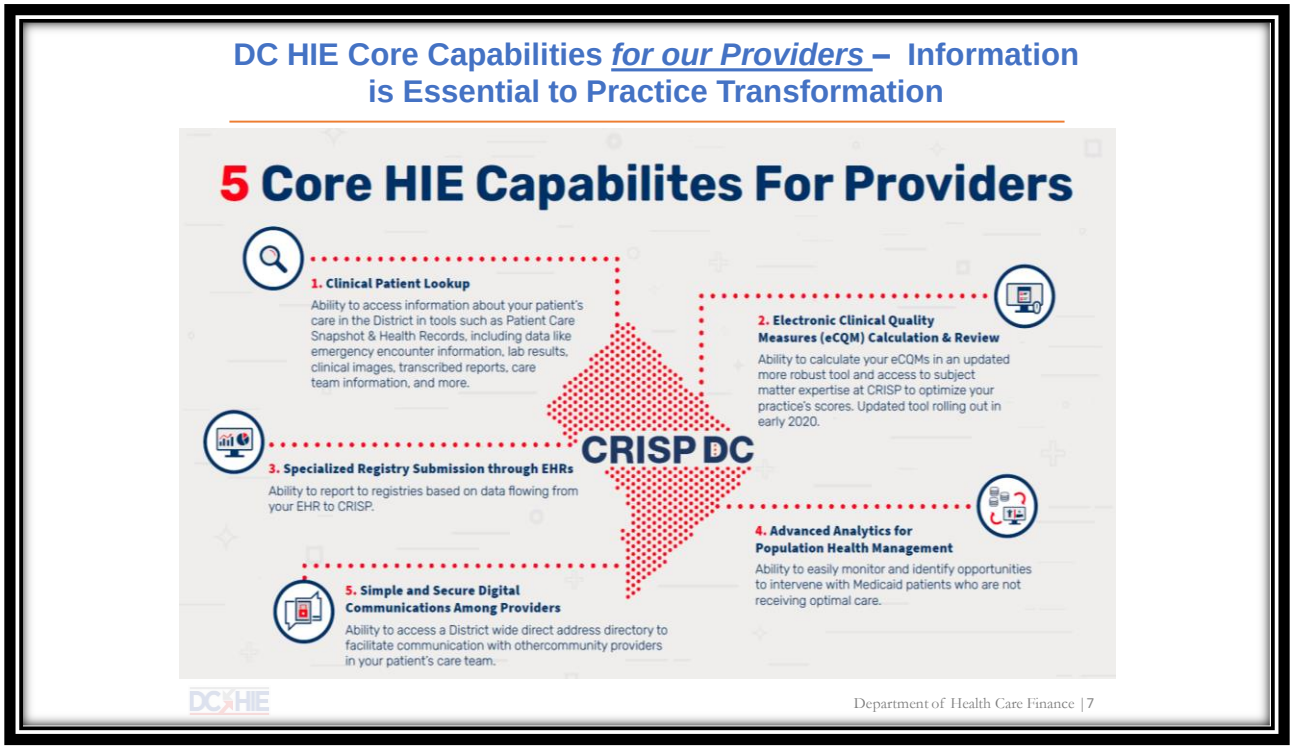
Enlightened, Inc. is working diligently to connect as many Medicaid providers as possible to HIE services and share health information with other providers. To date, Enlightened Inc. has connected more than half of the Medicaid- eligible providers in Wards 7 and 8. Enlightened Inc's overarching goal by the end of FY21 is to connect more than 90 percent of eligible Medicaid-enrolled provider organizations to HIE services. Their near-term priorities are closely aligned with our Medicaid reforms and focus on connecting independent practitioners, behavioral health providers and long-term services, especially those in Ward 7 and 8.

These provider organizations include ambulatory clinics, behavioral health providers, and long term care facilities such as Children's Health Center at THEARC, Ballou High School Based Health Center, United Medical Center Skilled Nursing Facility, United Medical Center Ambulatory Practice, and Deanwood Rehabilitation and Wellness Center.

Finally, in July 2019, DHCF published the final rules that formally established a regulated marketplace for HIE services—known as the DC HIE. I am pleased to testify that CRISP, Inc. and the DC Primary Care Association's HIE, Capital Partners in Care have been named as the first two participating entities in the DC HIE. These entities have committed to meet DHCF's expectations for privacy and security to bolster public trust in health information exchange.

These relationships will ensure DHCF has the public-private partnerships in place to ensure that we keep pace with new technology and that HIE services are reliable and sustainable. We also look forward to working with our agency partners and private plans to ensure that the HIE infrastructure we have built will be supported and even extended through a variety of channels. In addition to our ongoing collaboration with DC Health and other key District agencies, we have begun working with CRISP to further develop approved uses of the HIE.

The DC HIE is an important part of DHCF's efforts to transform the way Medicaid services are provided. This is the model for systems transformation. The five core features of the HIE are illustrated in the graphic below. Through the system, providers can conduct patient lookups, calculate their clinical quality scores, report to patient registries that capture emergency room information, identify opportunities to intervene with patients who may not be receiving optimal care, and immediately identify other providers involved in their patient's care. The HIE defines a modern digital health system where providers may compete on quality of care, availability of



appointments, or the best equipment, but do not have to compete for access to lifesaving information for the patients they serve. Every provider, no matter where they are or with what organization they work, should have basic information about any patient who walks in their doors. Every patient should have confidence that their allergies, medications, and care relationships are available to treating providers at the right time and place. Our ever expanding HIE makes these standards a reality.

Conclusions

Mr. Chairman, this concludes my performance oversight testimony on the activities of the Department of Health Care Finance over the last 16 months. As outlined, we have experienced a number of successes, moving the agency from its origins into a period of transformative change—one that holds the promise of improved services to 40 percent of the District residents, many of whom are struggling with serious medical issues.

As this transformation evolves, my staff and I look forward to working with you and the Council to move this agency forward. Thank you for this opportunity to testify. I am ready to receive your questions at this time.