GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2021-22 Performance Oversight Hearing

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

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WebEx Virtual Platform
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairperson Gray and members of the Committee on Health. My name is Wayne Turnage and I serve as the Deputy Mayor for Health and Human Services and the Director of the Department of Health Care Finance (DHCF). This is my fourth year in a dual role in the administration of Mayor Muriel Bowser and I remain grateful for her trust, as well as the expertise and dedication of my executive management teams at DHCF and in the Office of the Deputy Mayor for Health and Human Services. In both agencies, we continue to work closely with the Office of the City Administrator and the Executive Office of the Mayor (EOM), advancing the policies and programs that promote equitable access to quality health care across all neighborhoods of the District of Columbia.

Thank you for the opportunity to discuss the activities and accomplishments of DHCF in Fiscal Year 2021 (FY2021) and the first quarter of Fiscal Year 2022 (FY2022). Government operations in both fiscal years have been greatly impacted by the world-wide pandemic. Like other agencies across the city, DHCF maintained modified program operations for the duration of the year and began returning to the office in June 2021. Given the challenges of the pandemic, the agency's focus this past year was on maintaining stability across our programs, with an emphasis on the managed care program, our continuing response to COVID – 19, and articulating a clear message about unfettered access to the covid vaccine.

As we approach the mid-point of FY2022, DHCF is preparing for the conclusion of the federal public health emergency (PHE). While the most evident change will be the resumption of eligibility processes, there are a myriad of other programmatic changes which must be executed. These include both provider rate and benefit design changes. The unwinding period

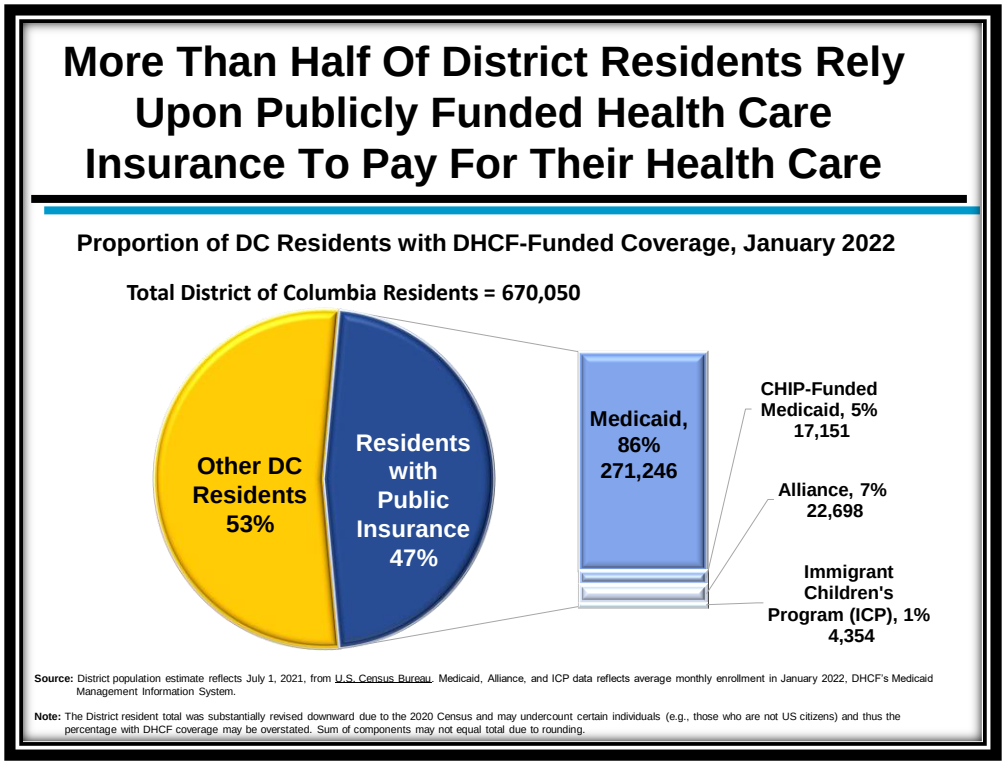
will be on-going and is anticipated to last for at least fourteen months. The administrative enormity of "returning to normal" Medicaid operations should not be underestimated.

My testimony today will outline the issues with unwinding the PHE and review DHCF's mission and priorities, including progress made on Medicaid reform. Following this discussion, I will reflect upon the major priorities and program accomplishments that DHCF pursued in FY2021 to further advance the broader goals we have for the Medicaid and Alliance programs. They are:

- Continued Pursuit of Medicaid Reform;
- Next steps in the transformation of Behavioral Health;
- Status of the District of Columbia Access System;
- Addressing vaccine hesitancy among Medicaid enrollees; and
- Status of Managed Care Contracts.

Agency Mission and Priorities

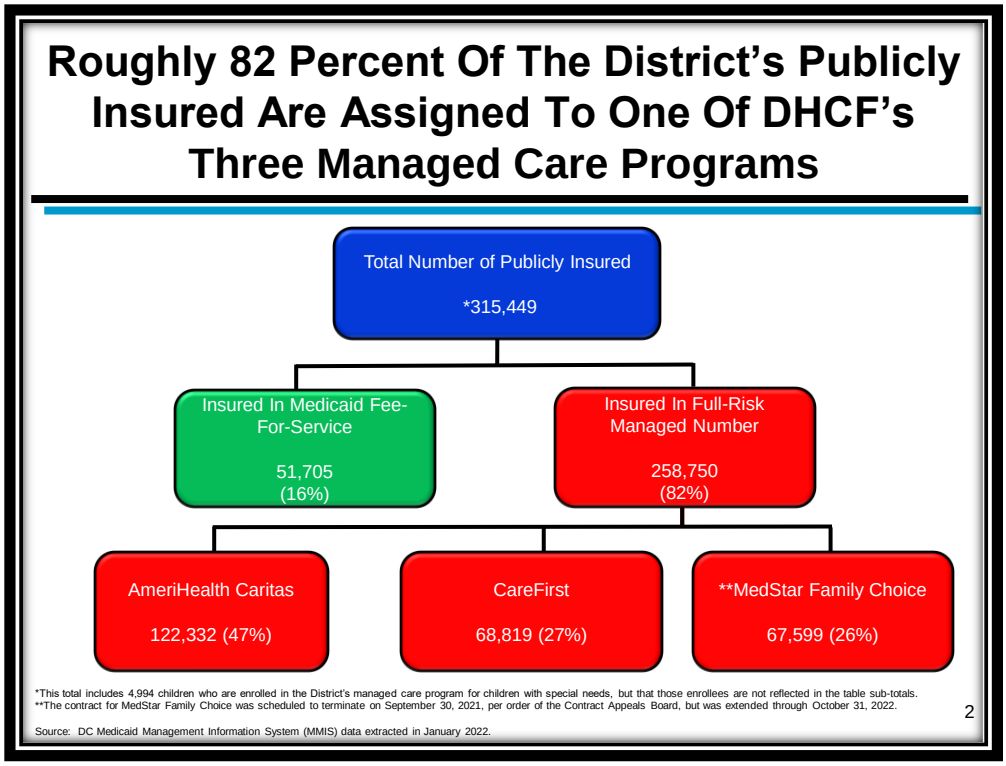
The mission of DHCF has remained unchanged since its formation in October 2008. The agency works to improve health outcomes by funding access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia. As the graphic on page 4 illustrates, more than 4 in every 10 residents have their health insurance fully funded through public insurance. This occurs through the administration of three primary insurance programs: (1) Medicaid (including coverage funded by the Children's Health Insurance Program (CHIP)), (2) DC Healthcare Alliance Program (Alliance), and (3) the Immigrant Children's Program (ICP). Most low-income, non-elderly adults in the District are eligible for either Medicaid (93 percent) or Alliance (7 percent).



DHCF operates a bifurcated system that includes managed care and the fee-for-service program. However, access to key providers – the District's acute care hospitals, hospital-affiliated physician groups, and federally qualified health centers – is available to all enrollees. Most beneficiaries receive benefits through managed care, a number that we increased in 2020 through expansion of the managed care program (see graph on next page). As shown, more than eight of every 10 enrollees in DHCF's insurance programs are enrolled in one of three managed care organizations (MCOs). A smaller number, approximately 51,000 residents, access benefits through the fee for service (FFS) program, a significant portion of whom use long-term services and supports (LTSS).

Unwinding From the Public Health Emergency

As a prelude to a discussion of the agency's major activities and programs, some attention to DHCF's activity relative to the federal public health emergency (PHE) is warranted. The federal PHE was extended, effective January 16, 2022, and can last up to ninety additional



days. The extension means the District's federal match increase of 6.25 percent remains in effect. Likewise, the emergency flexibilities we adopted to support continuous coverage for beneficiaries and enhanced rates for some providers are extended as well.

However, in anticipation of the end of the declaration, DHCF has initiated plans to return the Medicaid program to normal operations. We face a two-fold challenge of ensuring continuous coverage, where possible, while maintaining provider stability as costs and service utilization fluctuate. Perhaps the most daunting challenge is the resumption of Medicaid eligibility renewal processes.

Resumption of Eligibility Policies. Once the PHE ends, it will take at least 14 months to return to the normal cadence of eligibility renewals. This is necessary to maintain a roughly even volume of renewals per month for the purposes of managing case workload, while providing for the required advance notice of renewal. Currently, Medicaid and Alliance membership is at its highest in the program's history with over 300,000 residents presently enrolled. During the

initial post-PHE period, we anticipate several challenges – a higher number of renewals than witnessed historically, residents and staff with little to no familiarity of the renewal process, and a new system for accessing benefits through District Direct – also known as DCAS.

As we plan for the full resumption of eligibility renewal processing, we are considering the additional resources needed to successfully complete re-enrollment of all beneficiaries. The goal is to identify work that can be accomplished in advance to best prepare for renewals, such as collecting and updating address information. In addition, we will consider how best to communicate with beneficiaries and stakeholders about coming changes.

We are working closely with the Department of Human Services as well as the Health Benefits Exchange, and will eventually engage our managed care partners. The District is not unique in the challenges we face in resuming eligibility renewals and we are working closely with the federal government and collaborating with other states throughout the planning process.

Rate Adjustment and Other Operational Changes. Resuming eligibility renewals is just one component of "returning to normal" operations. In response to the PHE, DHCF made several changes allowing flexibility in program requirements, service delivery and provider payments. These changes were effectuated through one of three federal authorities and each authority has its own requirements and guidelines. As shown in the table on the next page, depending on the applicable authority, some of the changes will end at the conclusion of the federal PHE and some will end up to six (6) months following the end of the PHE.

There are some changes made during the PHE that have proven successful which we have and will explore as a permanent change. One example of this is the use of audio-only telemedicine which we have already made permanent. Other examples include the use of electronic means for assessments and case manager contacts. These considerations are part of

PHE and Emergency Authorities for the Medicaid Program

Authority	Effective Date	Termination Date	Example
Medicaid disaster relief/emergency SPA template for the COVID-19 PHE	March 1, 2020, or any later date elected by the state	End of the federal PHE (including any extensions), or any earlier date elected by the state	DC SPA 20-001: Temporary 20% increase to nursing facility rates
Appendix K (used for home and community-based services waivers)	January 27, 2020, or any later date elected by the state	Up to six (6) months following the conclusion of the federal PHE (including any extensions)	1915(c) HCBS Waiver Appendix K: Temporary 15% increase to assisted living facility rates
Medicaid 1135 Waivers	March 1, 2020	End of the federal PHE (including any extensions)	District 1135 Waiver Request: Temporarily suspend Medicaid fee-for-service prior authorization requirements

our planning for the eventual end of the PHE and will require approval by CMS as a permanent feature of the District's Medicaid program.

Provider Rate Issues. Another component of planning is understanding the current state of the health care workforce and the impact that could be felt when certain enhanced rates sunset. We are engaged with provider associations on this issue, most especially those that support and represent direct service professionals (DSPs). Through the American Rescue Plan Act (APRA), we can fund initiatives that have traditionally been unallowable through the Medicaid program, but now are permissible to enhance the home and community-based system. We are leveraging this opportunity to support HCBS providers in both the short- and long-term. This includes funding to facilitate DSP recruitment and retention, vaccine incentives for HCBS providers, and other training and professional development programs.

Sustainability is a federal requirement for ARPA initiatives. This means ARPA-funded initiatives, specifically rate increases, must be continued once ARPA funding ends. This

requirement has guided our spending plan, and DHCF has been careful not to commit the District to any future obligations that may not be sustainable in the six-year financial plan. Thus far, we have targeted a number of discreet, one-time obligations that could have systemic impact, while aligning with the following guiding principles:

1. Minimize existing gaps in the District Medicaid HCBS delivery system;
2. Increase capacity for HCBS providers to deliver high quality services to District residents in the wake of the COVID-19 public health emergency; and
3. Build upon existing care transformation efforts already under way in the District to be more inclusive of HCBS providers.

The Focus of DHCF's Medicaid Reform

As we noted in last year's performance review, DHCF is in the midst of a major reform of the District's Medicaid program. The overarching goal of this reform is to redirect programming in ways that will improve beneficiary outcomes per health care dollar spent. This five-year effort is guided by four strategic priorities:

1. Build a health system that provides whole person care;
2. Ensure value and accountability;
3. Strengthen internal operational infrastructure; and
4. Implement a meaningful PHE response, including monitoring and closure.

Since announcing Medicaid reform, DHCF has met several key milestones. In 2020, new managed care contracts were established to expand care coordination and case management and access to providers. Also, the continuum of care for behavioral health services was expanded through the implementation of the Behavioral Health Transformation waiver. So, much of Fiscal Year 2021 was dedicated to planning for the integration of Medicare and Medicaid services for

the dually eligible population through the development of the District Dual Choice (Dual Choice) and the Program for All-Inclusive Care for the Elderly (PACE) programs.

Medicaid Medicare Integration - Dual Choice Program and PACE. Currently about 37,000 District residents are enrolled in both the Medicare and Medicaid programs. Commonly referred to as "dually eligible," these residents must navigate both Medicare and Medicaid delivery systems for their healthcare benefits. Often, these two systems do not coordinate, resulting in fragmented care and additional administrative burdens for beneficiaries.

Accordingly, DHCF is implementing two major expansions to coverage and service delivery for dually eligible beneficiaries: an expansion of the existing District Dual Choice (or "D-SNP") program and the Program of All-inclusive Care for the Elderly (PACE). Through these initiatives, DHCF seeks better integration across Medicare and Medicaid to promote improved outcomes using a coordinated, interdisciplinary model of care, while incorporating value-based payment models into the delivery of LTSS. The implementation of the Dual Choice expansion and PACE represent the most significant changes to the District's publicly funded coverage in years for enrollees who are dually eligible and benefit from long-term care services.

The expansion of District Dual Choice launched on February 1, 2022. Through the program, DHCF pays a monthly capitation rate to a selected Medicare Advantage plan – UnitedHealthcare – that covers all Medicare and most Medicaid services, including EPD waiver services and comprehensive care management. About 12,000 beneficiaries are enrolled in Dual Choice. Participation is voluntary and initially limited to beneficiaries already enrolled in the Medicare Advantage plan prior to the expansion. Enrollees may opt out if they do not want to participate. Moreover, enrollment in the program does not impact beneficiaries' eligibility for

Medicare or Medicaid. Like other transitions involving managed care, DHCF has included a lengthy continuity of care (180 days) to ensure Medicaid services are not disrupted.

The integration of Medicaid and Medicare services not only impacts beneficiaries but also providers. For the past two years, DHCF engaged providers on the benefits and implications of integration in preparation for the Dual Choice launch. EPD waiver providers are accustomed to working directly with DHCF on EPD waiver services. For beneficiaries in Dual Choice and the EPD waiver, providers will now work with DHCF and UnitedHealthcare.

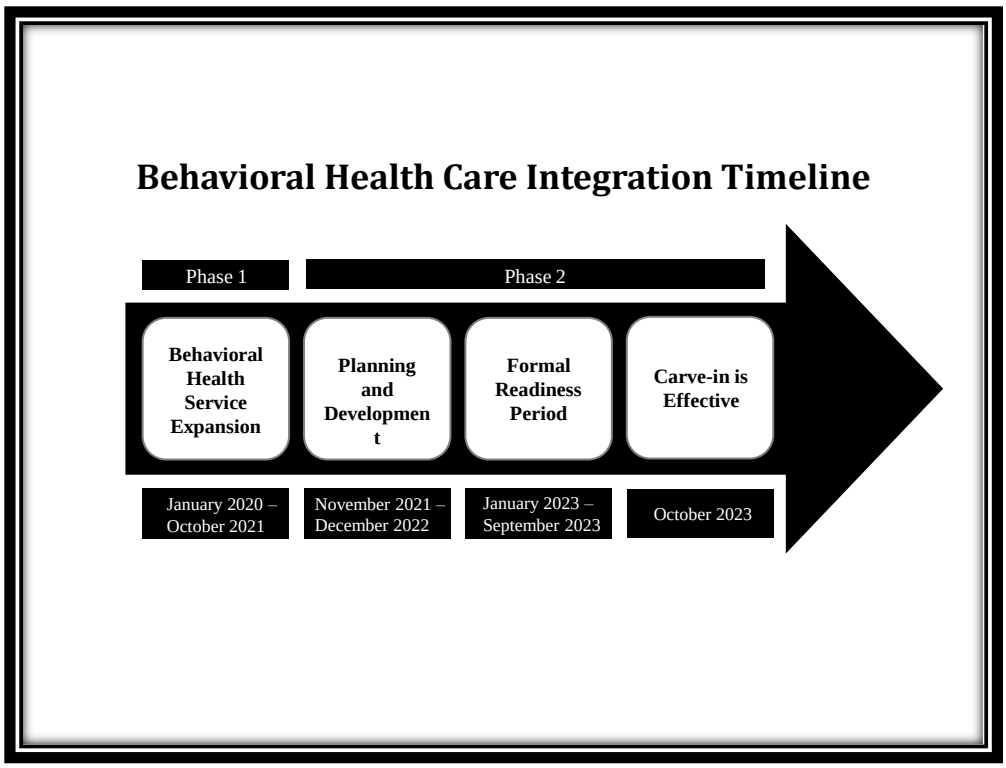
Under this arrangement, providers will bill and receive payment for services from UnitedHealthcare for those EPD waiver beneficiaries who enroll in Dual Choice. The contract requires UnitedHealthcare to offer a contract to all Medicaid-enrolled home health agencies (HHAs) and adult day health care programs (ADHPs). There is no similar requirement for case management agencies because the goal is to promote a single, integrated, comprehensive care management function. However, UnitedHealthcare has contracted with a several case management agencies to support its care management model. We expect to see similar changes with PACE program implementation and will continue to collaborate with our providers throughout these transitions.

Supporting Reform with Information Technology Changes. Over the past two and a half years, we have made strides in strengthening the foundation for these reform efforts on the technology front. This includes expanded use of the District's health information exchange (HIE) and the implementation of the District's DCAS integrated eligibility system, now called District Direct. Nearly all Medicaid beneficiaries today have a provider who is sending and receiving data through the DC HIE.

DHCF has also grown its technical assistance opportunities to support providers in preparing for a delivery system based on outcomes. Integrated Care DC is a comprehensive technical assistance program designed to improve Medicaid providers' readiness to deliver whole person, integrated physical and behavioral health care. Since February 2021, 26 practice sites from 19 provider organizations have engaged in an individual coaching session. Integrated Care DC has offered 19 provider training webinars on population health and evidence-based care topics and created the integratedcaredc.com hub for practice transformation resources.

Whereas Integrated Care DC focuses on service delivery, our newest program, RevUp DC focuses on supporting behavioral health providers in the transition to managed care and managing revenue cycle changes. A total of 31 providers have enrolled in RevUp since December and are now beginning to receive assistance. In FY2022, the new ARPA HCBS Digital Health Technical Assistance Program will provide support to HCBS providers on efforts to expand their use of Certified Electronic Health Record technology, connect to the DC's HIE, and encourage the utilization and optimization of telehealth tools across the District.

Behavioral Health Transformation Work. Two years ago, in November of 2019, we began an initiative to transform the behavioral health system with the end goal of establishing a whole person, population based, integrated Medicaid behavioral health system. The goal was to build a system that is comprehensive, coordinated, high quality, culturally competent, and equitable. Led by DHCF and our partner, the Department of Behavioral Health (DBH), a multi-year phased approach was set encompassing behavioral health service expansion (Phase I), managed care integration (Phase II), and integrated care payment models (Phase III). The graphic below illustrates the activities covered in the first two phases of the process.



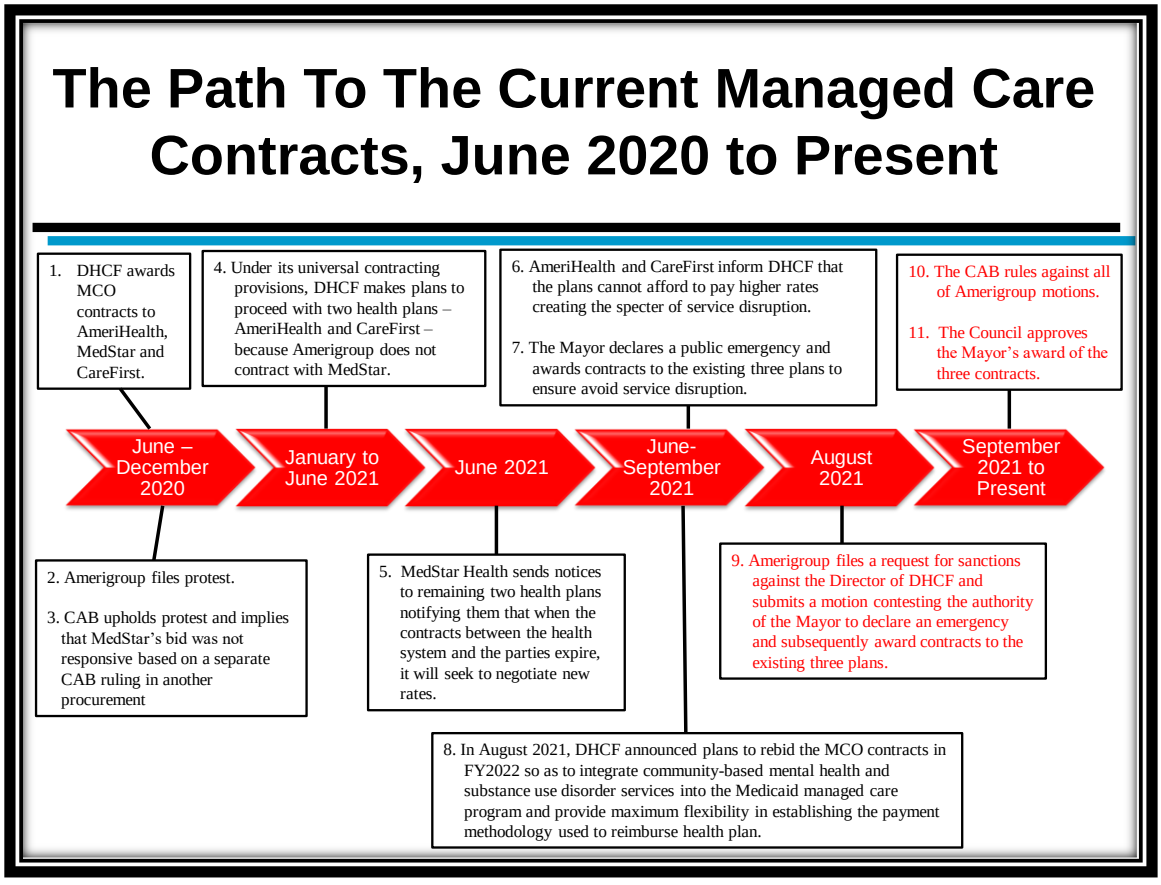
Presently, the District is in Phase II and working towards integrating the continuum of behavioral health services into our managed care program, effective October 1, 2023. Stakeholder engagement for this effort – which is often referred to as the "carve-in" – formally kicked off in January 2021 with the Stakeholder Advisory Group. Comprised of individuals who have the lived experience, advocates, community members, provider organizations, managed care organizations, and government agency staff, this group addressed core elements of a successful transition including the service array, contract considerations, beneficiary and provider engagement, quality and oversight, and rate enhancements.

DHCF announced its intent to reprocure the managed care contracts to allow for the inclusion of the full complement of behavioral health services as a part of this reform. This was necessary to set the baseline requirements for expanded behavioral health services – just as the current contract does for other services, like primary care and case management. The Stakeholder Advisory Group recommendations were considered by DHCF and DBH and they

informed the development of the behavioral health components of the solicitation for managed care services. Now, planning and development efforts are underway as we focus on assessing provider readiness, completing a behavioral health services rate study, providing tailored technical assistance to behavioral health providers, and identifying the department-level changes necessary for DHCF and DBH.

Status of MCO Contracts

Over the past 18 months, there have been multiple developments in DHCF's managed care program which are highlighted in the graphic below. The series of events is best summarized by Mayor Muriel Bowser's decision to declare an emergency in September of 2021 to ensure service continuity following several unanticipated events associated with DHCF's



procurement. In particular, the response triggered by a ruling of the Contract Appeals Board, left the program on a precipice that created uncertainty around the network of providers that would be available to health plans in the program for FY2022. Though the Mayor's actions were challenged by Amerigroup at the Contract Appeals Board, that motion was summarily rejected by the three-judge panel.

What is important to now note is that in August 2021, DHCF announced plans to reprocure the managed care contracts to allow for integration of the full continuum of behavioral health services into the Medicaid managed care program. This effort aligns with the agency's priority to build a health care system that provides whole person care and improves health outcomes. This service expansion changed the scope of services required by managed care which resulted in a material change to the current contract. Further, we announced that the new procurement would include the maximum flexibility in establishing the payment methodology used to reimburse health plans. More specifically, because we are introducing into managed care, larger numbers of enrollees who have high risk medical profiles, DHCF has adopted contract provisions to allow for the implementation of a risk-based corridor payment system. As opposed to the capitated or flat rate system that DHCF has historically used in this managed care program, risk corridors are employed to reimburse managed care plans at higher rates if enrollee medical expenses exceed a preset threshold. In effect, this is a stop-loss policy designed to reduce the concern health plans would otherwise have with being asked to take on a greater number of high-cost members under a capitated or flat payment system. Likewise, if the managed care plan's spending on enrollees falls below a certain threshold, some of the resulting profits must be shared with the District.

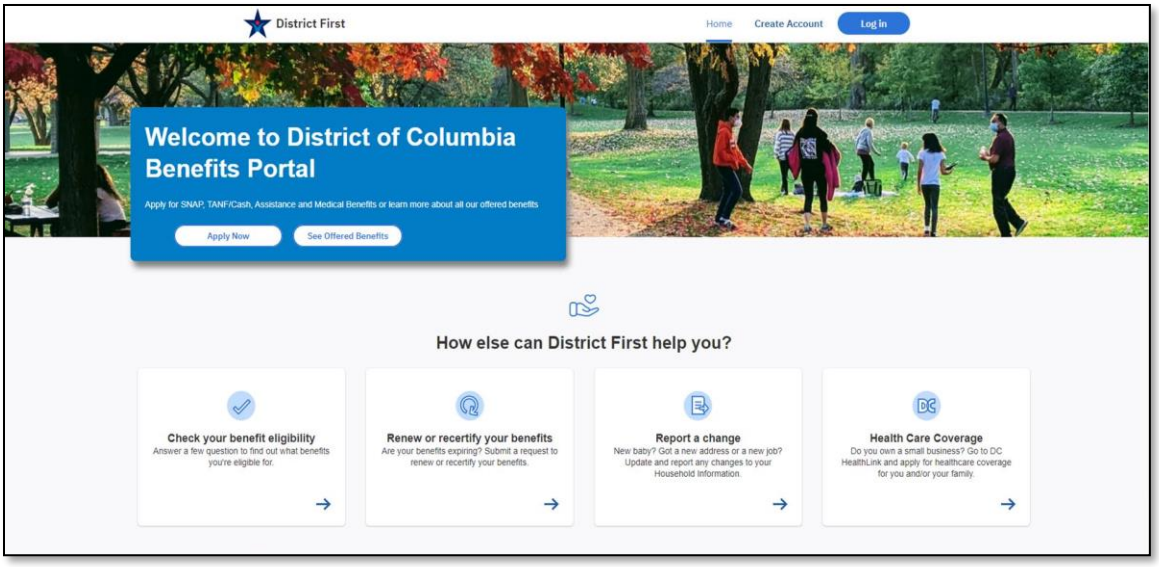
Current Procurement. On November 19, 2021, the Office of Contracting and Procurement (OCP), on behalf of the Department of Health Care Finance, issued a solicitation seeking MCO proposals for the District's Medicaid program. While this solicitation is still ongoing, on February 2, 2022, the District released a new and supplemental solicitation seeking additional MCOs. In accordance with District requirements and to ensure the sustainability of the District's Managed Care Program, the District will contract with up to three Managed Care Organizations (MCO) so that Medicaid beneficiaries have a choice of providers.

According to OCP's milestone chart, which highlights the appropriate tasks needed to complete a procurement, the District is still currently on schedule to meet the estimated award date of June 30, 2022. When awarded, the contracts will be for a five-year base period with one five-year option period. We are hopeful that extending the base period of the contract will bring stability to the managed care program after multiple protracted procurements.

Status of DCAS Project

Mr. Chairman, I am most pleased to report that the District successfully launched the final phase of DCAS on November 15, 2021. Now called District Direct, the project was an eight-year effort to transition from our outdated legacy eligibility system to an integrated platform that ensures District residents are connected to the tools and services that can enable them to live healthier, productive lives. Residents now have the ability to access applications for both health care programs and food or cash benefits through a single-entry point and integrated application, instead of the current time-consuming process that involves multiple systems and steps.

The District Direct resident portal, pictured on page 16, allows residents to complete the entire enrollment and eligibility process online, and hopefully will become the preferred way to manage their benefits. In addition to completing the new combined application at their leisure,



residents can also now complete multiple tasks that were previously impossible or burdensome to accomplish. This will undoubtedly introduce major efficiencies in case processing, greatly reducing the amount of time required to review and approve applications and process renewals.

Some of the functions that are now available through District Direct include the following:

- Apply and recertify for food, cash, and health benefits;
- Manage and view benefits (EBT balances, payment details)
- Connect to existing beneficiary accounts to see active cases or in progress tasks, such as needing to submit verification documents or recertify;
- View a personalized dashboard with required tasks, status, cases, and more available (must have a connected account);
- View electronic notices, allowing more time for responses (e.g., recertification deadlines, missing verifications, etc.), while still receiving notices by mail;
- Submit verification documents electronically; and,
- Review frequently asked questions (FAQs) and contact details for the agencies.

With the District Direct launch, our efforts have shifted to operation and maintenance of the functionality that supports the new eligibility system, while maintaining the ability to develop new functionality and make enhancements as policy changes and new programs dictate. We are presently onboarding new vendors to perform these tasks as well as complete outstanding Release 2 development work that was improperly designed a few years back. We are proud that District Direct is finally here to support and allow residents to quickly access care and assistance when they need it.

Vaccine Hesitancy Among Medicaid and Alliance Members

The last issue I would like to address concerns the vaccination penetration rate for members of the District's Medicaid and Alliance programs. Consistent with trends across the nation, District residents enrolled in the Medicaid/CHIP, Alliance, and ICP programs are less likely to be vaccinated against COVID when compared to the general population in the city. As demonstrated in the table on the next page, through January 22, 2022, only 52 percent of all enrollees ages 5 or older (i.e., those currently eligible for COVID vaccination) show evidence of having been vaccinated. This compares unfavorably with a Districtwide rate of 65 percent.

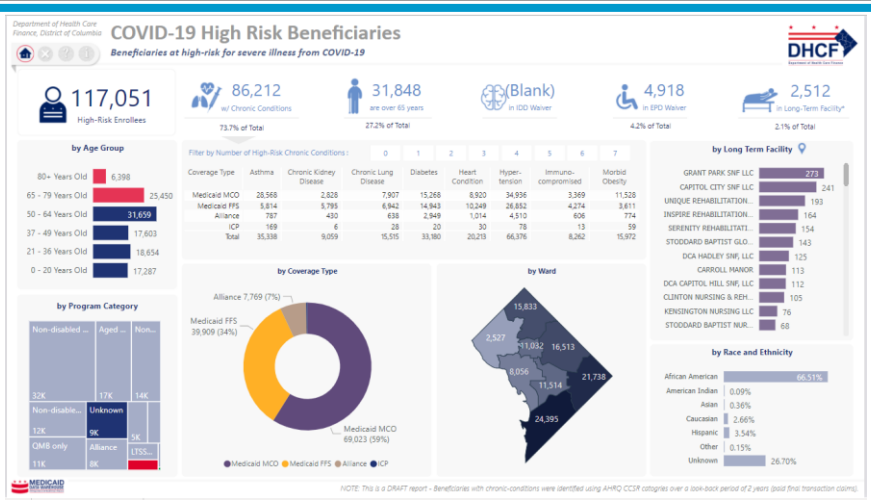
Vaccine Rates for Managed Care Enrollees. In managed care plans, the vaccine numbers are also low. Among those eligible for the vaccine, only 49 percent of DHCF's managed care members have been vaccinated. This compares unfavorable to fee-for-service enrollees who have 65 percent rate. Differences in COVID vaccination rates between these two programs are partly due to varying age profiles, with older populations being the most likely to be vaccinated.

Nonetheless, the low vaccination rates for managed care enrollees are concerning because of data that indicates the high-risk medical profile for persons enrolled in the Medicaid program.

A Comparison of Districtwide Vaccination Rates To The Levels Observed In DHCF's Programs, By Age as of January 2022		
Population Groups	DC Health Vaccine Data	DHCF Medicaid And Alliance Populations
Total population	67%	47%
5 years of age & up	71%	52%
12 years of age & up	75%	56%
18 years of age & up	75%	57%
65 years of age & up	86%	73%
Source: DHCF analysis of DC Health immunization registry data received via CRISP and DHCF Medicaid Management Information System data as of 1/22/2022. District-wide vaccination rates are from https://coronavirus.dc.gov/data/vaccination as of 1/18/2022.		

As the graphic below illustrates, more than 100,000 DHCF enrollees, two-thirds of whom are in managed care, are at risk for a severe COVID infection which makes their refusal to get vaccinated in large numbers especially perilous.

More Than 100,000 DHCF Enrollees Are Considered High Risk For COVID-19 And Two-Thirds Are Enrolled In DHCF's Managed Care Program



Note: Does not include data reflecting the CDC's recent expansion of high-risk categories.

In response to the general problem of low vaccination rates, DHCF initially engaged a vendor to conduct direct outreach to the total population of unvaccinated Medicaid fee-for-service beneficiaries during the summer of 2021. Further, we directed our managed care plans to conduct outreach to their Medicaid and Alliance beneficiaries, including vaccine print and digital ads, text messaging, and use of social media, radio, and more.

Although much has been done to date regarding communications and messaging to increase awareness and availability of information about COVID vaccines, disparities in vaccine uptake in the District persist due to the longstanding lack of trust in the health care system and vaccine misinformation among Black and Brown communities.

Maximizing MCO activities directed towards increasing vaccine uptake and supporting provider outreach are key strategies for closing the vaccine equity gap for Medicaid & Alliance beneficiaries. Hence, we continue to work with our health plan partners by stressing the need for new targeted strategies to improve vaccination rates across the Medicaid and Alliance populations. In the coming weeks, a beneficiary financial incentive program will be implemented through managed care where members will be eligible for up to $75 in gift cards when they complete initial and booster vaccinations.

We have learned from previous COVID-19 outreach work that providers are among the most trusted source of health care and vaccine information for DC residents. Efforts to capitalize on existing provider relationships and to enhance capacity for providers to serve as trusted messengers regarding health and vaccine information will be essential if progress is to be made in addressing the District's racial/ethnic and geographic disparities in vaccine uptake.

Conclusion

Mr. Chairman, this concludes my performance oversight testimony on the activities of DHCF. As outlined, we continue to reform the Medicaid program while preparing for the end of the public health emergency. My staff and I look forward to working with you and the Council as we negotiate this challenging environment for both residents and health care providers. Thank you for this opportunity to testify and we are happy to receive your questions and those of the members of the Committee on Health.