GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

FY 2013 Oversight Hearing

Testimony of

Wayne Turnage

Director

Department of Health Care Finance

Before the

Council of the District of Columbia

Committee on Health

Thursday, March 6, 2014

John A. Wilson Building

1350 Pennsylvania Avenue, NW

Introduction

Good morning Chairwoman Alexander and members of the Committee on Health. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and it is my pleasure today to provide a status report on the activities of DHCF over the past year. Joining me are members of my Executive Management Team as well as the Administrators and Managers from key departments across the agency. Although I am admittedly biased, I believe that the management team at DHCF is among the strongest in District government and we welcome the opportunity to respond to your questions in this hearing.

Before discussing the mission and priorities of DHCF, I would like to acknowledge the guidance and support provided by the Office of the Deputy Mayor for Health and Human Services. Due to the leadership of Deputy Mayor Otero, DHCF is actively engaged with our sister agencies in the human services cluster to coordinate the activities we administer and, where possible, leverage resources to ensure that the multiple systems springing from our collective operations work together for the benefit of those who rely upon the care we fund or deliver.

My testimony today provides a high level summary of the major issues that we faced in FY2013 and addresses the considerable progress we have made in response to these challenges. While there is considerable work before us on a

number of fronts, my testimony today will demonstrate just how far we have come as an agency in tackling some of our most vexing problems.

Mission and Priorities of DHCF

DHCF was established as a cabinet-level agency on October 1, 2008 to operate the District's Medicaid and Alliance programs with the fundamental mission to improve the health outcomes of low-income residents of the District. We attempt to accomplish this by providing access to comprehensive health care services through both the Medicaid and Alliance programs. In FY2013, DHCF spent nearly $2.3 billion to implement these health insurance programs.

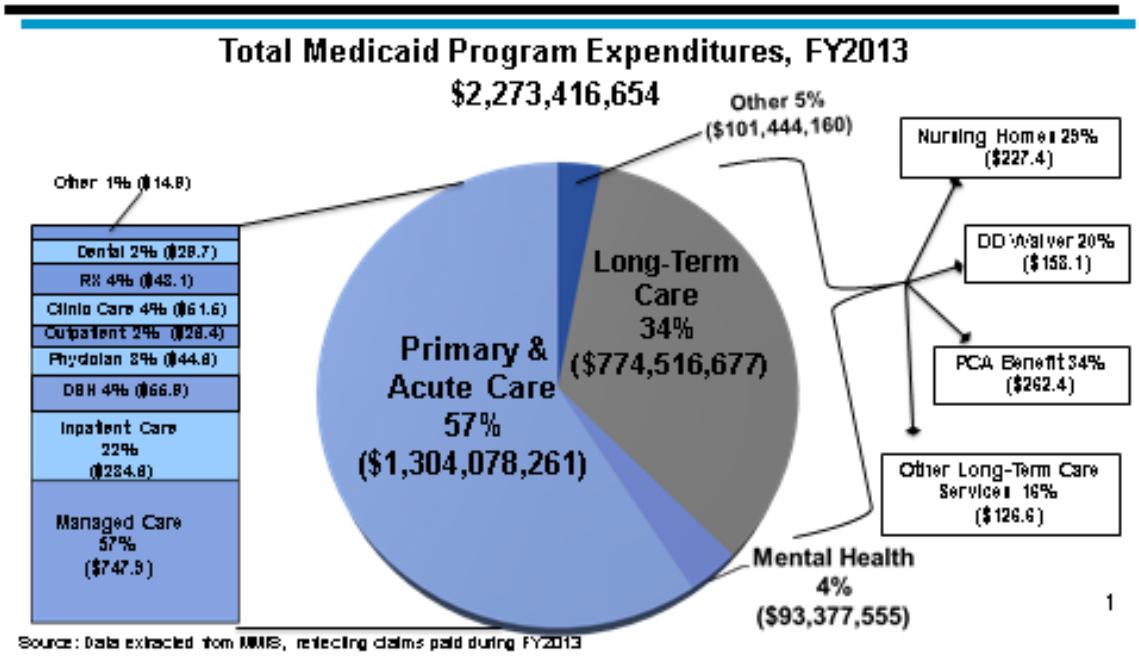
While DHCF funds the Medicaid program's provider payments, administrative overhead, and vendor contracts through a combination of federal and local dollars, dedicated tax revenue, and special purpose funds, our most significant partner is the federal government as they cover 70 percent of Medicaid's program cost.

Unchanged from previous years is the direction and focus of this agency. Our day-to-day work is guided by the four major priorities first established in 2011 to support the agency's broadly defined mission. These priorities -- improve patient outcomes, strengthen DHCF's program integrity operations, resolve Medicaid billing issues with our partner agencies, and successfully implement

health care reform -- reflect the core mission of DHCF and provide a valuable roadmap to guide the work of agency staff.

Not surprisingly, much of the work at DHCF in FY2013 was focused on those programs and activities which are the cost drivers of the Medicaid program. As shown in the graph below, the nearly $2.3 billion in program spending by DHCF was arrayed between primary and acute care services (57 percent) and long-term care (34 percent). In FY2013, DHCF faced a number of operational challenges in both of these major program areas that threatened the stability of the program, created challenges with our federal partner, and severely tested the problem solving skills of our staff.

DHCF's Key Oversight Issues Often Track With The Agency's Major Areas of Program Spending



Without question, the most significant challenge we faced in FY2013 was managing the unexpected collapse of our largest health plan, DC Chartered. DHCF's Medicaid managed care program is the single largest item in the agency's budget covering over 160,000 beneficiaries at a cost of $747 million. DC Chartered was responsible for managing the care for more than 100,000 of those beneficiaries and received over $360 million annually to do so.

When Chartered began to experience significant problems covering its expenses and subsequently entered voluntary receivership in FY2013, neither of the remaining two plans in the program at that time was positioned to absorb the company's membership. Thus DHCF had to work closely with the Office of Contracts and Procurement to expedite the procurement process in hopes that DHCF's request for proposal would attract a plan that had both the financial means and health care expertise to replace our largest managed care plan.

More complicating, we were forced to wrestle with procurement issues in the midst of Chartered's insolvency which left health care providers with $65 million in unpaid receivables and questions from our regulator -- the Centers for Medicare and Medicaid Services (CMS) -- about the origin of this problem. Although DHCF was not legally responsible to pay those claims, Mayor Gray recognized that our failure to do so would threaten the very fabric of the health care network that the District of Columbia had worked so hard to develop.

Accordingly, we worked with CMS on a legally permissible solution that resulted in the federal government and the District of Columbia sharing this burden.

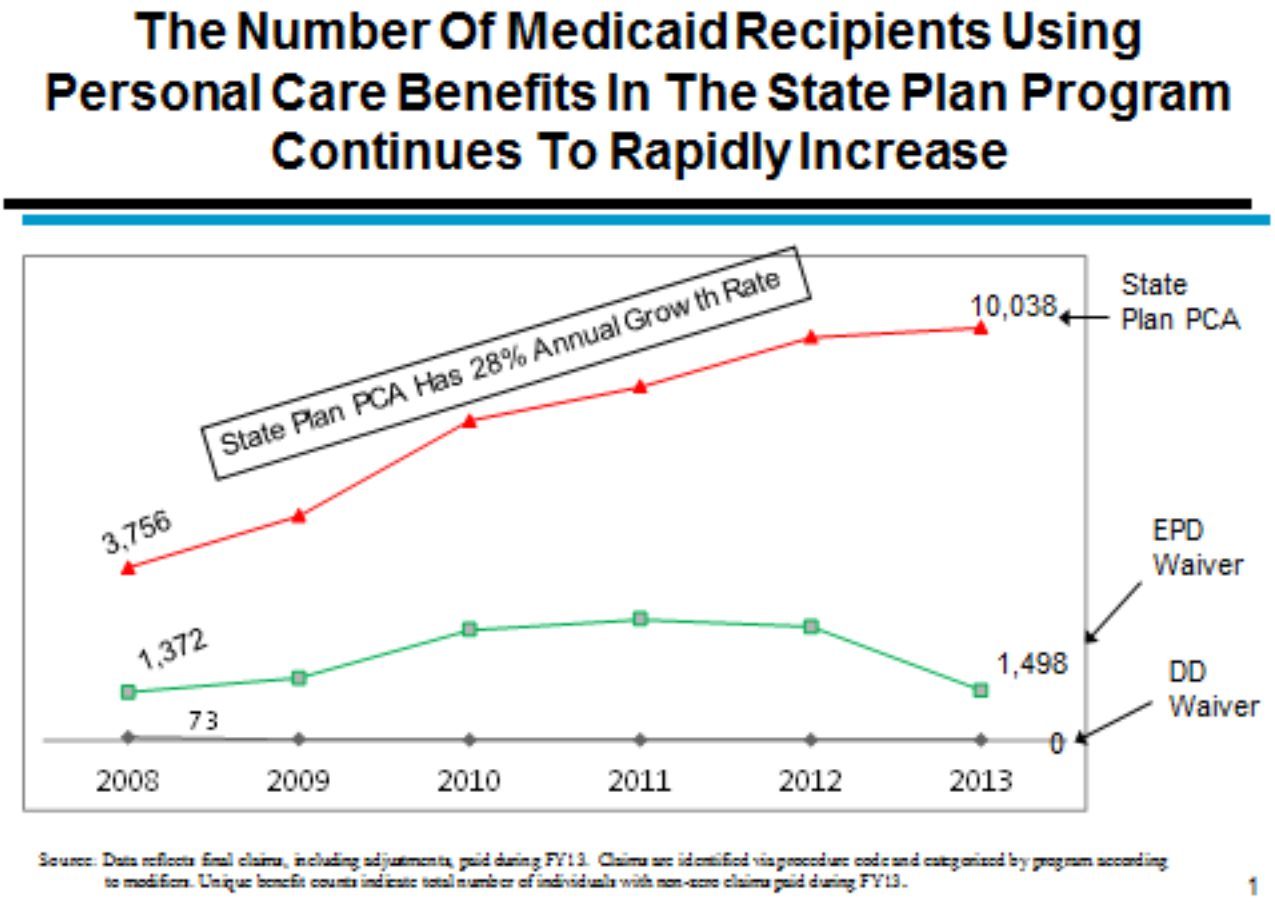
Equally challenging were the problems we faced in our long term care program, more specifically personal care. In 2011, we first sounded the alarm bell about this program due to the rapid and unexplainable pace with which it was growing. At that time, the cost of this optional benefit in the District's Medicaid program had grown from $71 million in FY2008 to $110 million by FY2010. This increase was fueled by a sharp rise in the number of beneficiaries in the program from 3,756 in FY2008 to 6,295 during in FY2010. These year-to-year growth rates of 25% and 35% respectively were more than six times the level observed for the entire Medicaid program over this same period.

Equally significant, DHCF's long-term care unit -- inherited by the Gray Administration -- was largely dysfunctional and incapable of providing the required oversight and monitoring. Specifically:

- The long-term care unit was severely understaffed with a 50 percent vacancy rate;
- DHCF did not have a patient assessment tool in place to evaluate the level of care needs for Medicaid beneficiaries seeking personal care; and,
- More importantly, the agency entrusted the home health care providers with the responsibility for patient assessments to establish the number of hours of personal care their beneficiaries would

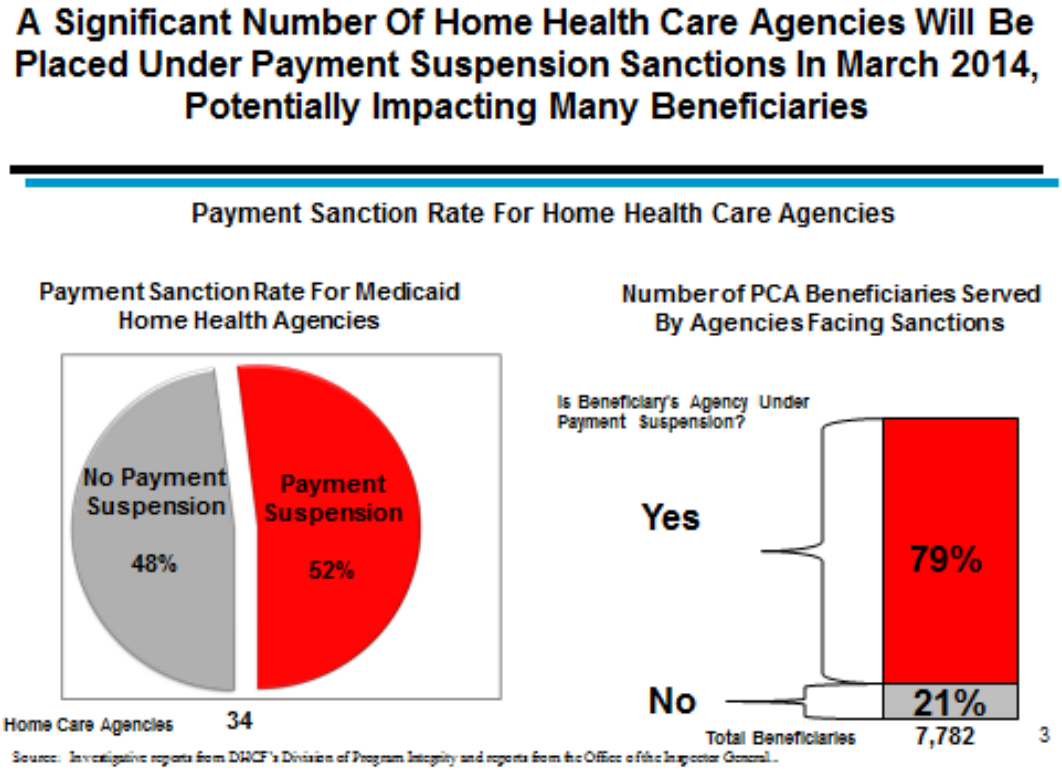
receive. This was a blatant conflict that fueled a considerable portion of the unchecked growth in the program.

With the support of the Mayor, DHCF began the arduous process of rebuilding the long-term care program and addressing what were clear weaknesses in the oversight of personal care. However, as shown by the graphic below, while we worked to fix the problems through FY2013, the growth in the personal care program was largely unabated. Specifically, by the end of FY2013, there were more than 10,000 beneficiaries receiving personal care services, reflecting an annual growth rate of 28 percent.



This unprecedented growth in the program created serious budget challenges for DHCF and forced us to more urgently wrestle with the question of how we could better contain the growth in this benefit while protecting the care for those Medicaid recipients who really need it.

More recently, the challenge of ensuring appropriate access to this benefit has been made more daunting due to the credible evidence of fraud uncovered by DHCF staff in our Long-Term Care Administration and Division of Program Integrity. Based on their outstanding work and referrals to law enforcement over the past five years, we are now required to suspend payments for 52 percent of our home health care providers (see below).



This action will potentially impact 79 percent of the beneficiaries who receive personal care and will require DHCF to expeditiously develop another option for the delivery of this benefit in FY2014 and beyond. We have developed a temporary solution that has been approved by CMS which we will discuss in more detail later in this hearing.

Status of Major Projects at DHCF

While the aforementioned issues demanded the attention of a significant portion of the agency's resources, we pushed forward with a number of projects that are in line with our four previously mentioned priorities. At this time, Madam Chairwoman, I would like to provide an overview and current status of these and a few other projects.

During FY2013, we continued work on a number of projects to improve both the design and operation of the Medicaid program. These projects ranged from building a new managed care program, continuing work on payment reform for the hospitals, establishing a program to improve our long-term care services while mitigating fraud, redesigning key benefits to ensure compliance with federal regulations, and addressing other key health reform requirements.

For details, I refer you to the status report outlined in the table on pages 10 through 12 which addresses a range of projects cutting across DHCF's four major priorities.

Agency Challenge	Status In FY2013	Most Recent Progress	Next Steps
Reform managed care program. *Agency Priority - Improve patient outcomes through strong Managed Care Program*	• Largest health plan entered receivership • Health care provider network left with more than $65 million in receivables • Needed to find a replacement for Chartered that had the financial resources to secure a contract for more than 100,000 beneficiaries • Old contract expired creating an opportunity to sharply define the language of the new contract	• Signed DC AmeriHealth -- the largest managed care plan in the nation -- to replace DC Chartered • Developed quantifiable and enforceable contract standards regarding network adequacy, and sanctions for non-performance. • Made the decision to employ risk-adjusted rates in the new contract for the first time in the history of the District's managed care program • Worked with the Office of the Attorney General and Department of Insurance, Securities, and Banking to manage Chartered's receivership and ensure full payment to all providers	• Implement a new MCO evaluation program to further enhance monitoring, assessment and performance of the three health plans • Make additional changes to the contract to clarify requirements regarding the medical loss ratio and the link between health plan solvency requirements and membership enrollment • Implement the first full year of risk-adjusted payment rates which are specific to each MCO's Medicaid pharmacy utilization rather than apply uniform rates across all plans
Payment Reform for Hospitals. *Agency Priority - Improve program integrity by redesigning hospital payment rates*	• Existing hospital outpatient reimbursement methodology was antiquated and only covered 47 percent of hospital Medicaid costs • Completed work plan to bring DHCF in compliance with new federal coding requirements for classifying all patient diagnoses by October 1, 2014 • Completed the work plan to update the grouper used to calculate in-patient payment rates, modernize the hospital outpatient payment methodology, and develop new payment methods for non-DRG hospitals	• DHCF sought and received approval from CMS for a supplemental payment methodology to enhance reimbursement to hospitals for outpatient care • Began implementation of the work plan to shift hospitals to the ICD-10-CM system used to classify and code all diagnoses	• Fully implement the plan to shift hospitals to the ICD-10-CM system used to classify and code all diagnoses • Fully implement the plan to update the grouper used to calculate in-patient payment rates, modernize the hospital outpatient payment methodology, and develop new payment methods for non-DRG hospitals

Agency Challenge	Status In FY2013	Most Recent Progress	Next Steps
Reform the personal care program. *Agency Priority - Enhance program integrity by modifying the rules around the delivery of personal care and developing an enhanced system of monitoring*	• Published and implemented all rules to allow DHCF to use its newly created and validated assessment tool to conduct conflict-free evaluations of beneficiaries need for personal care. Removed this responsibility from the home health care provider • Awarded long term care services contract to vendor in July for the purpose of ensuring that beneficiaries are assessed and approved for the adequate number of personal care hours that meets their true needs. • Designed the new Quality Improvement System (QIS) for overseeing vendor and service providers	• Vendor for the long-term care services contract began work assessing personal care beneficiaries to determine the appropriate hours of care needed • DHCF suspended payments for 52 percent of its home care providers who face credible allegations of fraud • DHCF submitted to CMS a proposal for an alternative home health care delivery plan. Through this plan, DHCF will be established as a Medicaid home health provider and we will contract with a staffing agency to provide personal care aides to beneficiaries in need of care. The staffing agencies will submit its bills for their services to DHCF and we will use a claims adjudicator to review the bills before we pay them. All claims that are approved for payment will receive a 70 percent federal match. CMS has approved this plan	• Build an in-house, temporary home health care delivery system to mitigate any shortage of providers as a temporary solution to the problems created by DHCF's payment suspensions • Ensure that the long-term care services contractor completes at least one assessment for every person who is receiving personal care or requests this service • Right-size the personal care program through aggressive monitoring of all home health providers who are receiving or request personal care services • Work with the Office of the Inspector General to determine, as expeditiously as possible, the case disposition of all home care agencies that have been referred to the Medicaid Fraud Control Unit for allegations of fraud
Redesign Day Treatment Services *Agency Priority - Enhance program integrity by modifying the rules around the delivery of day treatment services to ensure federal compliance*	• CMS informed DHCF that it has been providing day treatment services without proper authorization for more than 20 years • Enrollment of new participants halted in January 2013 based on agreed upon criteria with CMS and key stakeholders	• SPA submitted to CMS for an informal review. CMS has met internally and is scheduling a meeting with DHCF in March 2014 to discuss the current plan	• Obtain approval by CMS for the SPA and begin implementation of the new program

Agency Challenge	Status In FY2013	Most Recent Progress	Next Steps
Enhance Medicaid public provider billing. *Agency Priority - Enhance program integrity by improving the accuracy of public provider billing*	• DCPS and OSSE continued to bill Medicaid after the agencies established their own billing systems and successfully linked to the ASO claims adjudication system • For CFSA, claiming continues for clinic services • Worked with DCPS and OSSE to increase the claims volume now that the billing system is operational • Abandoned plan to bill Medicaid for targeted case management and rehabilitation services • Tracked progress on the State Plan Amendment to allow OSSE to bill for services provided in non-public schools	• DHCF is monitoring the performance of the agencies with independent billing systems to determine if claims activity is increasing	• Continue to monitor billing activity for DCPS and OSSE • Obtain CMS approval for State Plan Amendment to allow billing by non-public schools • Explore whether non-public schools would be willing to employ an ASO to process their billing function
Implement Health Care Reform. *Agency Priority – Successfully implement health care reform in the District.*	• RAC contract awarded to vendor to start claims analysis • Developed a plan to bring DHCF in compliance with federal regulations for identifying so called "bad apple providers" • Hospitals solicited to participate in the Health Information Exchange program that would allow the facilities to transmit real time information on patient utilization data • Application for Health Homes grant was approved and the planning for the program was initiated	• RAC vendor is analyzing claims detail in search of possible savings • Providers informed of new requirements to participate as prescribing physicians in the Medicaid program • Six hospitals received funds from the Office of the National Coordinator (ONC) and DHCF to participate in the Maryland Health Information Exchange program. Primary care organizations and Medicaid Managed Care Organizations (MCOs) are also working with the Maryland HIE to receive this valuable information • DHCF has distributed $13 million to eligible providers and hospitals that have reached the adopt, implement, and upgrade (AIU) stage in MEIP based on the purchase of electronic health records • Leadership at DHCF and DBH are working through details of program implementation for the Health Home program	• Determine savings attributable to implementation of the RAC contract • Finalize the process for applying the new requirements of the "bad apple" program to the relevant providers • Determine the viable options available to the District to continue this program once the funding ends in FY2014 • Exercise the option year of the contract for Xerox to operate the web portal that providers must use to establish meaningful use • Complete the planning for the Health Homes project and begin implementation October 1, 2014

Councilwoman Alexander, our work with the DC Health Benefits Exchange also warrants mentioning. During FY2013, we implemented major changes to Medicaid eligibility mandated by the ACA. The result is that Medicaid eligibility has been greatly simplified through the consolidation of eligibility categories and the creation of new income methodologies.

Further, DHCF worked in partnership with the DC Health Benefits Exchange and the Economic Security Administration of the Department of Human Services in their efforts to design, build, and implement DC Healthlink – our new automated, consolidated eligibility system. During the first four months after launch -- which began October 1, 2013 -- the District received over 36,689 applications for medical assistance and 27,634 (75 percent) were found eligible for Medicaid. Nearly one-quarter of these applications (8,753) were filed directly by consumers using DC Healthlink.

Finally, in FY2013, DHCF received a temporary, one year extension of our Section 1115 Demonstration Waiver that provides coverage to approximately 4,200 childless adults from age 22 and up to age 65, with incomes between 133 and 200 percent of the Federal Poverty Limit (FPL). The purpose of the extension is to give the District the opportunity to evaluate and implement alternative coverage options for this population.

After extensive financial modeling and analysis of current costs, DHCF determined that the most cost effective (and least disruptive) model will be to maintain these individuals in the Medicaid program. Accordingly, this year, DHCF will be working to draft and obtain approval of new SPA that would enable the District to continue Medicaid coverage of childless adults up to 200 percent of FPL.

Conclusion

Madam Chairwoman, we have reached a pivotal time at DHCF as we close the book on FY2014 and prepare for the new fiscal year. In the coming months, the actions we take (or fail to take) will undoubtedly shape the nature, direction, and destiny of the Medicaid program in the District of Columbia. The success that we experience with our new health plans, the continued implementation of hospital payment reform, our efforts to right size and restore integrity to the long-term care program, and the degree to which we become an integral partner with the DC Exchange will go a long way towards defining the future for the Medicaid program in the District of Columbia.

With the strong team we are building at DHCF and the leadership, direction and guidance provided by Mayor Gray and his very capable Deputy Mayor, I have no doubt that we will succeed in our efforts. These projects demand great effort but they promise great reward. I can assure you that we will work tirelessly to

improve the programs for which DHCF is responsible. And, as always, while working on these issues, we look forward to and depend upon an open, productive dialogue with the Committee on Health.

This concludes my presentation and my staff and I are happy to address your questions as well as those of other Committee members.