

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance**



Public Hearing on

B24-0115, the “Department of Health Care Finance Support Act of 2021”

**Testimony of
Wayne Turnage
Deputy Mayor for Health and Human Services
and
Director, Department of Health Care Finance**

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

Wednesday, April 21, 2021
10:00 a.m.
WebEx Virtual Platform
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Introduction

Good morning, Chairman 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. I am here today to discuss the impact of the “Department of Health Care Finance Support Act of 2021.” Joining me are Melisa Byrd, State Medicaid Director; Melanie Bell, Interim Chief Operating Officer and Operations Manager; Melanie Williamson, Interim DCAS Director and Chief of Staff, Don Shearer, Director of the Health Care Operations Administration, and Lisa Truitt, Director of the Health Care Delivery and Management Administration.

The Mayor’s bill seeks to ameliorate issues that are now facing the Department of Health Care Finance (DHCF) as a result of a Contract Appeals Board (CAB) ruling on a contract initially awarded as part of a solicitation for the Core Medicaid Management Information System (MMIS). In the CAB’s August 20, 2020 opinion, the three-judge panel found that the proposal for the selected winner of the contract was non-responsive for failing to submit a compliant subcontracting plan with its initial proposal, even though the subcontracting plan was submitted later in the procurement process. Thus, the District’s contract award was overturned and the CAB decision echoed through two other procurements for the Medicaid managed care program and the District’s major automated eligibility system.

It is critical to note that this CAB’s ruling runs contrary to the standing practice of the Office of Contracting and Procurement (OCP) which, for more than a decade, has permitted offerors to submit a subcontracting plan when the District receives the last best and final offer (BAFO) from the offeror. If the Mayor’s bill is passed, this legislation will: (1) ensure that the District is able to continue the procurement process for this limited set of solicitations under the

longstanding District practice that existed at the time the Request for Proposals (RFPs) were issued; (2) allow the District to implement or continue contracts with offerors meeting the expectation of the Technical Evaluation Panel (TEP) and the Centers for Medicare and Medicaid Services (CMS) to provide the level of services required; and, (3) ensure there is minimal disruption and cost impact on the progression of the three impacted contracts—Medicaid Managed Care, the Medicaid Management Information System, and the District of Columbia Access System—which are discussed further in my testimony. No other contracts will benefit from the Mayor’s bill.

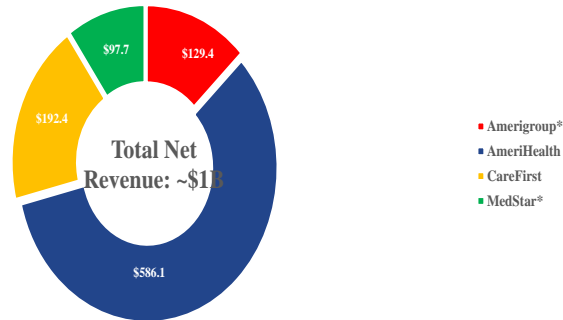
Medicaid Managed Care Contracts (MCOs)

DHCF has been operating the Medicaid and DC Healthcare Alliance (Alliance) programs since 2009 and 2001, respectively. Presently, the agency is working towards a more comprehensive Medicaid managed care program and has redesigned the managed care organization (MCO) contracts with a focus on: (1) securing health care value for Medicaid enrollees over a historical and disproportionate provider focus on volume, (2) achieving more coordinated care to ensure that the totality of members’ health care needs are addressed, and (3) increasing access to care using every acute care hospital, clinic, and large physician practice plan in the city.

Effective October 1, 2020, the Medicaid managed care program was expanded to include persons characterized as “non-dual Social Security Income (SSI)” adults, ages 21 and older, who were previously served through the District’s Fee-For-Service (FFS) program. As shown in the graphic on page 4, between January 1 and December 31, 2020, over \$1 billion in total net revenue was paid to the four full risk-based MCOs that served the Medicaid and Alliance health plan enrollees during all or a portion of this period.

Net Revenue By MCO and Total DCHFP & Alliance Program (\$M)

Net Revenue By MCO and Total DCHFP & Alliance Program (\$M)



Data Sources: Financial Condition values from MCOs' Annual Statements as of December 31, 2020 filed with DC Department of Insurance Securities and Banking.

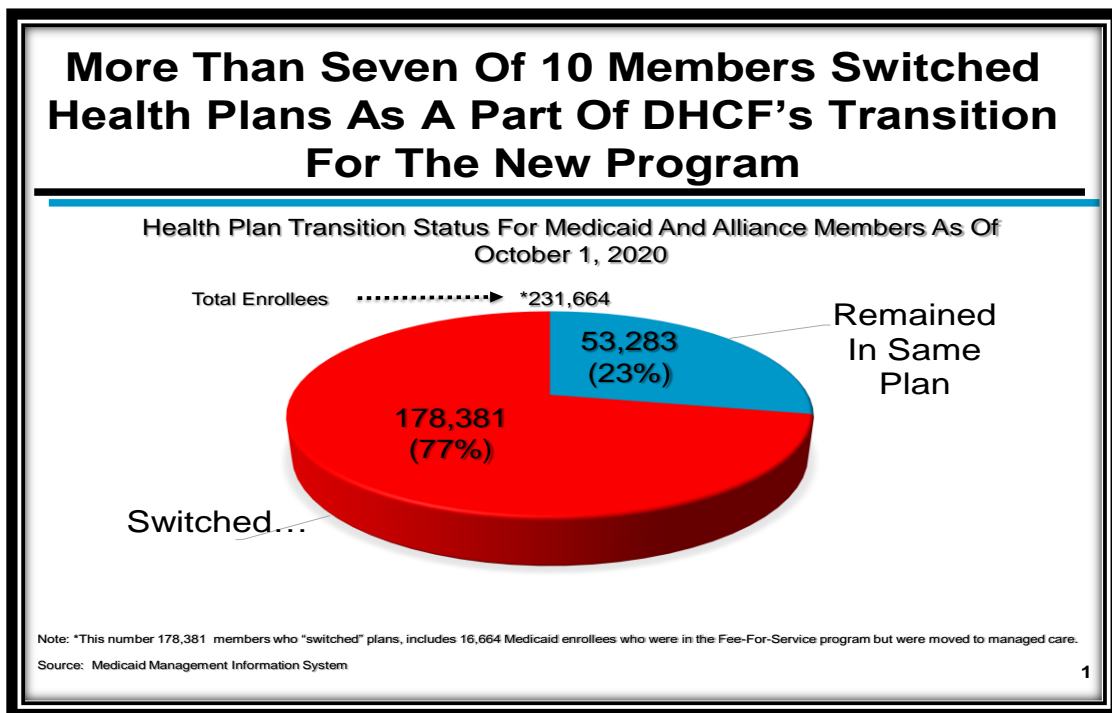
Notes: *Amerigroup amounts represent 9 months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020. MedStar began contracted services as of October 1, 2020. Financial results shown for MedStar represent 3 months of operation from October 1, 2020 to December 31, 2020. For all MCOs, Total Capitation Revenue excluding HIPF payments and DC Exchange/Premium Taxes. DC Exchange/Premium Taxes based on the MLR letters and calculations provided by the health plans.

The MCO RFP Process. DHCF, through OCP, issued an RFP in January 2020 with the goal of stabilizing its system of managed care by addressing chronic issues within the program, including the problem of adverse selection. In a managed care environment, adverse selection occurs when sicker members of the Medicaid population gravitate towards a single MCO, thus creating an imbalance of healthy and sick enrollees across the three health plans. When sicker enrollees, primarily those with one or more chronic health conditions, disproportionately enroll in one plan because of the care and services offered, they increase the risk level for that health plan, generating escalating and ultimately unsustainable costs.

In the new procurement, DHCF selected the following three MCOs for the award of new contracts: AmeriHealth Caritas District of Columbia, Inc. (AmeriHealth); MedStar Family Choice (MedStar); and CareFirst BlueCross BlueShield Community Health Plan District of Columbia (CareFirst), formerly known as Trusted Health Plan. The new contract addressed problems with the uneven distribution of high-cost members across the agency's three health plans with a random

redistribution of member assignments, and a provision that allows DHCF to reduce funding for any MCO in amounts that ensure the medical expenditures are least 85 percent of total MCO revenue. Other provisions increase access to care through mandated universal contracting, emphasize the use of value-based payments, and expand care coordination. Additionally, it should be especially noted that these contracts included *over \$78 million Small Business Enterprise (SBE) and Certified Business Enterprise (CBE) contracts.*

The implementation of these three contracts represented the most significant transition of the District’s managed care enrollees in the program’s history. As noted, all enrollees were randomly assigned to one of the three MCOs, including those new enrollees who were previously served through the FFS program. The graphic below illustrates the magnitude of Medicaid and Alliance members that received new health plan assignments under the transition. As shown, 178,381 members were reassigned to new plans, including more than 16,000 former FFS members.

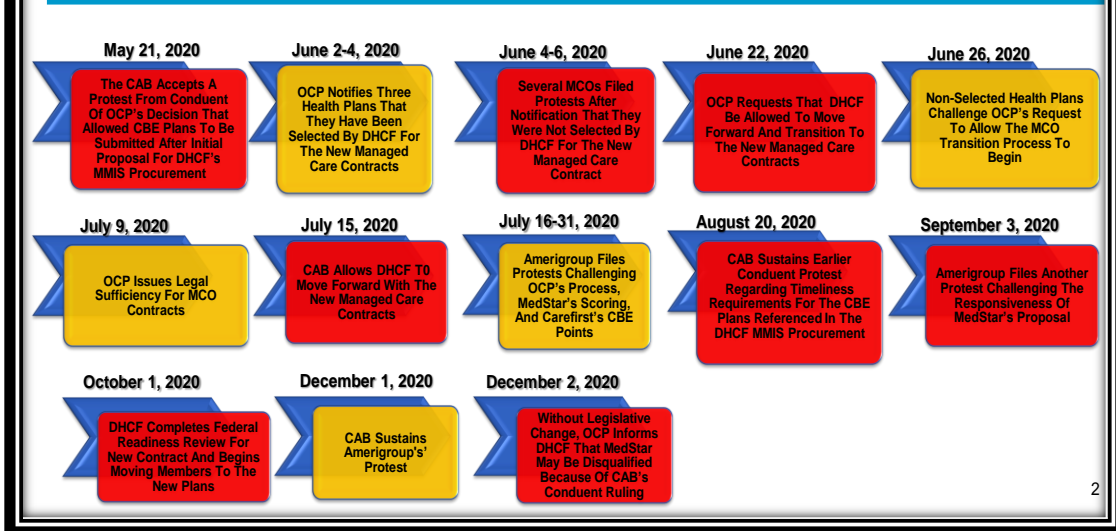


To carry out this transition, DHCF took significant steps to engage enrollees and stakeholders, informing them of the planned transition. In addition, a concerted effort was made to communicate with physicians in hospitals, large practice plans, and clinics on the importance of ensuring a continuity of care with the goal of preventing potentially dangerous disruptions in enrollees' treatment plans. Finally, we established in-house call center services to supplement those provided by the enrollment broker for the purpose of addressing concerns raised by any enrollees who had questions about their new plan assignments.

In light of these changes, the CAB's ruling regarding the Conduent Protest on the MMIS procurement has created substantial challenges for the managed care contracts. Because the OCP Contracting Officer is now required to apply the Conduent ruling to the managed care procurement, any managed care contract that does not meet the requirements of this ruling, by law, must be treated as non-responsive, disqualifying that plan from any further review. Absent a statutory change, this standard must be applied even if the technical evaluation team has rated the impacted proposal as one of the top three in the procurement.

The illustration on page 7 shows the trajectory of events following the filing of the MMIS procurement protest, and how it ultimately impacts the managed care contract procurement process. Notice the CAB accepted a protest of the award of the MMIS contract on May 21, 2020. Approximately three weeks later, OCP notified the three health plans—AmeriHealth, MedStar, and CareFirst—of their selection by DHCF's technical evaluation team. Within that same week, several protests were filed by the MCOs and the CAB accepted one such protest. Nonetheless, two weeks later, based on a request by OCP, the CAB ruled that DHCF could move forward with the process of transitioning the plans into the program, which included the reassignment of more than 178,000 members. This transition process would take nearly seven months.

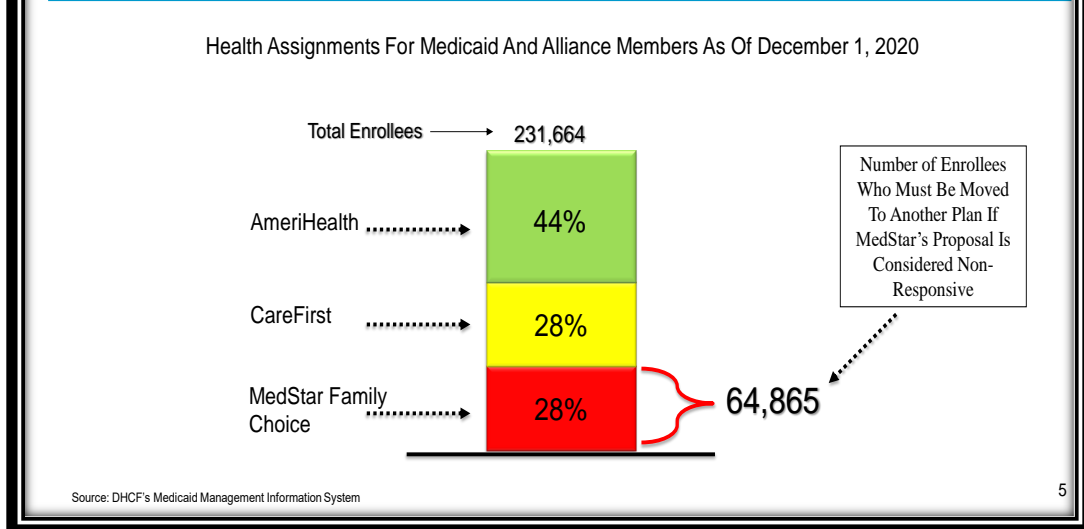
Key Activities In The Managed Care Procurement Timeline Which Have Created DHCF's Current Problem



It was during this period that the CAB issued a ruling sustaining the MMIS protest that invalidated OCP's interpretation of the CBE law, before later sustaining Amerigroup's protest of DHCF's award of the MCO contracts. This last decision came after the agency had completed the reassignment of the health plan members. More critically, evidence emerged that the CAB's ruling on the MMIS contract could invalidate DHCF's award of one of its MCO contracts to MedStar.

In the absence of legislative action, this confluence of events leaves DHCF with two options. The first would be to accept Amerigroup into the program and move the members who had been reassigned to MedStar to this plan. Of course, this would require that MedStar's more than 65,000 enrollees be reassigned to Amerigroup, another health plan yet again, and within 12 months of the previous transition (see graphic on page 8). Such an action would be both unprecedented and highly disruptive to both Medicaid and Alliance members. Equally significant, many of these members now rely upon the MedStar Health System for their care. Should Amerigroup be added to the program, we have no guarantees that the health plan will be able to

Unaddressed, The CAB Decision Will Require DHCF To Change The Health Plan Assignments, Yet Again, For More Than 64,000 Members



secure an agreement with the MedStar Health System. In fact, history suggests they will not. Such a failure for a second time will leave many of the members in the plan without access to their hospital and physicians of choice. This is a program risk that DHCF is not willing to take.

Hence, if the Mayor's bill is not passed, DHCF's second and best option, essentially reflects a Hobson's choice—requiring that we proceed with only two health plans in the program. Under this approach, the members who are currently enrolled in MedStar would be allowed to select a new plan from the remaining two MCOs. While they will be required to switch plans, the members will at least have the benefit of enrolling in a MCO that has precisely the same network of providers who are contracted with their current plan.

Still, the members must be moved for a second time and this comes with its own set of stressors for some of the District's most medically fragile residents. Further, DHCF will need to allocate system hours from our contracted Fiscal Agent to conduct a mass transfer of enrollees

from MedStar, randomly reassigning members who do not make a health plan selection amongst the two remaining health plans.

In addition to the stress and confusion that may be placed on the managed care population with another transition, this process will cost the agency more than \$1.3 million due to increased hours of operation, additional staff to manage enrollee phone calls, and the production of revised or updated outreach materials (see below).

Service	September	October	November	December	Total
Labor	\$134,992.62	\$128,564.40	\$128,564.40	\$ 141,420.85	\$533,542.28
Postage	\$ 399,855.27	--			\$399,855.27
Fulfillment	\$353,853.74	--	--	--	\$ 353,853.74
ODC's	\$1,355.09	\$10,530.64	\$10,530.64	\$10,530.64	\$42,946.99
Total Costs	\$900,056.72	\$139,095.04	\$139,095.04	\$151,951.48	\$1,330,198.28
Postage (includes mailing for one postcard, three letters, and welcome packages) Fulfillment (includes printing for postcard, letters and welcome package materials) Labor/Staffing (includes addition of a Supervisor and 16 temporary Customer Service Representatives (CSRs) Language Line (additional costs)					

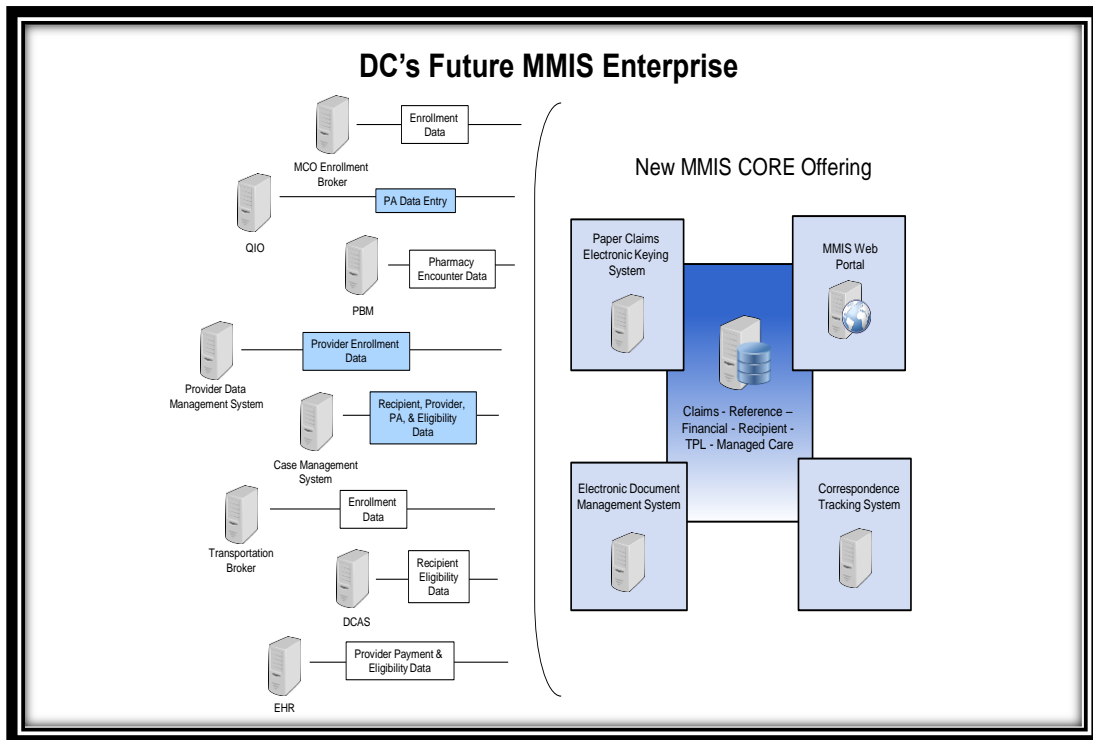
Medicaid Management Information System (MMIS)

MMIS, the claims payment system for DHCF, is a necessary and crucial system that fulfills one of the core administrative functions the agency. MMIS has a role in both the FFS and managed care programs in that the system uses an extensive verification and edit check process to receive, review, approve or deny payment for health care claims submitted directly by Medicaid providers. In addition, the system is used to process monthly capitation payments to the MCOs for the beneficiaries in their respective health plans. Finally, MMIS is instrumental in the generation of required CMS reporting. In summary, approximately 95 percent of DHCF’s \$3 billion budget passes through the MMIS and is subsequently allocated to provider payments.

Historically, the procurement approach for MMIS was to solicit one claims processing system with multiple subsystems from one vendor. However, DHCF’s federal regulator rejected

the agency’s proposed traditional approach in February 2014. Instead, CMS adopted a new strategy for the design of Medicaid MMIS requirements for state Medicaid programs. Responding to concerns about the amount of time and money required to implement and support monolithic systems—namely, the slow return on investment and the paucity of available vendors, CMS directed states to separate the MMIS into modules and to implement these subsystems separately.

To meet the modularity design requirements imposed by CMS, DHCF procured separate contracts to implement various functions, including case management, provider enrollment, pharmacy benefit manager, electronic visit verification, third party liability, and the Medicaid data warehouse. The remaining component to complete the full transition from a monolithic system to a modular system is the procurement of the Core MMIS. The Core MMIS will become the hub for the other modules that make up the Medicaid Enterprise System. The graphic below illustrates the future MMIS enterprise. The modules on the left side will have batch and/or real time exchange of data with the Core MMIS.



The modular approach allows the District to secure systems that are built specifically for the required function. For example, with the monolithic system, the current MMIS vendor (Conduent) processed provider paper applications after staff at DHCF reviewed and manually screened the documents. With the implementation of the provider data management system (PDMS), providers submit completed applications through an online portal and the provider screening is done through an automated process. It is a more efficient system and process that allows DHCF to respond timelier to provider inquiries related to enrollment.

Likewise, when DHCF implements new benefit or reimbursement methodologies, our current fiscal agent and system operator must engage its programmers to make the changes. Depending on the scope of the change, this process can take weeks. Our goal for the new Core MMIS is to procure a system where these changes can be made and tested through online screens, allowing DHCF to be nimbler and more responsive to changes—nearly in real time.

Finally, because we are procuring a commercial off the shelf (COTS) product, we anticipate reduced costs to the District when implementing new federal mandates. The vendor will be required to add new federal requirements to the system and work with DHCF to implement the change, without additional costs.

The Procurement Process For MMIS. OCP issued the Core MMIS RFP on February 12, 2019, and the contract was subsequently awarded to DXC Technology Services, LLC on March 31, 2020. The approved CBE planned spend for DXC Technology Services, LLC was 35 percent of \$76,547,415 or \$26,791,596. On April 14, 2020, Conduent filed a protest resulting in the OCP issuing a Stop Work Order on April 17, 2020. Subsequently, Conduent filed a supplemental protest that was sustained by the CAB. Per the CAB's August 20, 2020 Opinion, the District was ordered to: "(1) terminate the contract awarded to DXC under the solicitation; (2) re-evaluate the

offerors' proposals in accordance with procurement law and the solicitation, consistent with the CAB's decision, and award a new contract under the solicitation, or re-procure for the subject MMIS system and services; and (3) report to the Board on the status of the District's compliance as ordered herein within thirty days." Consequently, OCP issued a contract termination letter to DXC on September 15, 2020. The procurement remains open and DHCF has not completed its transition from a monolithic system to a modular system.

The cost of building a new MMIS claims system can range anywhere between \$75 to \$100 million depending on requirements. In Fiscal Year 2015, when DHCF began the procurement for the Core MMIS, the anticipated cost was \$60 million. However, by Fiscal Year 2020, the procurement estimate reached \$80 million. If DHCF is required to begin the process of a new procurement for the MMIS project, there will be a further increase in the cost of the award due to the complexity of the MMIS.

As this legislation allows the District to accept the submission of a subcontracting plan from an offeror when the District receives the last best and final offer (BAFO) from the offeror for certain DHCF solicitations, should it pass, the District will be able to move forward with the MMIS procurement, thus preventing the cost increases associated with a new procurement.

The District of Columbia Access System (DCAS)

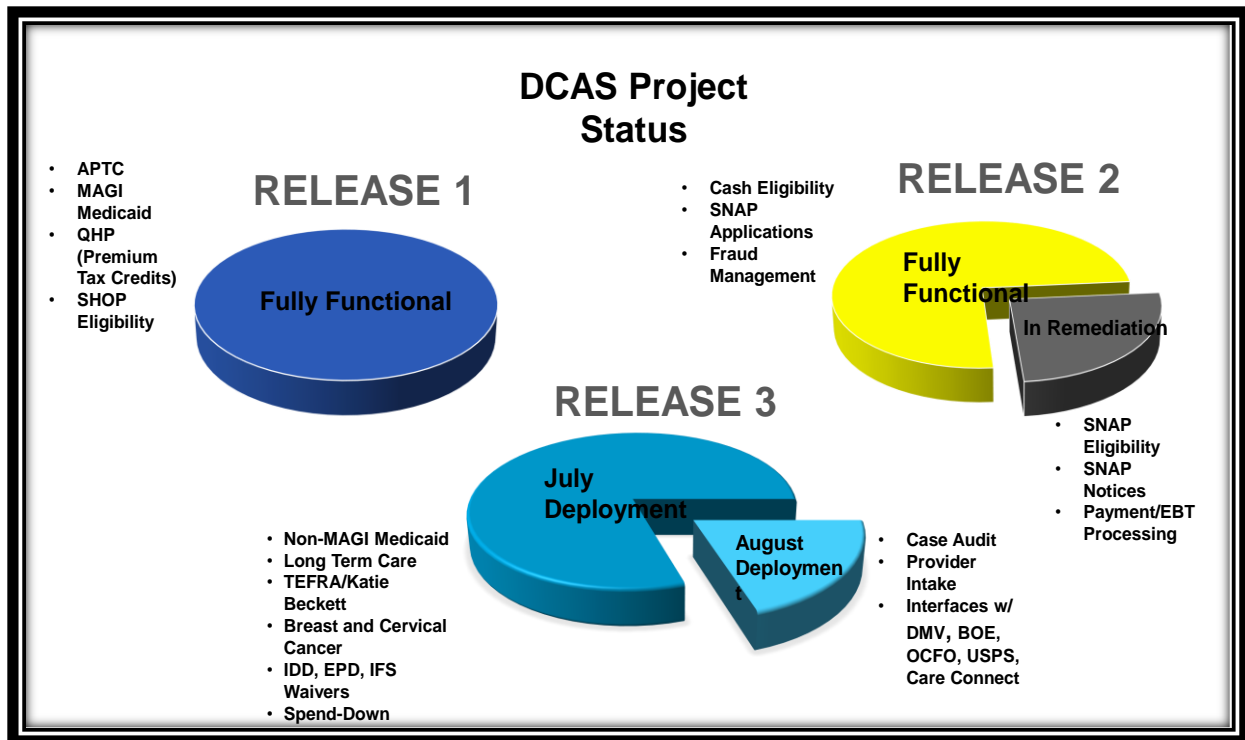
DCAS is a major DHCF IT project that was launched in 2012 and is now near completion, despite the existence of multiple challenges and setbacks throughout the project's history. Once fully implemented, DCAS will streamline eligibility and enrollment for a substantial number of health and human services programs offered in the District, through a state-of-the art, integrated health care and human services eligibility and enrollment platform. This platform also includes both an insurance marketplace and enhanced case management capabilities.

Upon completion, residents will be able 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. DCAS will also provide caseworkers with a new, holistic view of eligibility by centralizing access to information required for eligibility determinations, thereby reducing the level of manual effort needed to determine eligibility, and the need for in-person visits to service centers.

To minimize the level of service disruption to residents, DCAS has been developed in three major phases, or “releases”:

- Release 1 (R1) of the project, which focused on building and deploying the health insurance marketplace and Medicaid functionality needed to determine eligibility for individuals using the new Modified Adjusted Gross Income (MAGI) standards, was rolled out on October 1, 2013. This phase established a platform for streamlined eligibility determinations for individuals seeking private, subsidized, or public insurance, using eligibility rules for Insurance Affordability Programs such as advanced premium tax credits and cost sharing reductions.
- Release 2 (R2) was designed to focus on the components needed to establish functionality for the District’s Cash and Food benefit programs. This module includes eligibility and renewal functionality for various versions of the Supplemental Nutrition Assistance Program, and the Temporary Assistance for Needy Families Program. In sum, this module addresses technical issues creating barriers to accurate SNAP and TANF functionality. When DHCF assumed control of the project in October 2016, the project was underperforming. Since then, a focused team of IT experts has been engaged in the ongoing stabilization of R2, as additional development and system integration continues.
- Release 3 (R3) builds upon the functionality that was deployed in R2. R3 incorporates the functionality needed for eligibility processes for the Medicaid non-MAGI population – otherwise known as Medicaid long-term care. While the R3 design phase began in January 2018, several factors ultimately pushed its launch date to the now rapidly approaching date of July 2021.

The graphic on the next page offers a snapshot of the trajectory of each Release, and its current status while providing a roadmap to the many programs that benefit from the advanced technology being developed to expedite eligibility and case processing.



The Procurement Process for DCAS. The CAB ruling on the MMIS procurement also impacted the DCAS procurement which is now being held in abeyance pending the outcome of the Mayor’s proposed bill. DCAS procurements largely fall into three broad categories: (1) design and development; (2) operations and maintenance and application development; and (3) miscellaneous services (software, marketing, strategic consulting). In addition, each of the three Releases is managed by a diverse team of contractors procured through staff augmentation and other vehicles to supplement the work of full-time District employees.

In late 2019, DHCF sought to leverage a single vendor to manage the IT staff that would accelerate the remediation of R2 and issued an RFP solicitation on July 14, 2020. On November 25, 2020, Trillian Technologies, Inc. (Trillian) filed a protest challenging the District’s proposed contract award to another vendor that ranked behind Trillian in the scoring of proposals. Consistent with the CAB’s August 20, 2020 ruling in the MMIS procurement protest, after scoring

and prior to award, the Contracting Officer rejected Trillian's proposal as non-responsive for failure to submit the compliant subcontracting plan required by the RFP and the law.

Trillian sought to overturn that action, arguing that it had submitted a proposal three days before the CAB's ruling, in reliance on "the District's historical interpretation of its laws and best procurement practices." On February 24, 2021, the CAB found that the District had properly rejected Trillian's proposal as non-responsive given its prior ruling in the Conduent matter and dismissed Trillian's protest. Notably, the CAB stated that Trillian was itself a CBE and not required to contract with other such entities, however, because it noted an intent to subcontract when it responded to the RFP, it thereby needed to submit a compliant and complete subcontracting plan in accordance with the law and the MMIS ruling.

The proposed legislation would ultimately invalidate the Contracting Officer's action, thereby changing the result of this protest, and make Trillian—the highest scoring offeror according to the CAB's opinion—eligible for the award, as well as possibly also other vendors that may have been excluded. Because the legislation changes the outcome significantly, the District's proposed award to the second-place bidder has been put on hold pending the outcome of this legislation. Should the legislation not move forward, however, DHCF would be forced to make an award that potentially excludes vendors with better management, more expertise, higher value, or better prices. As described in detail above, these were the precise reasons DHCF executed the solicitation. Moreover, while the legislation is pending, DHCF must try to obtain the resources and expertise that would have been provided under this contract—a necessity that continually adds to project cost.

The additional cost of delaying moving this legislation forward are significant, although the precise amount is unknown. Any delay in DCAS contracts can cause either federal

disallowances or a suspension of funding from federal partners due to the District's inability to meet project requirements timely. Delays can also trigger an increase in local funding participation requirements and a shift in cost allocation for this project. This problem will be activated if implementation is pushed into Fiscal Year 2022. While delays in the procurement may have already exposed the District to additional cost, putting the legislation in place quickly would minimize impact and ensure the District completes the project timely with the services of the most capable and cost-effective bidder.

Conclusion

Mr. Chairman, in closing, the CAB's ruling is of consequence to the major contracts in DHCF and will have extraordinary implications for DHCF's Medicaid program. Indeed, the OCP rule governing the submission of contracting plans has existed for many years, but because of the manner in which the agency has interpreted the law, vendors have developed a reliance interest on the agency's policies.

For DHCF, executing this change now and, impacting procurements that proceeded the CAB's August 2020 ruling, will result in significant cost and considerable disruption, given the nature of the programs and IT projects that these contracts support. On the other hand, there would be no impact to the CBE community if these contracts were awarded to the vendors that were originally selected. In fact, such a decision would have upheld and furthered the purpose and intent of the subcontracting law with a multi-million dollar infusion of funds to the CBE community, according to the vendors' final CBE plans. We respectfully request the Committee on Health's support for the Mayor's bill to minimize further adverse impact to DHCF.

Thank you for allowing me to testify and my staff and I are pleased to receive your questions.