GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

FY 2014 Oversight Hearing

Testimony of

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Before the

Council of the District of Columbia

Committee on Health and Human Services

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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. I am joined today by members of my Executive Management Team as well as other key staff members who perform various functions across the department. While the responsibilities of formulating a budget, developing policy proposals, executing new and existing program requirements, and managing the budget for a nearly $3 billion agency are both considerable and complex, the management team at DHCF is appropriately equipped to address these challenges.

Before discussing the mission and priorities of DHCF, I would like to acknowledge the guidance and support provided by Mayor Muriel Bowser as well as the Deputy Mayor for Health and Human Services, Brenda Donald. We look forward to working with the Deputy Mayor as we respond to the emphasis Mayor Bowser has placed on the use of performance analytics to drive agency operational improvements.

I have structured my testimony today to provide a high level summary of the major issues that we faced in FY2014. The first part of my testimony discusses both the challenges encountered and the progress made in several key program areas – specifically: the rebuild and reform of DHCF's Medicaid managed care program; the execution of fraud control activities in the home health care program; the development of plans to reform the agency's long-term care operations; and the diagnosis, assessment, and planning for the issues around the growing health care utilization for the Medicaid fee-for service population. Following this discussion is a report on the status of DHCF's major projects and the next steps for advancing the work in these critical areas.

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. The straightforward mission of the agency is to improve the health outcomes of low-income residents of the District by providing access to a full range of preventative, primary, urgent, and critical health care services. In FY2014, with the assistance of a 70 percent federal Medicaid match, DHCF spent more than $2.7 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, with the aforementioned Medicaid match rate, the federal government is our most significant partner.

In January 2015, we established the major priorities to support the agency's broadly defined mission over the next four years. DHCF's work will now be guided by efforts to: (1) improve patient outcomes through the use of care coordination; (2) strengthen program integrity efforts; (3) reform DHCF's long-term care program; and (4) support the District's public safety net hospitals and the related efforts to build an integrated health care network in Wards 7 and 8.

DHCF's Major Focus in FY2014

While DHCF staff routinely performed a myriad of functions in support of the day-to-day operations of the Medicaid and Alliance programs in FY2014, work on several major projects consumed the attention of the Executive Management Team and key administrators in the agency. Perhaps the most significant and time consuming of these projects was our work on DHCF's managed care program (MCO).

Managed Care Program. The District developed its MCO program in pursuit of three broad goals:

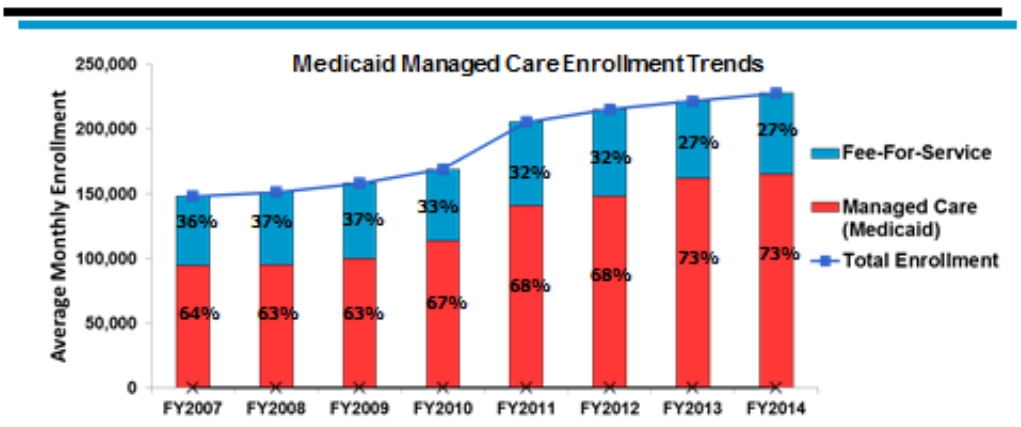
1. Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members.

2. Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services.

3. Establish greater control and predictability over the District's spending on health care.

In terms of funding and program size, the MCO program represents DHCF's most significant investment. As shown below, more than seven of every 10 persons in the Medicaid program receive their health care services through a managed health care plan. In the first year of the current five year contract for the District's three full risk health plans, DHCF spent just over $720 million to pay for the health care services funded by the MCOs, as well as the plan's associated administrative cost and taxes.

More Than Seven of Ten Medicaid Beneficiaries Are Assigned To One Of The District's Three Managed Care Plans



Source: DHCF staff analysis of data extracted from the agency's MMIS.

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In FY2013 this program was not without serious problems. So with the conclusion of the MCO contract in that year and the subsequent procurement, DHCF used the opportunity to address a number of longstanding concerns with the program. Under the previous contract there were only two plans in the program - one of which ended the fiscal year in a state of insolvency. Additionally, the previous contract had no language which held the two health plans to quantifiable performance standards. Moreover, there was an absence of a systematic process to assess the degree to which the plans successfully managed patient access to health care services or executed appropriate care coordination strategies.

In FY2014, DHCF addressed each of these problems. Notably, we created more competition in the program by replacing the two existing health plans with three MCOs who were new to the program. Programmatically, we instituted major changes to the new five-year MCO contracts by developing quantifiable standards for network adequacy, enhanced case management, and aggressive outreach requirements. Most significantly, we developed a system of performance accountability in which the health plans are evaluated in five areas that are important for the operation of any health plan.

This new evaluation process culminates each year with a managed care report card and the graded performance of the plans is made public. The first such report card was developed last month and is presented on the next page. These changes provide an important vehicle to evaluate the success of the health plans while informing decision making about the direction of the program. We believe this process will prove invaluable to the agency as we make decisions each year about the future status of the three plans under contract with the District of Columbia. The complete MCO performance report is available online at http://dhcf.dc.gov/page/dhcf-policies-and-publications.

Year One Grades For Managed Care Organizations

Program Area	AmeriHealth	MedStar	Trusted
Financial Condition			
Risk-Based Capital Level	A-	A-	C-
Reserve Capacity	A-	A	B-
Administrative Performance			
Provider Network	A	A	A
Claims Payment	A-	A	C+
Utilization of Physician Care			
Adults	B+	C+	C
Children	A	B	A-
"Well-Child" Visits	A-	C-	C+
Care Coordination			
Managing ER	D	D	D
Avoidable Hospital Admissions	B-	C-	C+
Reducing Hospital Readmissions	C	C-	D+
Overall Grade Year One	**B+**	**B-**	**C+** [60]

Personal Care Program. FY2014 was a seminal year for the District's Medicaid Personal Care Assistance (PCA) program. As noted in the past, this was once the fastest growing service line in the Medicaid program. Over a five-year period from 2008 to 2013, the enrollment levels grew at annual rate of 28 percent. Across this same time period, the cost of the program ballooned from $73 million to $261 million – an annual growth rate of 51 percent. Because these increases could not be sensibly explained by any known program factors, the concern persisted that much of the growth was not sustainable and likely attributable to widespread Medicaid fraud.

Several actions were taken in FY2014 that greatly impacted the enrollment and expenditure level in the PCA program. First, DHCF initiated an independent patient assessment process to substantially change the manner in which PCA benefits could be authorized. This change called for the use of an assessment tool to determine the number of hours of personal care a beneficiary needed. Most important, this new assessment process was designed to be free from conflict meaning that the home health care agency which benefited from the approved hours of

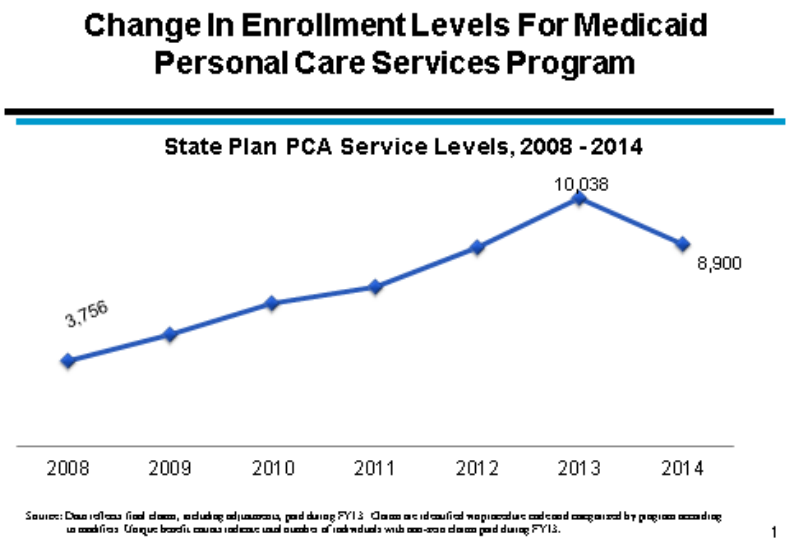
personal care could no longer be assigned the responsibility for conducting the assessment – a major flaw in the previous system. This new policy was made effective on November 20, 2013 and an independent vendor was selected to implement the program.

The second issue involved the suspension of nearly half of the home health care providers in the program. On February 20, 2014, following a four-year investigation, the United States Attorney issued 25 arrest warrants against various employees of home health agencies who were alleged to have committed fraud through numerous schemes designed to bilk millions of dollars in reimbursements from the District's Medicaid program.

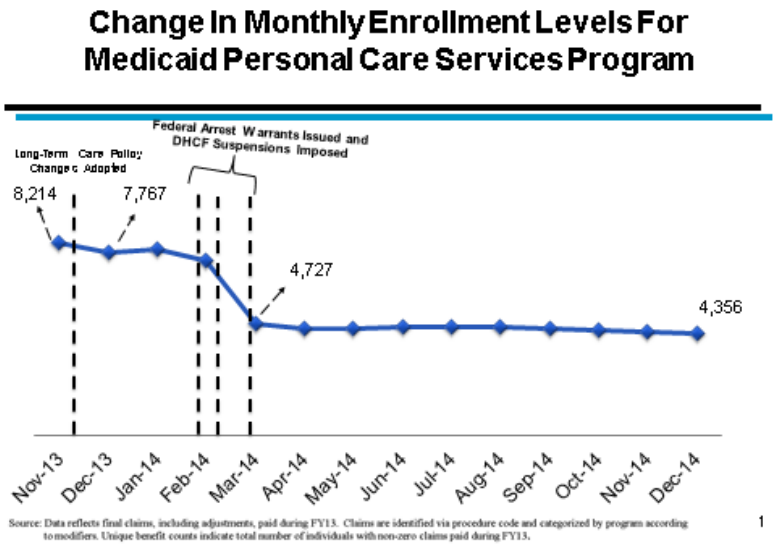
Based on these arrest warrants and DHCF's own internal investigative reports, we suspended payments to 13 home health care providers. Ultimately, through numerous settlement discussions during the appeals process, DHCF terminated six providers from the Medicaid program, lifted the payment suspension for another four providers without any further restrictions, and rescinded the payment suspension for three providers but imposed restrictions on their immediate future operations.

The dampening effect on program enrollments from these combined actions -- the conflict free assessments and the provider payment suspensions and terminations -- is illustrated on the next page through two separate measures.

We first report on the change in number of beneficiaries who received personal care at any point in the calendar year. In 2013, the year prior to the imposition of the provider suspensions and terminations and 11 months before DHCF put the independent assessment process in place, home health providers were reimbursed for personal care services reportedly delivered to 10,038 Medicaid recipients. In the next calendar year, the number of beneficiaries served at any point in the year declined by 11 percent to 8,900.



Next, the impact of these actions is more precisely revealed by examining monthly PCA enrollment levels which by November, 2013 had reached 8,214 beneficiaries. As shown, in December 2013, one month after DHCF established the conflict free assessment policy, there were 7,767 persons enrolled in the State Plan PCA program. Following the federal arrest warrants and the two-stage DHCF payment suspension process in February and March of 2014, the number of enrollees in the program dropped precipitously to 4,727. By December 2014, even with the new enrollments that occur monthly in this program there were only 4,356 persons



receiving services. This represented a 47 percent decline from November 2013 - the month in which the independent patient assessments were initiated.

These numbers indicate that we have come very close to right sizing a program which just one year ago was costing the District millions of dollars in fraudulent payments. PCA services remain an entitlement under DC Medicaid and persons who truly need the benefit continue to receive it. During the remainder of this fiscal year and moving forward, DHCF staff will work attentively to ensure that payments are made only for services to persons who need and actually receive this benefit.

Long-Term Care. Separate and apart from efforts to reign in fraud in the PCA program, DHCF initiated a period of significant operational and programmatic reforms for Medicaid long-term care services beginning in FY2014. Operationally, due to growing concerns regarding the manner in which the agency was executing a host of long-term care policies, we conducted a 360 degree review of the agency's Long-Term Care Administration (LTCA) and its operations. There were persistent complaints about the length of time it takes to process applications for long-term care services, especially the EPD Waiver. In addition, questions have been raised about both the adequacy and appropriateness of some of the program services that are offered through various long-term care programs.

Based on the results of this review and additional DHCF data analysis, we proposed an organizational realignment of the LTCA coupled with significant programmatic changes. Together, these changes are designed to increase the productivity of DHCF staff while streamlining access for District residents seeking long-term care services and supports. This includes improving EPD Waiver service offerings, bringing the Adult Day Health program into

compliance with federal requirements, and implementing a conflict free case management program.

With respect to access, in partnership with the DC Office on Aging (DCOA) and the Department of Human Services (DHS), we identified process improvements designed to modernize the application process for the EPD waiver and PCA services. Additionally, we entered into an agreement with DCOA to ensure that District residents and their families receive greater assistance when applying for long-term care services and hopefully experience a more seamless transition once an application for services is approved.

We anticipate that these changes will be in place by May 2015 leaving DHCF in a much better position to focus on the numerous program and policy changes that must be executed in FY2016 and beyond to both improve long-term care services and bring the agency into compliance with federal requirements.

Our long-term care planning in FY2014 also included the formation of a partnership with DHS to design and incorporate long-term care eligibility into the District's new automated, streamlined application system. A key part of this process will be the deployment of an automated uniform assessment process across all long term care programs. It is expected that the long-term care eligibility system will be deployed in late 2016. However, implementation of our assessment tool for all long-term services is scheduled for January 2016 to coincide with the proposed effective date of the new EPD waiver amendments.

In terms of programming, DHCF embarked on a collaborative transition and planning process as early as FY2012 with the goal of replacing the Adult Day Treatment Program with the necessary SPA changes. Unfortunately, approval of the SPA was delayed for many months as our regulator, the Centers for Medicare and Medicaid (CMS), worked to finalize and then

implement the new rules for the federal waiver and home and community based services programs.

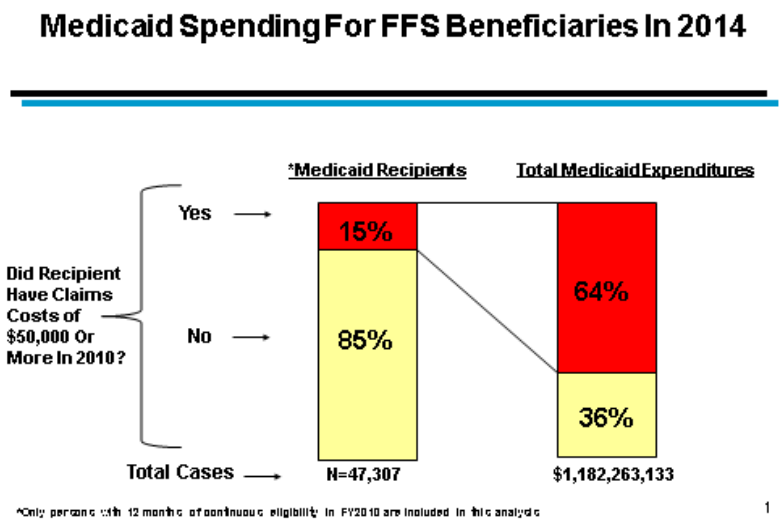
The SPA was ultimately approved in February 2015 and we have initiated the necessary work to finalize procedures for provider and beneficiary enrollment. In addition, we are bringing to closure the work on the process for assessing and transitioning existing day treatment beneficiaries. The provider enrollment process began this month and we expect beneficiary assessments to begin in April.

Care Coordination for the Fee-For-Service Population. In FY2014, DHCF spent a significant amount of time studying health care utilization trends by the District's Medicaid fee-for-service (FFS) program and planning a care coordination program to improve health outcomes for this group.

In a FFS delivery system, health care providers are paid a fee for each medical service they provide to beneficiaries who are not assigned to a managed care plan. FFS beneficiaries have complete independence in choosing among the existing pool of Medicaid-eligible providers since they do not have a prescribed network of providers. Unfortunately, this means that these same beneficiaries are also without the advantage of care coordination assistance from a third party such as a MCO and are forced to navigate the District's health care system with minimal support.

Complicating this issue is the fact that many FFS beneficiaries have complex medical problems which can be expensive to treat. In FY2014, though they represented only 23 percent of all Medicaid beneficiaries in the District, these members consumed 55 percent of the program's health care resources.

Among FFS members, the disproportionate spending impact is especially noteworthy and reflective of the complex health problems for a sub-group of this population. To wit, in FY2014, DHCF spent more than $1.1 billion for the health care services to 47,307 FFS beneficiaries who were in the Medicaid program for all 12 months of that year (see below). However, fully 64 percent of these expenditures were accounted for by just 15 percent of the FFS population.



These high cost beneficiaries have distinctly different health care utilization patterns than their low cost counterparts, especially with respect to the use of hospital services. The Table on the page 15 reveals the sometimes striking differences between these two groups of beneficiaries. Specifically, the high cost group is older and had slightly more hospital admissions but these typically lasted almost twice as long. The high cost group was more likely to have multiple chronic conditions; they visited the emergency room 61 percent more than their counterparts, and received almost 3 times the number of different prescriptions

We know from additional analysis that this group struggles with a high incidence of mental illness. Moreover, they experience problems with repeated hospital readmissions over a short time period, often for the same problem that was the basis for their initial admission. There

Differences Between High-And Low-Cost Recipients Who Are In Medicaid's Fee-For-Service Program

Comparison of High And Low Cost Recipients

Characteristic	High Cost Group	Low Cost Group
Average Age	58	46
Average Hospital Admissions	1.32	1.20
Median Length of Stay (In Days)	10	6.5
Average Emergency Room Visits	4.1	2.5
Median Prescriptions Per Person	34	12
Percent with Multiple Chronic Conditions	39%	25%

Note: High cost is defined as having continuous eligibility for 12 months and at least $50,000 in claims. [2]

are also concerns that much of their emergency room use is inappropriate, possibly driven by the previously referenced mental health needs.

In FY2013, CMS approved DHCF's application to establish a Health Homes program to assist States in their efforts to manage persons with complex medical problems. Authorized by the Affordable Care Act, Health Homes can be directly targeted to Medicaid beneficiaries who have chronic conditions. CMS expects the medical and social work team in Health Homes to integrate and coordinate all primary, acute, behavioral health, long-term services and related supports for persons who are enrolled the program.

We correctly viewed this action by CMS as a propitious opportunity that afforded DHCF the option to target the health homes concept to a portion of the FFS population. Thus, in conjunction with the Department of Behavioral Health (DBH), DHCF worked on the design of this program in FY2013 with plans to launch the initiative for possibly as many as 20,000 beneficiaries on October 1, 2014.

However, our efforts stalled considerably in FY2014 resulting in numerous delays to the planned implementation date. While both DHCF and DBH believe the most significant hurdle -- the challenge of building payment models to properly incentivize providers who will implement the program -- has finally been cleared, we anticipate the program will begin no sooner than October 2015.

Summary of Major Activities for FY2014 and Current Status

Madam Chairwoman, the last section of my testimony provides a status report on a number of projects that we worked on in FY2014 to improve both the design and operation of the Medicaid program. Rather than walk you through each listed project, I refer you to the report outlined in the table beginning on pages 14 through 17.

Agency Challenge	Status In FY2014	Most Recent Progress	Next Steps
Reform managed care program. *Agency Priority - Improve patient outcomes through strong Managed Care Program*	• Implemented a new MCO evaluation program to further enhance monitoring, assessment and performance of the three health plans • Made additional changes to the contract to clarify requirements regarding the medical loss ratio and the link between health plan solvency requirements and membership enrollment • Rather than apply uniform rates across all plans, implemented the first full year of risk-adjusted payment rates which are specific to each MCO's Medicaid pharmacy utilization	• Released the first MCO report card in February 2015, grading the health plans on five critical areas essential to the effective operation of any health plan • Began to modify the contracts to impose a pay for performance system in which the MCOs will be required to meet certain performance benchmarks or lose a portion of their capitated payment. This is contingent upon the District establishing a target rate for each MCO in FY2016.	• Professionally produce the annual report card and distribute to all stakeholders • Work with the Actuary to develop the specific benchmarks for the pay-for performance system • Examine with the Actuary, the feasibility of using medical claims data rather than pharmacy data as a basis for establishing the plans' risk scores.

Agency Challenge	Status In FY2014	Most Recent Progress	Next Steps
Payment Reform for Hospitals. *Agency Priority - Improve patient outcomes by developing patient-centered reimbursement strategies*	• Submitted SPA to CMS to fully implement the plan to shift hospitals to the ICD-10-CM system used to classify and code all diagnoses • Submitted SPA to CMS to 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.	• Waiting for CMS approval of the new SPA language	• Once approval is provided, reprocess and price all claims under the new systems
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*	• Built an in-house, temporary home health care delivery system to mitigate any shortage of providers as a solution to the problems created by DHCF's payment suspensions • Implemented the independent assessments for the program. • Right-sized the personal care program through providers suspensions and terminations, independent patient assessments, and monitoring of home health providers who delivered services • Developed a plan to establish a cost-reimbursement methodology for home health care providers	• DHCF continued to serve more than 600 beneficiaries in FY2014 and into FY2015. However, the process of transferring beneficiaries to other home care agencies has begun • Through the assessment process, payment suspensions, and provider terminations, DHCF continues to reduce the number of persons who are engaged in fraudulent billing, • All home care agencies have submitted cost reports which are now being audited	• Complete transfers for all beneficiaries from DHCF's home care agency to providers who have the capacity and are not under the cloud of a DHCF or OIG fraud investigation. Once the transfer is complete, disband the DHCF agency • Continue the patients assessments for new applicants and annual renewals • Finalize a new rate methodology for home health care providers based on audited cost reports.

Agency Challenge	Status In FY2014	Most Recent Progress	Next Steps
Redesign Day Treatment Services *Agency Priority – Long-Term Care Reform*	• CMS approved the new SPA establishing a revised Adult Day Treatment Program	• The necessary work to finalize procedures for provider and beneficiary enrollment in the revised Adult Day Treatment Program has been initiated	Implement the process for assessing and transitioning existing day treatment beneficiaries. The beneficiary assessments will begin in April 2015
Implement Health Homes Project. *Agency Priority – Improve care coordination for Medicaid beneficiaries.*	• No real progress was made on this project in FY2014 and the plans for a full-scale implementation of the project were pushed to October 1, 2015	• Leadership at DHCF and DBH have worked through the details of the program reimbursement methodology for the Health Home program	• Launch the program by October 1, 2015
Build An Integrated Health Care Network In Wards 7 and 8 *Agency Priority – Protect the District's Safety Net Hospital*	• Huron Consulting was selected to turnaround the operations of UMC and over the course of FY2014 implemented a number of strategies to end the operational losses at the hospital • As a second part of the contract Huron initiated and completed a search to find a partner for UMC with the goal of building an integrated health care network in Wards 7 and 8	• The potential UMC partners identified by Huron -- Paladin and Howard University Hospital -- signed a letter of intent to establish a joint venture company and purchase the operations of UMC but not the land and the assets. • All parties involved have continue their separate due diligence work • Two documents for the proposal -- the Definitive Agreement and the Operating Lease -- have been submitted to members of a working group headed by Deputy Mayor Donald for review and comment.	• Complete the due diligence required for all parties to establish comfort with the proposal • Based on the results of the due diligence and a legal review of the Definitive Agreement and Operating Lease, make recommendations to Mayor Bowser for next steps on this project

Agency Challenge	Status In FY2014	Most Recent Progress	Next Steps
Establish A Health Information Exchange For District Providers *Agency Priority – Improve Patient Outcomes*	• DHCF supported the connection of 6 of the 8 DC hospitals to the Chesapeake Regional Information System for our Patients (CRISP). As a result, any DC payer or provider can receive a notification when one of their patients goes to the hospital, offering opportunities for improved service delivery.	• Through the launch of the Capitol Partners in Care HIE, several Federally Qualified Health Centers (FQHCs) have been connected with Providence Hospital's ambulatory care services. The goal is to bring all of the District's behavioral health providers into one electronic system. • The Capitol Partners in Care System has also established a connection with CRISP that enables ambulatory care data to be uploaded for distribution through the CRISP network. This has created capacity for CRISP notifications to directly populate its electronic health records (EHR) which will increase data use.	• Continue to build upon the existing HIE capacity in the District to work toward a more fully integrated system that connects with our region. Currently working with the DBH and Capitol Partners in Care to facilitate electronic connections between their two systems to promote coordination between behavioral health services and primary care. • Plans are also being made to increase ambulatory connectivity to CRISP.

Conclusion

Madam Chairwoman, my testimony today was designed to shed some light on the challenges DHCF faced in FY2014 and the very real progress we have made in moving both the Medicaid and Alliance programs forward. While I admit to some bias, there can be little question that DHCF continues to make remarkable strides forward with the strategic planning for these important health care programs and the day-to-day oversight of providers in their efforts to appropriately deliver health care services. The changes we have put in place with managed care,

fraud mitigation, and hospital payment reform, will redound to the benefit of the stakeholders for these programs as well as the citizens of the District of Columbia for some time.

Although there is room for improvement and much work remains, we approach the coming fiscal year with the anticipation of continued progress in the design and execution of the District's publicly funded health care programs. Under the guidance of Mayor Muriel Bowser and the general direction of Deputy Mayor Donald, we look forward to open dialogue with the Committee on Health and Human Services as well as opportunities to work with you and your staff in the coming months to improve service delivery to some of the District's most vulnerable residents.

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