GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2017-18 Performance Oversight Hearing

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

John A. Wilson Building
Room 500
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11:00am

Introduction

Good morning, Chairperson 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 Mayor Muriel Bowser in today's hearing to discuss the activities and accomplishments of DHCF in Fiscal Year 2017 (FY2017) and the first quarter of Fiscal Year 2018 (FY2018).

The key theme underpinning Mayor Bowser's administration and the policies she advances is her commitment to building pathways to the middle class. This commitment is aggressively pursued through targeted and meaningful investments in education, infrastructure, public safety, and people.

In no area of government is this more critical than the activities the Mayor supports to advance access to health care. Health care spending, which typically grows faster than inflation and the overall economy, remains the largest threat to the security of the middle class. Recent research shows that the average amount spent by middle income households on health care increased by almost twice the rate of growth in their incomes. Moreover, we know that 20 percent of families struggle to pay their medical bills which have been shown to crowd out spending on food and other family expenses, frequently pushing many to the edge of, and often into bankruptcy.

And these are problems for the middle class. With the rising cost of private health insurance premiums, commercial insurance coverage is simply beyond the reach of persons who live either below or slightly above the official federal poverty level. Without the benefit of publicly funded health care insurance or federal subsidies that defray substantial portions of the

premium cost for commercial insurance, these individuals would be forced into the ranks of the uninsured, disrupting their access to health care, while exposing them to staggering medical bills.

Hence, the programs we administer to those whose incomes are near or slightly above the federally drawn poverty line, are invaluable in assisting these District residents in their efforts to gain access to affordable, sometimes lifesaving health care.

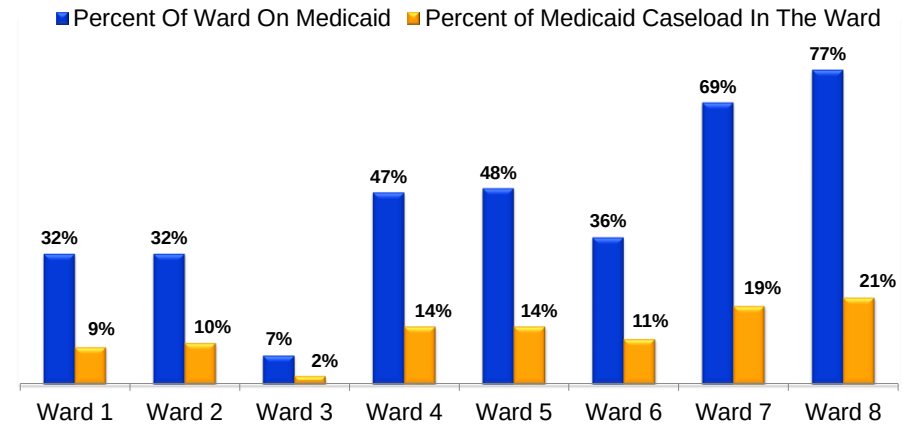
Agency Mission and Evolution

Before I turn to a discussion of DHCF's mission, evolution, and our key initiatives for this period of oversight, I would like to first acknowledge the continuing support provided by the Deputy Mayor for Health and Human Services, Hyesook Chung, and her capable team. We work each day with the Deputy Mayor's team as well as other members of Mayor Bowser's executive team to advance policies that address health care access and quality of care issues.

With respect to our mission, as one of its architects, you are aware that DHCF was established as a cabinet-level agency on October 1, 2008 to operate the District's Medicaid and Alliance programs. The mission of the Department is simple but complex -- improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia through both insurance programs that we administer.

Our very important work is guided by four major priorities. ***The first is to ensure access to a comprehensive array of health care services***. To that end, we provide health insurance coverage to more than 285,000 people – over four in 10 District residents. As the graph on the next page shows, these beneficiaries are disproportionately concentrated in Wards 7 and 8 of the city. Specifically, 69 percent of the residents in Ward 7 and 77 percent of those in Ward 8 are enrolled in the District's Medicaid program. In no other Ward does the level of enrollment for Medicaid exceed 50 percent of the estimated population. Not surprisingly, the graphic also

Medicaid Enrollment Levels In Each District Ward



Source: Ward population reported from United States Census Bureau. Medicaid caseload data reported from DHCF's MMIS system.

[1]

reveals that 40 percent of all Medicaid enrollees live either in Ward 7 (19 percent) or Ward 8 (21 percent).

With such wide coverage of the District's residents, our budget of more than $3 billion is the largest in local government. Approximately 96percent of this amount is dedicated to provider payments that reimburse health care entities for the range of services delivered to our beneficiaries. ***Hence, our second priority is to improve patient health outcomes for those who participate in the Medicaid and Alliance programs.*** This is a considerable challenge. Although we spend $3 billion on health care and administrative support services for 285,000 members, a question persists about the health status of our beneficiaries: Is their health status improving?

The threshold issue that we specifically struggle with every day is how best to use the dollars we spend on beneficiary health care to systematically improve patient outcomes. Related to this priority, we endeavor to increase our members' use of preventative care services offered

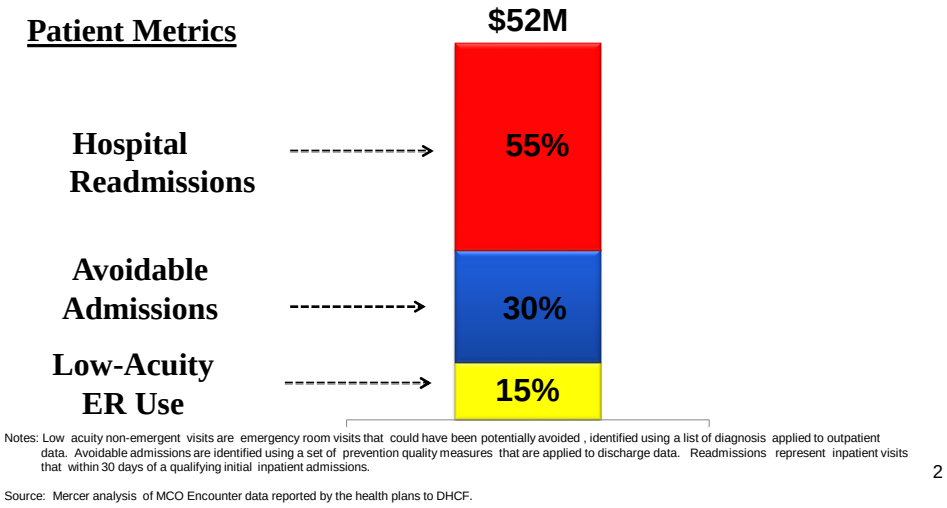
by their primary care doctors. We know from years of research that early detection of illness is the key to effective treatment -- it costs less and has a proven efficacy.

This means we must pursue targeted efforts to aggressively move Medicaid and Alliance recipients away from hospitals as a source of their primary care – often their entry point into the system of care. The focus of service delivery in Medicaid and Alliance is clearly hospital-based care. We spend over $700 million per year on inpatient hospital services, which is not surprising given the cost of acute care and the complexity of medical problems faced by some of our beneficiaries. More troubling, however, is the fact the seven of every 10 visits made by our beneficiaries to hospital emergency rooms (ER) are for non-emergency reasons. That is unacceptably high.

Moreover, if admitted to the ER, treated, and subsequently discharged, we know that many return to the hospital too quickly. Additionally, significant numbers are admitted to inpatient care for illnesses that were easily avoidable. As one example illustrated by the graphic on page 6, each year the health plans are spending more than $50 million on medical care for avoidable illnesses, hospital readmissions, and non-emergency ER visits to area hospitals by their members.

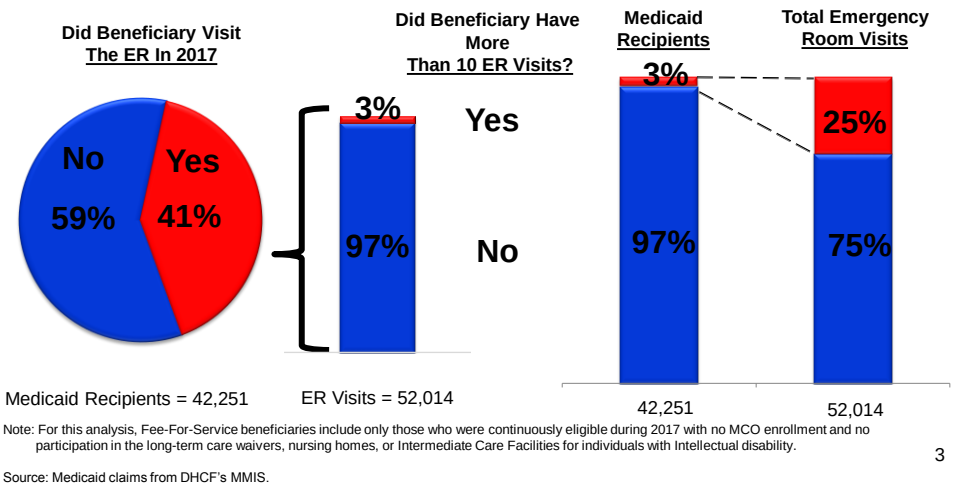
Further, other data show that after excluding people who receive institutional care or services through our community-based waivers, about 30 percent of all remaining Medicaid recipients who are eligible for DHCF's new care management program have multiple chronic conditions, as well as health care costs that are 140 percent higher than observed for other members who do not qualify for the program. On average, these high-cost members visit the ER at an annual rate that is nearly four times their peers.

Avoidable Medical Expenses For Medicaid Managed Care Beneficiaries



More concerning, when ER utilization patterns are examined exclusively for the fee-for-service population, a daunting challenge is more clearly revealed. On the one hand, the portion of beneficiaries that sought treatment from the ER in 2017 is not especially remarkable. Roughly four in 10 beneficiaries visited the ER in 2017, and only three percent of these Medicaid recipients made more than 10 such visits (see graphic on page 7). However, though this small group of frequent users only represent three percent of beneficiaries, they account for 25 percent of all annual ER visits. At the extreme, 32 members made at least 50 trips to the ER with one person making 236 separate visits – nearly two-thirds of the year's calendar days.

Previous DHCF research revealed that a significant percentage of these frequent users have serious mental health challenges. Many have problems with drug addiction, and a substantial number are likely homeless. Of course, this greatly complicates efforts to manage their health care, contributes to crowding in hospital ERs across the city, and creates avoidable cost pressures in the system.



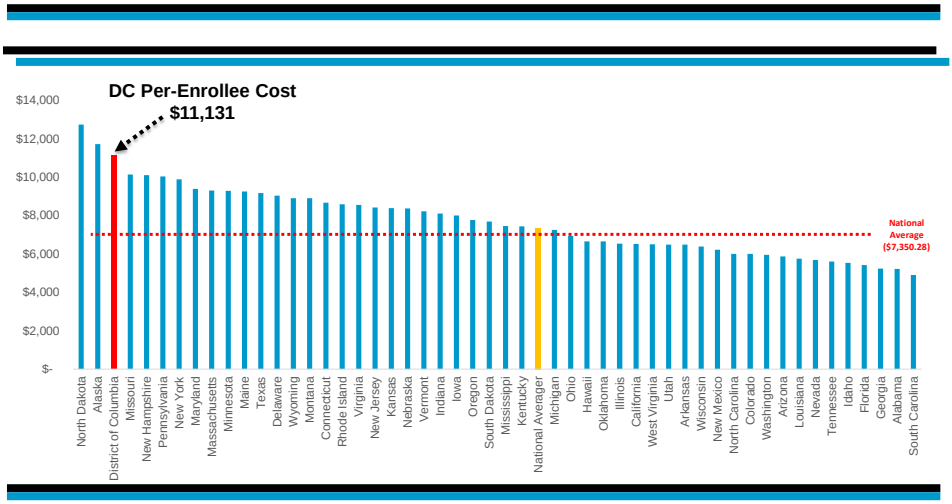
Since these members are not required to enroll with a health plan, DHCF assumed the responsibility of designing a system of care concept with a goal of reducing unnecessary utilization of health care resources while improving the members' health status.

Mr. Chairman, ***our final priority is to protect the integrity of the programs we administer.*** As stewards of the District's tax dollars, we are always concerned about waste, fraud, and abuse in publicly funded health care programs. Nothing threatens funding for these programs more than evidence of rampant fraud that inflates the cost of health care and raises public cynicism about the government's stewardship of their tax dollars.

We know that, historically, the District's Medicaid per-enrollee program cost consistently ranks among the top three or four states in the nation. The most recent data available for all states is from 2016, but the cross-state differences in Medicaid per-enrollee cost tend to be rather stable from year-to-year. In 2016, the District spent an average of $11,131 per enrollee in the city's Medicaid program. By comparison, the national average for Medicaid spending was

$7,350 per enrollee in that year – 41 percent less than the spending level observed for the District (see graph below). Likewise, the neighboring states of Maryland and Virginia also spend less on their programs per enrollee than the District. Specifically, Maryland spent 17 percent less per enrollee in FY2016, while Virginia's program was 26 percent cheaper.

Annual Medicaid Spending Per-Enrollee In The District Is Among The Highest In The Nation



Source: Data referenced from MACPAC's Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY2016 (https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/)

While geographic differences in health care cost and benefit design play a role in these differences, they are not fully explanatory. This leaves open the question of how much the problem of fraud adds to the cost of the District's Medicaid program relative to its peers. We regularly pursue cases where fraud seems evident, making a concerted effort to identify those health care providers that submit false claims and then work with the Office of the Inspector General and, occasionally, the FBI to remove these providers from the program.

DHCF's Evolution. Given the mission and complexity of this operation, it is essential that the agency be staffed with highly qualified employees who are provided with the best in technology to execute their jobs. When I arrived at DHCF in 2011, I found an agency that was

flat on its back – more than 40 percent of the positions were vacant. Moreover, due to a set of complicated issues, both staff morale and productivity levels were astonishingly low, directly feeding a dismal culture of underperformance. When work was performed on the program side of the agency, it was carried out by small numbers of staff in narrow silos, where employees struggled with inefficient work methods and rudimentary analytical tools.

Working closely with a newly hired executive management team, we first focused on filling the many vacant positions with a formidable team of motivated, analytical staff members who possessed the necessary subject matter expertise to help steer this $3 billion enterprise.

Next, we worked assiduously on upgrading our information technology capabilities. Each year, we process roughly 13.5 million provider claims, managed care encounters, and capitated payments. The claims and encounters contain thousands of variables on each member receiving care. These data offer a window into the health care needs of our beneficiaries, potentially revealing the opportunities for meaningful solutions to address their often-complex health problems. But to benefit from this information, we had to build sophisticated enterprise data management systems that capably retrieve and seamlessly integrate claims data for internal applications that are specifically designed to support staff efforts in analyzing large volumes of data.

The changes produced by our efforts are ubiquitous. DHCF is growing as a sophisticated operation, fully equipped with a remarkable executive team and agency fiscal officer, senior level staff, and mid-level managers who provide stewardship of the staff under the very watchful eye of our federal regulator.

With our hands on the program levers governing more than $3 billion in health care spending, we welcome the challenge of being the premier voice in the District of Columbia on

how to manage the delivery of health care for persons who receive publicly-funded health care insurance.

As we have evolved, the staff requirements to work successfully in the agency had to closely track with the skills required at any given point in DHCF's trajectory. This has allowed us to gradually move away from the standard hierarchical, top-down model that characterized the early development of DHCF – a model in which the work of non-managers was rigidly balkanized, narrowly prescribed, and largely devoid of the team work approach so common in modern organizations.

What is emerging now is a system that rewards those employees who can handle projects that require an abundance of subject matter expertise, sufficient interpersonal skills to work in a coordinated and collaborative manner, and the ability to operate and execute under the pressure of deadlines which we simply cannot afford to miss.

This approach requires considerable interpersonal collaborations among staff, attacking directly the tendency of large organizations to force all communications and project interactions through narrow, controlled, and counterproductive channels.

So, what have we gained from this novel approach?

- We created a culture of problem-solving through the rapid deployment of teams staffed with capable professionals who are serious about their work and can move projects forward in an expeditious manner;
- We secured comprehensive, more accurate solutions to complex problems that fully contemplate issues that cut cross different functional areas of DHCF;
- We broke down formal and rigid process controls while seeking solutions through flexible and cross-functional operations that exploit the use of our powerful and rapidly evolving data systems; and

- We disabused staff of the false notion that no work can proceed unless an executive or senior manager is intimately involved in the day-to-day management of existing projects.

Focus of DHCF's Oversight Activities

A core part of my testimony today reflects our efforts in administering the Medicaid and Alliance program in FY2017 through January of 2018. What follows is a high-level summary of a few of our most significant projects, offering remarks on the progress we have made along with our next steps for advancing the important work of the agency.

I specifically would like to discuss five primary projects that consumed significant amounts of the agency's resources during the period in question. They are as follows:

1. Procurement of DHCF's $1 billion managed care program;
2. Status of My Health GPS – a program to coordinate care and improve health outcomes for some of our members with complex medical difficulties;
3. Provider payment reform efforts for nursing homes and Federally Qualified Health Centers (FQHCs);
4. Implementation of the District of Columbia Access System – our integrated eligibility system; and
5. Building a Data Warehouse.

Status of MCO Procurement. In July 2017, a DHCF procurement team awarded three offerors separate, five-year contracts -- one base year and four option years -- to manage the delivery of health care for members of the Medicaid and Alliance programs. The contracts had a start date of October 1, 2017. The work of the technical panel was independently reviewed by a contracting officer from the Office of Contracting and Procurement. Subsequent to this review and the contracting officer's independent

assessment of the proposals and award recommendation, the contracts were later approved by Council in June 2017.

In that same month, MedStar Family Choice (MedStar) filed a protest of the contract awards, specifically charging that the District's evaluation of its proposal and those of the awardees was unreasonable, further alleging that the District conducted misleading discussions with the health plan.

In November 2017, the Contract Appeals Board (CAB) issued a written opinion sustaining MedStar's protest of DHCF's decision to award managed care contracts to AmeriHealth, Amerigroup, and Trusted. Labeling the scoring by the contracting officer as "arbitrary and capricious," the CAB further concluded that the District's determination of Amerigroup's responsibility did not have a reasonable basis.

The basis for the judge's conclusion was the fact that Amerigroup only submitted past performance evaluation forms for the performance of its affiliates on contracts in other states; thus, the judge concluded that the responsibility determination provided no basis for the contracting officer's determination that Amerigroup DC, a new company without any officers or employees, would be able to perform a contract which was to begin in less than five months' time – this despite the fact that Amerigroup, with 7.7 million members, is the largest insurer for public health programs in the nation.

The judge also found that the District's past performance evaluation of Amerigroup's and AmeriHealth's past performance was unreasonable because the contracting officer failed to discuss how the experience of the affiliates pertains to the offerors. Where the offerors' proposals provided general attestations of affiliate support,

the CAB essentially held that greater specificity was required to show how the affiliates would be meaningfully involved.

Notwithstanding the judge's ruling, the CAB did not order that the solicitation be cancelled. Rather, DHCF was instructed to reevaluate the proposals according to the corrective action outlined in the opinion – a directive that stated the proposals to be re-evaluated using the existing record (i.e. the offerors' initial technical and price proposals, first Best and Final Offers (BAFOs) and second BAFOs). The CAB's opinion did not provide the District with an opportunity to request revised BAFOs from the offerors to examine in greater detail the support that would be provided by the affiliates.

After careful examination, the Office of the Attorney General (OAG), on behalf of DHCF, petitioned the DC Superior Court in December 2017 for a review of the CAB decision requesting that the Court find the ruling "arbitrary, capricious, erroneous as a matter of law, and not supported by substantial evidence." OAG further asked the Court to either reverse or set aside the decision of the CAB or, alternatively, remand the case to the Board with instructions to modify its order of corrective action, allowing the District to obtain from the offerors their BAFOs prior to completing any re-evaluation of the proposals.

At the same time, the three offerors that were awarded contracts have either filed separate appeals or intervened in the District's appeal with the Superior Court regarding the CAB's decision, including a request for a stay of the judge's order that DHCF conduct a re-evaluation of the proposals without a BAFO. However, because the Superior Court failed to rule on the request for a stay prior to the date that DHCF was

ordered to complete the reevaluation and submit a status report to the CAB, the technical panel reevaluated the offerors' proposals.

Following the revaluation by DHCF's technical team, OCP's contracting officer reviewed the technical team's consensus report and independently scored and commented on each proposal against the evaluation factors. Following her reevaluation, the contracting officer determined that she is unable to make any award determinations based on the re-evaluation without first requesting BAFOs to resolve questions, such as proposal validity.

DHCF is holding further action in abeyance pending a ruling from the CAB on the agency's recently submitted status report or, a response by the Superior Court to the request for a stay of the judge's initial ruling or the Superior Court's ruling on the District's Petition for Review. While these deliberations are underway, we are considering DHCF's options.

My Health GPS. As I have previously noted, the challenge of managing and coordinating care across providers has been shown to contribute to poor outcomes for Medicaid beneficiaries, especially those in the fee-for-service program. Accordingly, we established the My Health GPS program toward the end of FY2016 to improve health outcomes while reducing inappropriate hospital utilization and hospital readmissions.

With this model, multiple teams of community providers are assigned a group of beneficiaries and asked to fully manage all aspects of their care. With a benefit design that includes a pay for performance component, providers who successfully improve outcomes for their assigned patients will be financially rewarded. This concept directly

supports DHCF's efforts to strengthen relationships between providers and beneficiaries while promoting shared accountability to improve patient health outcomes.

In terms of the program's status, the My Health GPS program was officially launched on July 1, 2017. Twelve providers and thirty-three participating sites are involved, including service sites in all eight wards. Providers have reported that My Health GPS has enabled them to create more than 30 new positions, including roles for nurse care managers, social workers, community health workers, and clinical pharmacists.

As of February 2018, approximately 3,400 beneficiaries are enrolled in My Health GPS, which is on target with expectations. Unity, Providence Health Services, Whitman Walker, Mary's Center, and Community of Hope are among the larger programs. As a group, all providers have billed approximately $1.69 million in My Health GPS claims to date.

The challenge of the program is that it requires significant practice transformation. This is more than a buzzword; it is difficult work that takes time. As national studies have shown, integrating innovative technology and asking providers to change the way they deliver care is an intimidating shift. DHCF has worked diligently to support providers' efforts by:

- Working with providers to design the program and support local innovations in practice, such as giving providers the flexibility to design their own staffing models (within some accepted parameters);
- Supporting the development of new health information exchange tools, such as a patient care snapshot, which provides an overview of all the care a patient has received across different settings in the District; and

- Providing technical assistance -- such as in person meetings and individualized support to help providers adapt to using new technology -- identify new clinical strategies to support patients, and conduct more rigorously designed performance evaluations.

Patient recruitment remains a challenge, especially for beneficiaries who are not in an active managed care relationship. DHCF anticipated this issue and negotiated with CMS to offer a first-quarter 'enhanced' service rate for completing an assessment, developing a care plan, and establishing a health goal, including a level of effort for outreach. Despite this initial effort, providers continue to express concerns regarding the challenges of outreach.

My Health GPS is now part of the District's state plan, and is an available service to qualifying Medicaid beneficiaries. We expect that the My Health GPS teams will continue to refine their programs to maximize the efficiency and effectiveness of care coordination services. DHCF will contribute to these efforts, working closely with providers and beneficiaries. We have a strong start with an innovative model that has been lauded by CMS leadership and our local providers – but we know we are not done and will continue efforts to grow and improve this program.

Provider Payment Reforms. A key focus of our work over the past year and a half has been on provider payment reform for two critical industries – nursing homes and FQHCs.

Nursing Homes. With respect to nursing homes, the current nursing home methodology is beset with problems. Initially established in 2006, the methodology is outdated and encumbered by policies that create disincentives for the care of bariatric patients or persons who struggle with mental health issues. Additionally, the lengthy

audit appeals process and rate rebasing system frequently results in retroactive rate adjustments that give rise to financial challenges for nursing home providers, especially as it relates to budgeting and cashflow management.

Hence, one of the goals of our nursing home payment reform is to improve the link between patient acuity and reimbursement so that the nursing facility receives higher payments for sicker residents. By aligning incentives to improve appropriate access in the most integrated setting, residents will be placed in a nursing facility based on the care required, thereby ensuring the delivery of care that is appropriate to their needs. At the same, this new patient-based methodology is designed in a way that significantly decreases the administrative burden for both DHCF and nursing facilities, while enhancing overall rate transparency.

We are now awaiting approval of the SPA by our federal regulator and we anticipate an effective date for the new system of February 1, 2018. Since CMS will approve the SPA after the official effective date, DHCF will make retroactive adjustments once approval is granted. This is accomplished by recycling all paid claims with the new approved rate and then reconciling the new payments to the earlier disbursements – this is always a challenge, but we stand ready.

FQHCs. Since 2001, federal law has required State Medicaid agencies to reimburse the FQHCs using a Prospective Payment System (PPS). Congress established this system to ensure predictability and financial stability for an industry that provides care to nearly one-quarter of all Medicaid recipients nationwide.

The FQHC's PPS is essentially a bundled payment that strategically moved away from cost-based reimbursement methodologies to enhance the efficiency in the delivery

of care. With this approach, FQHCs receive one bundled rate for each qualifying patient visit that was designed to cover the service and supply cost of the visit.

Overtime, PPS rates did not keep pace with inflation. In addition, the system did not allow multiple same day visits by patients, while states struggled to adequately price new services into the PPS rate structure. Compounding these problems in the District, the costs used to establish the PPS rates were not updated to consider the entry of new FQHCs in the market. Instead, the rates were only adjusted annually using the CMS inflation index.

The result was a widening gap between the cost of services provided by FQHCs and the PPS rate. This reality persisted for years, despite federal regulations mandating that FQHCs be reimbursed 100 percent of their cost.

To address these problems, DHCF worked to build a new payment methodology that better aligns the Medicaid FQHC reimbursement rates with the providers' service profile and reasonable cost. As a part of this approach, we made the following additional changes:

- Implement reimbursement for multiple same-day visits;
- Incorporate value-based payment concepts thorough a quality incentive payment plan that rewards the FQHCs for certain performance outcomes;
- Build efficiencies into the payment process that supplement MCO payments to FQHCs with a so-called WRAP payment;
- Ensure accuracy of claims data through the inclusion of procedure codes on claims used by the FQHCs to invoice the agency for payment; and
- Establish a claims appeals process.

DHCF worked extensively with the providers over a two-year time frame to develop this new rate methodology. This included extensive collaboration with the stakeholders, cost report audit and analysis, drafting of the SPA, and publication of the rules.

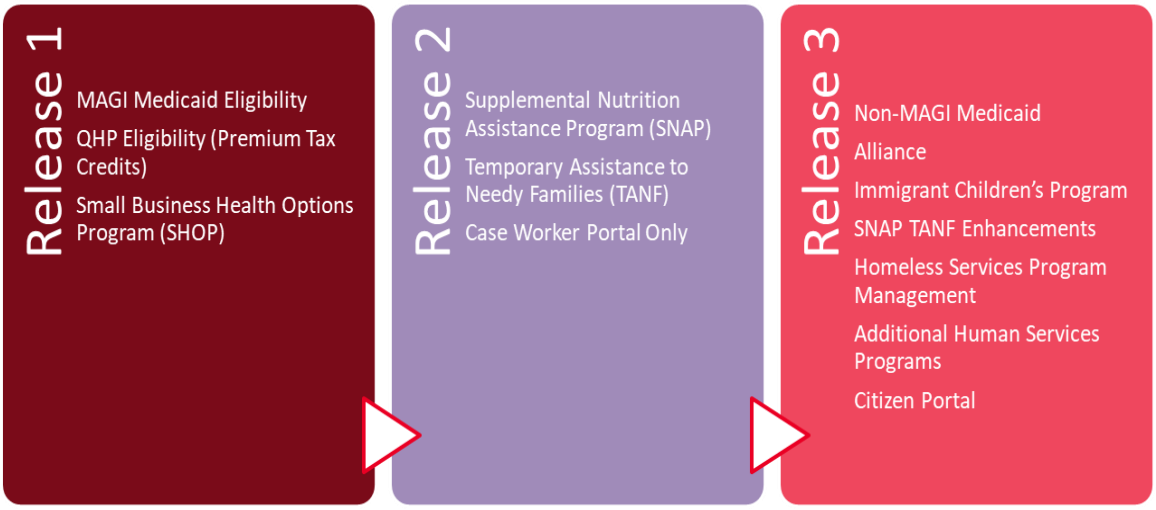
At the completion of this iterative process, we submitted the new SPA to CMS and obtained final approval in September 2017. Now, our remaining challenges are to ensure the accuracy of the encounter data, which we use to govern supplemental or WRAP payments to the FQHCs, then to recycle previously paid claims and reconcile these payments with those made during the period in which the rate methodology was being developed.

Although aspects relating to the rate setting and reimbursement methodology are complete, DHCF staff have been working diligently with the MCOs and FQHCs to address the operational challenges endemic to this last phase of this process. DHCF anticipates a final resolution of all issues and a recycling of claims by July 2018.

District of Columbia Access System (DCAS). With the passage of the Affordable Care Act in 2010, the District joined many states that sought to replace their legacy and outdated eligibility systems with more modern, federally funded technology. The vision of DCAS in the District is to provide an integrated eligibility and enrollment platform for health care and human services programs, including an insurance marketplace, integrated application data functionality, and enhanced case management capabilities. When complete, DCAS will facilitate seamless access to health care and human service benefits to all District residents, regardless of income.

The vision for DCAS is ambitious and the project is immensely complex. In 2012, to minimize work disruption while the project was underway, the District separated the project into

three phases – Release 1 (R1), Release 2 (R2), and Release 3 (R3), as shown below. At that time, the management of the execution of the phases were assigned to separate agencies - R1 to the Health Benefits Exchange, R2 to DHS, and R3 to DHCF.



Due to a confluence of both external and internal agency factors, DCAS has faced barriers to implementation since its inception. Each phase has experienced major delays in the development of complete system functionality, including cross-agency challenges with communication, coordination, and governance of the project. These problems generated significant issues that slowed District residents in their efforts to successfully submit applications and enroll in government assistance programs.

In February 2017, to facilitate tight alignment of project deadlines, budget, and DCAS deliverables, the City Administrator made the decision to transition the project to single agency leadership, eventually placing the responsibility for the program under the aegis of DHCF in June 2017. Accordingly, DHCF assumed complete responsibility and oversight for DCAS across all three Releases. The scope of responsibility included both application development and operations and maintenance.

In the first 90 days of taking on management responsibility for DCAS, the project team focused on the significant operational and design issues that hampered the functionality of R2. Steps have been initiated to ensure that the R2 system will by fully compliant with federal and local requirements. Further, we established a Project Management Office (PMO) that worked to ameliorate the referenced technical and programmatic issues with the system.

In the PMO role, DHCF's newly appointed project manager conducted a full review of all onsite resources, transitioned more than 60 additional resources to the project, aligned these assets to the correct work stream, identified resources not reflected in the supplied structure, and removed those who needed to be transitioned out of the project. This realignment has allowed leadership and the budget team to ensure that the cost-allocation required by our federal regulator is accurate.

Additionally, DHCF is currently engaged in active recruitment of talented expertise to work with a soon-to-be-hired vendor on the development of R3. Given the tight timelines for project completion, DHCF has been working to ensure the appropriate staffing model is engaged, while closely scrutinizing all DCAS deliverables to ensure fiscal accountability and technical efficiency.

The District anticipates that the R3 contract will be awarded this summer. Completion of R3 will include the automation of Medicaid applications and renewals for the long-term care population and the remaining human services programs. CMS has approved funding for R3 and the District is in the process of issuing the solicitation for the IT contractor who will build the system. We anticipate functionality for this phase will be built and ready for use in the fall of 2019, while full completion of DCAS is anticipated for 2021.

When this program is complete, the impact to District residents will be considerable, offering the following benefits:

- DCAS will allow the District to better meet customer needs and improve program results by authorizing case workers and service providers to have a single source of information about residents' eligibility for and participation in District social programs;
- The District will be better able to support low-income residents by coordinating health and human service delivery to residents across multiple agencies;
- DCAS will offer District residents a one stop portal to access health and human services benefits; and
- DCAS will provide horizontal program integration so that District residents can apply for health insurance and/or public benefits, including Medicaid, Children's Health Insurance Program (CHIP), Supplemental Assistance Nutrition Program (SNAP), Temporary Assistance to Needy Families (TANF), and other health and human service benefit programs.

Medicaid Data Warehouse. Mr. Chairman, the final project that I would like to discuss today is our Medicaid Data Warehouse (MDW). The main goal of MDW is to replace our legacy data management system with a modern, state-of-the-art data warehouse. With our expanding datasets, DHCF's legacy system can no longer provide efficient access to the files or support the rigorous algorithms we regularly need to construct to analyze data and inform our efforts to manage the program. Substandard data query capabilities, limited reporting tools, restricted access to historical claims data, unreasonable limits on the number of data elements, and an inability to simultaneously pull data from multiple files are the major shortcomings of our legacy system.

The MDW was designed to address each of these problems and, as a result, the system offers enhanced functionality. Now, tasks that once took days -- even weeks -- have been compressed into minutes. They include:

- Rapid access to at least 12 years of historical Medicaid and Alliance claims data with over a thousand variables (once unthinkable);

- Informative interactive reports and dashboards that allow staff to select multiple years of data with immediate queries;

- Pre-built subject-specific reports and dashboards that allow the end-user to select data using a variety of filters, then efficiently array the data by any number of program or patient variables are the hallmarks of this new system.

Now, staff can perform complex forecasting and predictive analytics in minutes with a fuller set of claims and variables. This is especially useful for "what-if" modeling scenarios that allow us to more precisely gauge the likely impact of proposed policy changes.

The MDW had its formal go-live on September 30, 2017, exhibiting an impressive array of high performance reports, dashboards and functional features that now meet most of the data needs of the agency. Still, a few challenges remain. These include:

- Implementation of a rigorous validation and testing protocol;

- A roll out of data products and features once the appropriate levels of validation are complete; and

- Continuation of training for DHCF management and staff.

We anticipate completing the MDW validation process in May 2018 and hope to secure federal certification by June 30, 2018.

Conclusion

Mr. Chairman, while significant work remains, DHCF's record of performance over the past 16 months, I believe, has been admirable. Launching a new system of care for a group of beneficiaries with serious health issues, tackling payment reform for providers with whom we spend over $200 million, procuring three managed care plans

for a program with a $1 billion price tag, assuming control of the complex DCAS project, and significantly enhancing the data management and analytical capabilities of the agency to levels previously unseen are important achievements.

As we move toward the end of FY2018, the team at DHCF looks forward to working with the Committee to address the pressing issues of concern, operating, as always, with complete transparency.

Mr. Chairman, before I close my testimony, allow me to address a very different issue - the matter of the United Medical Center Board's decision to challenge the request that the record of its deliberations regarding the closure of the obstetrics unit be fully released.

Chairman LaRuby May believes the issue of whether the Board violated the substantive spirit of the open meeting law is subject to question. As you have agreed, there is an obvious value to having closed meeting deliberations to protect confidentiality on matters covered by the open meeting laws, and the Board will continue to protect that privilege for its deliberations as appropriate.

However, in the spirt of transparency and the hospital's commitment to open government, Chairman May has decided to release both the transcripts and the recordings as soon as they can be expeditiously processed. With this decision, the Board hopes this matter and any question about the value it places on full transparency are soon put to rest.

Allow me to close by thanking you for your leadership and support as well as that of other Committee members. At this point, my staff and I are happy to answer any questions that you and other Committee members might have. Thank you.