



Public Roundtable on

“The Department of Health Care Finance”

**Status of Medicaid Managed Care Contracts and Issues Involving
United Medical Center Not-For-Profit Hospital**

Presentation Outline

- Status Of Medicaid Managed Care Contracts**
 - *Rationale for Re-Procurement*
 - *Importance of New Universal Contracting Provisions*

- Movement of Fee-For-Service (FFS) Enrollees Into Managed Care**

- Issues At United Medical Center**
 - *Relocation of Nursing Home Residents*
 - *Power Outage At United Medical Center*

The Department Of Health Care Finance (DHCF) Made The Decision To Re-Procure The Managed Care Contracts In 2019 To Fight Growing Instability In The Program

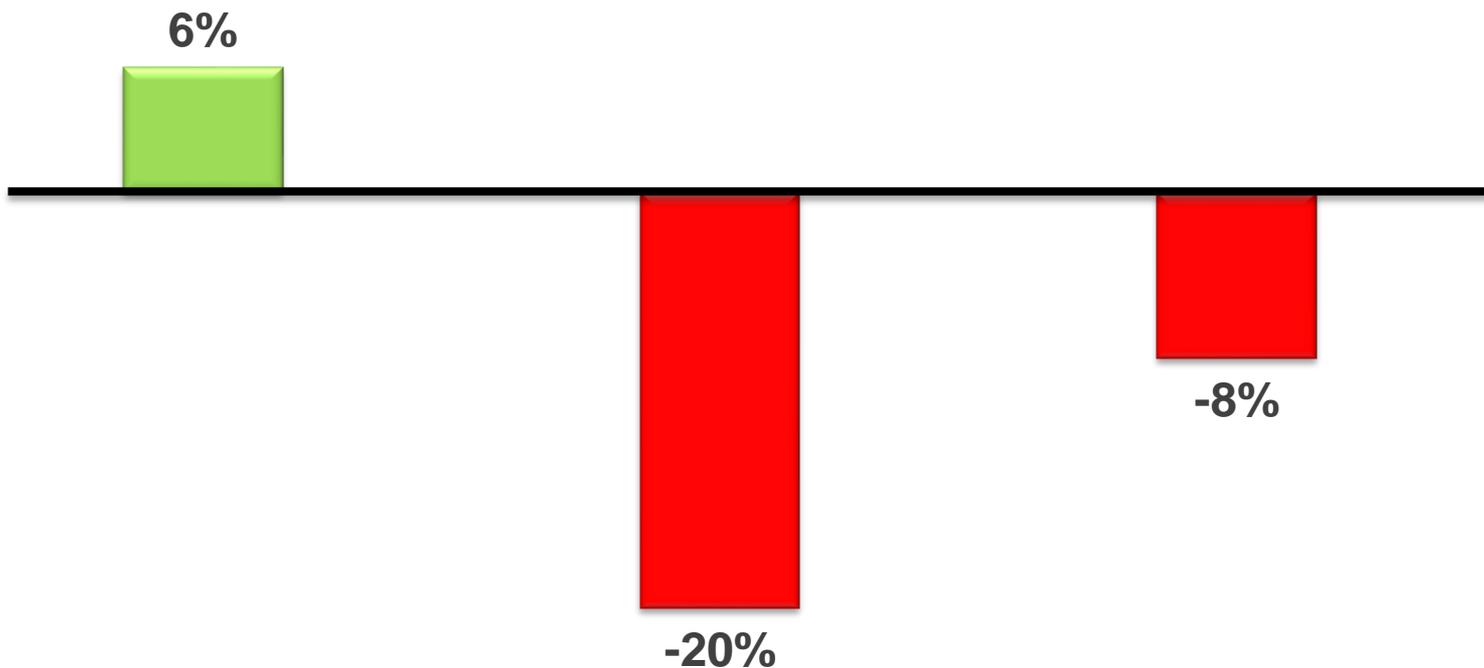
- ❑ Fiscally sound and qualified health plans are needed to manage and administer an array of covered services in DHCF's managed care program
- ❑ In the summer of 2019, DHCF decided to terminate the existing contracts with the three Medicaid managed care plans at the conclusion of Option Year Two
- ❑ This decision was occasioned by problems endemic to the program that prevented compliance with basic tenants of access and actuarial soundness – problems that threatened the stability of the program

Pooling Risk Is A Fundamental Necessity To Secure A Stable Health Plan

- ❑ In the managed care environment, financial solvency is determined by the rate that health plans are paid for managing and paying for the care of enrollees, and the relative balance of enrollee risk pools
- ❑ CMS imposes the requirement for actuarially sound rates, but this can be completely undone by the unique problem of adverse selection
- ❑ Effective risk pooling requires a diverse membership panel -
 - Favorable combination of high-cost and low-cost members in same plan
 - Sufficient number of lower cost members needed to offset the medical expenses for high-cost beneficiaries in the plan
- ❑ Adverse selection is the most significant threat to stable risk pools
 - In Medicaid, this occurs when a disproportionate share of unhealthy individuals gravitates to a particular plan.
 - Beneficiaries are randomly assigned to avoid disproportionate pooling
 - However, members can request a change to another plan at **anytime during the year** – even after initial enrollment closes

In Medicaid Program Health Plan Adverse Selection Drove Changes In Enrollment Patterns

Percent Change In Enrollment For Medicaid Health Plans
From October 2017 to June 2018



AmeriHealth

Amerigroup

Trusted

110,333

58,998

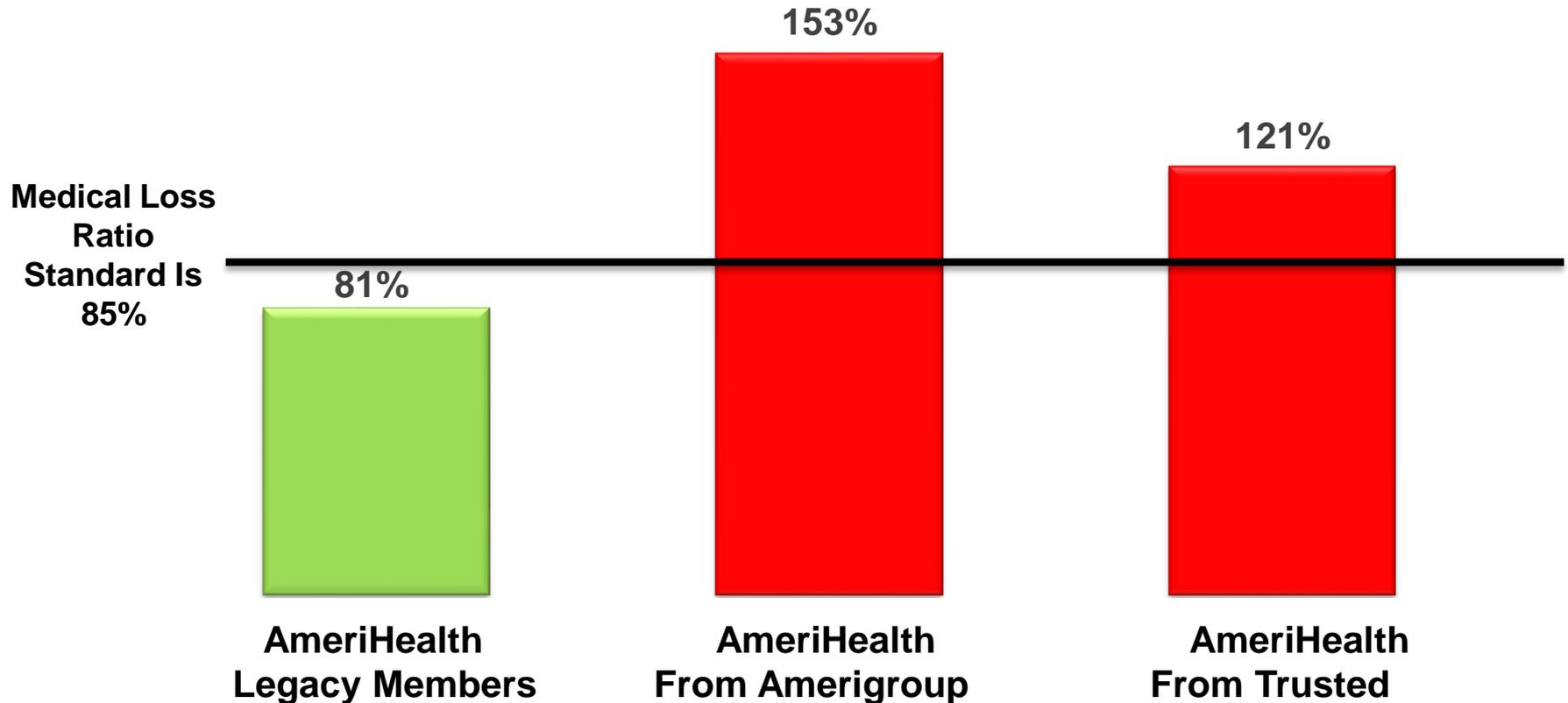
37,444

MCO
Medicaid
Enrollment
Levels

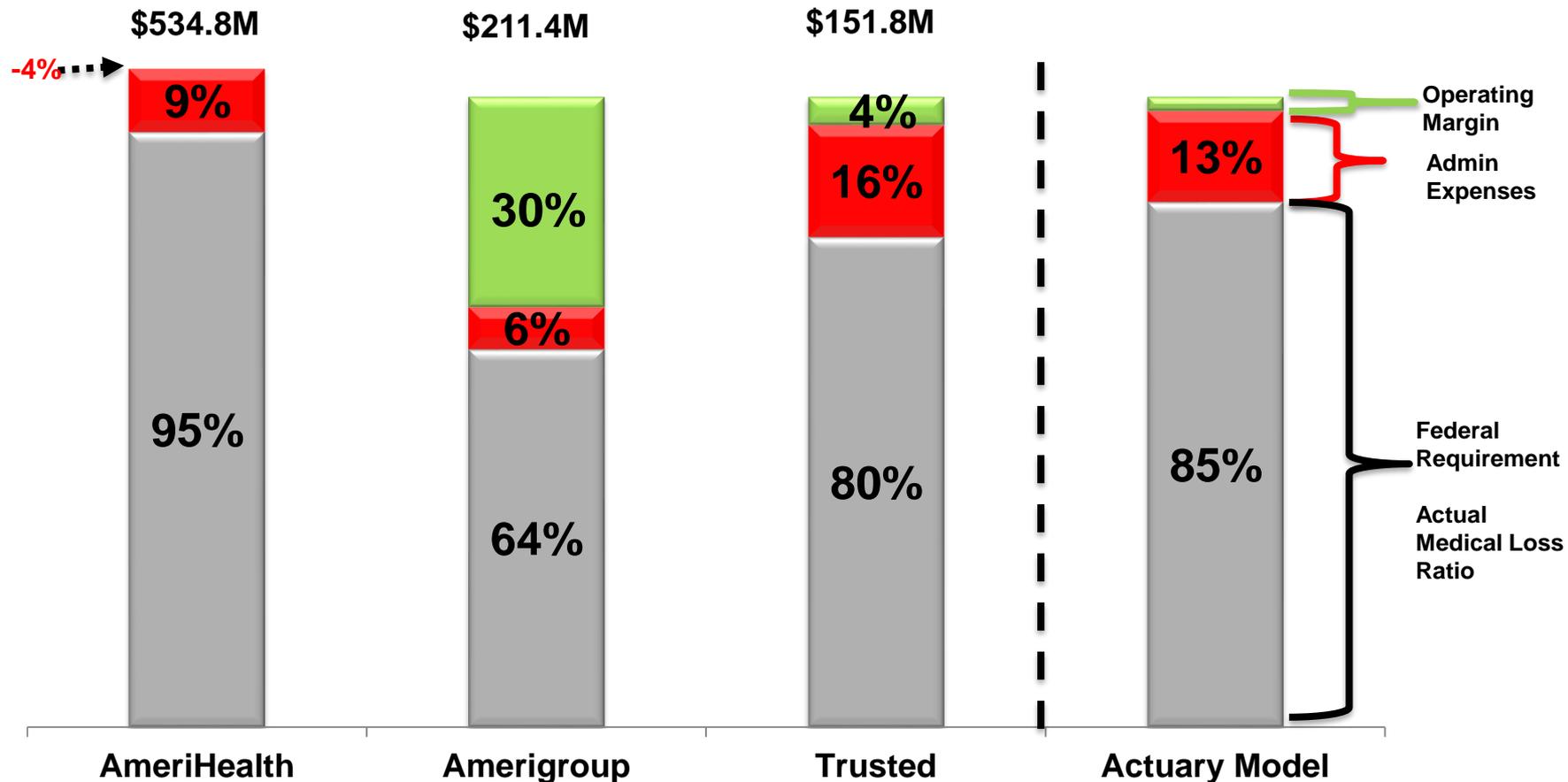
Source: Reported figures are from the DHCF's MMIS system

Clearly The Members Who Transferred From Amerigroup And Trusted To AmeriHealth In 2018 Were Much Sicker Than Those Already In AmeriHealth's Plan

A Comparison of the Medical Expenses for AmeriHealth's Legacy Members to Those Who Switched To AmeriHealth From The Other MCOs



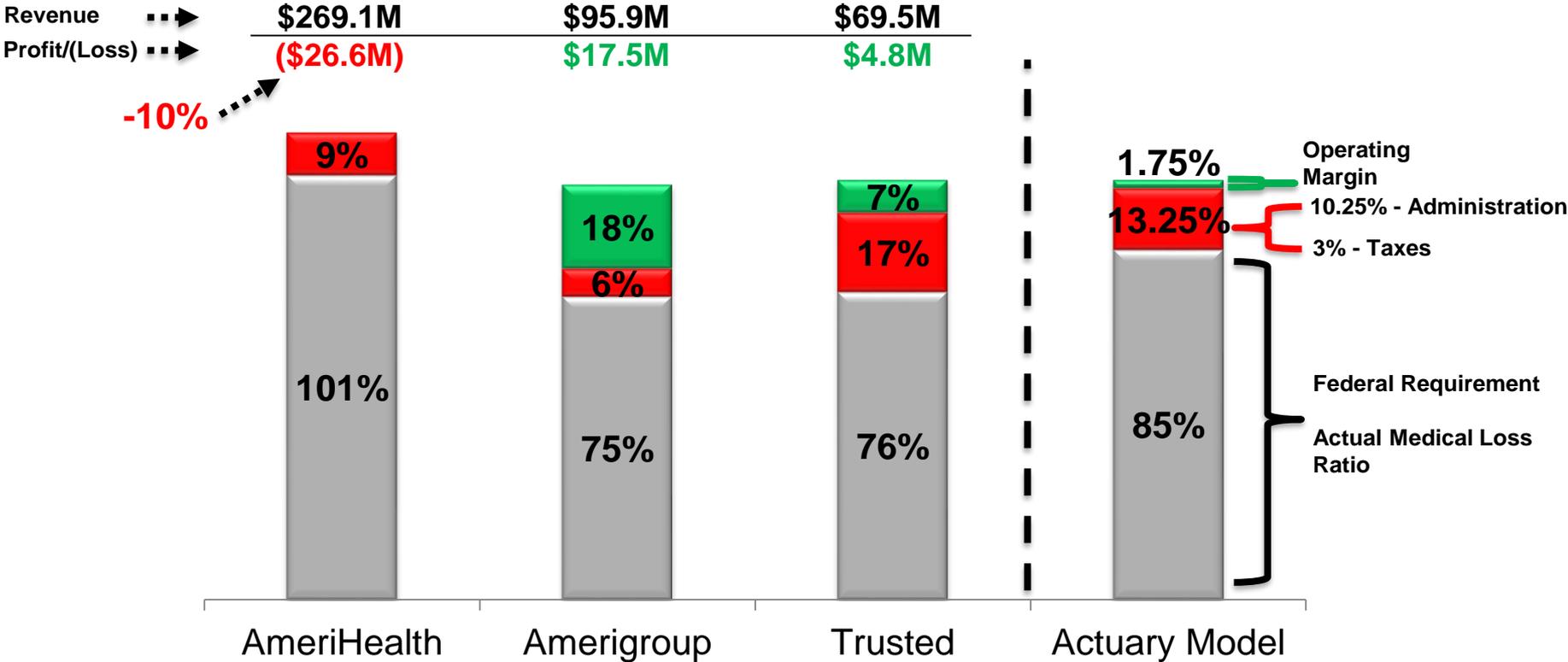
The Impact Of Adverse Selection On The 2018 Financial Profiles For The District's Three Full Risk Health Plans Is Substantial



Source: MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Annual Statements for shared risk plan, HSCSN, as of December 2018. **Note:** MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. Total annual incurred claims (including IBNR) and cost containment expenses as of December 31, 2018, net of reinsurance recoveries. *As Amerigroup began operations in October 2017, limited claims history was used to set initial reserves. This may have resulted in higher reserves than actual claims experience over the reporting period

The Notable Gap In Medical Service Costs Among The Three Full Risk MCOs That Was Observed In 2018, Continued In The First Half Of 2019

Actual MCO Revenue for January 2019 to June 2019



Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. Total annual incurred claims (including IBNR) and cost containment expenses as of June 30, 2019, net of reinsurance recoveries. Source: MCO Quarterly Statements filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk-based MCOs.

The New Contracts Contain Three Provisions With The Promise To Completely Remedy This Problem

1. The requirement that all enrollees are reassigned across the health plans using a random and approximately equal auto-assignment process
 - Removes deeply engrained selection bias in the program
2. A provision that allows DHCF to reduce funding for any health plan by amounts that ensure the medical expenditures will be at least 85 percent of the total health plan's revenue
 - Consistent with federal law and prevents excess plan profits and losses
3. A requirement that all health plans contract with each acute care hospital in the District of Columbia (and vice versa)
 - Eliminates the necessity of enrollees moving from one health plan to another to secure access to certain hospitals

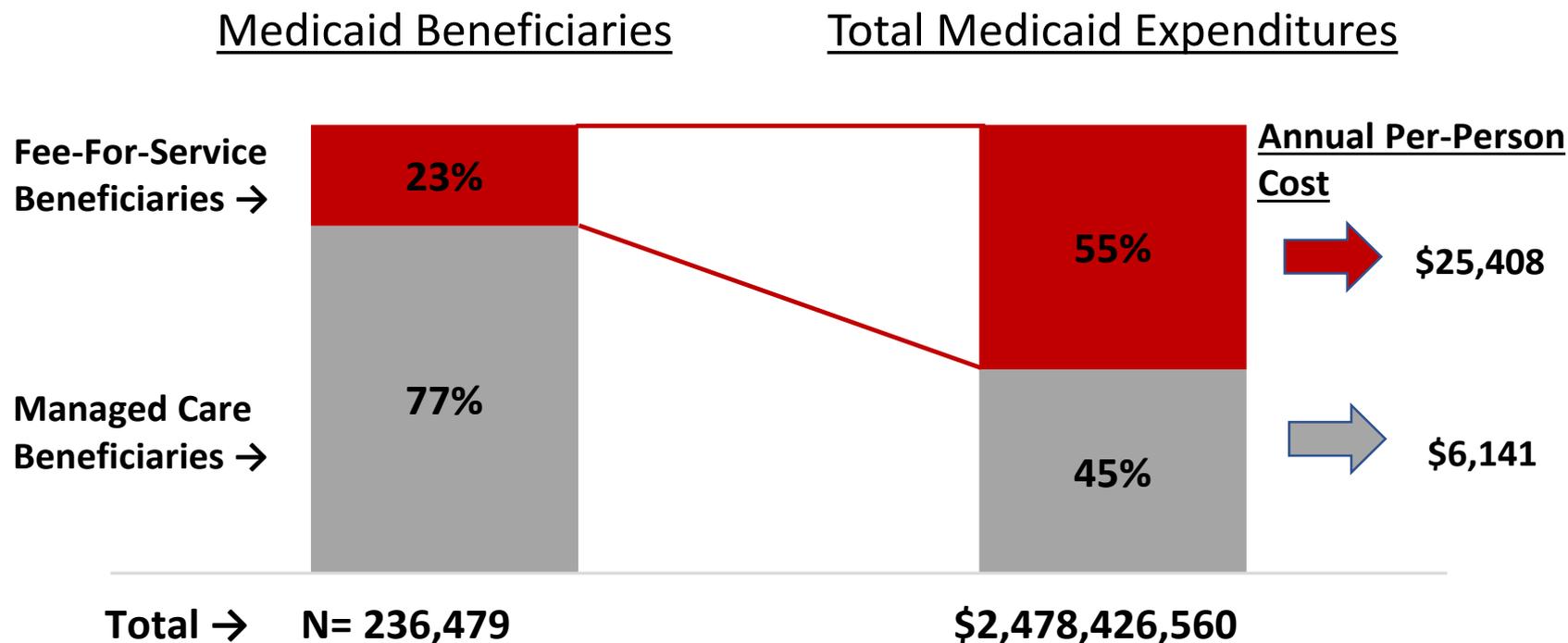
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Those Who Are Not In Managed Care Have Health Care Needs That Are Significantly More Expensive To Treat



Source: Data were extracted from DHCF MMIS system.

Note: Only persons with 12 months of continuous eligibility in 2018 are included in this analysis.

With The New Managed Care Contracts, DHCF Will Transform The Medicaid Delivery System For The FFS Population

- ❑ The goal of this reform is to make the managed care program more accountable and person-centered for a larger share of Medicaid beneficiaries
- ❑ To facilitate this change, DHCF plans to transition approximately 19,000 individuals—identified as Adults with Special Health Care Needs—from the FFS Medicaid program into managed care on October 1, 2020
- ❑ Enrollment will be proportional and will permit these more vulnerable and medically fragile populations to benefit from care coordination and case management services not provided in the FFS program

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The District of Columbia Has One Of The Highest Nursing Home Occupancy Rates In The United States

The District of Columbia's Nursing Home Environment

Total Number of Nursing Homes In The District	16
Total Beds	2,405
Occupied Beds	2,258 (94%)
Occupied by Medicaid	1827 (76%)
Total Beneficiaries in NH (DC, MD, VA)	2298
Total Persons In-District	1827 (80%)
Total Persons Out-of-District	471 (20%)
All DC Medicaid Enrollees	273,500

Medicaid Occupancy Source: Based on claims from DHCF Medicaid Management Information System (MMIS) data as of July 27, 2020. Includes paid final FFS claims and small number of MCO encounters.

- March information is provided because at least three full months of run-out is typically required to obtain stable claims data
- UMC SNF data was modified to reflect the closure and the occupancy rate was recalculated. The recalculation presumes the three residents currently in the hospital will be placed in MD once discharged.

Licensed Beds Source: DC Health

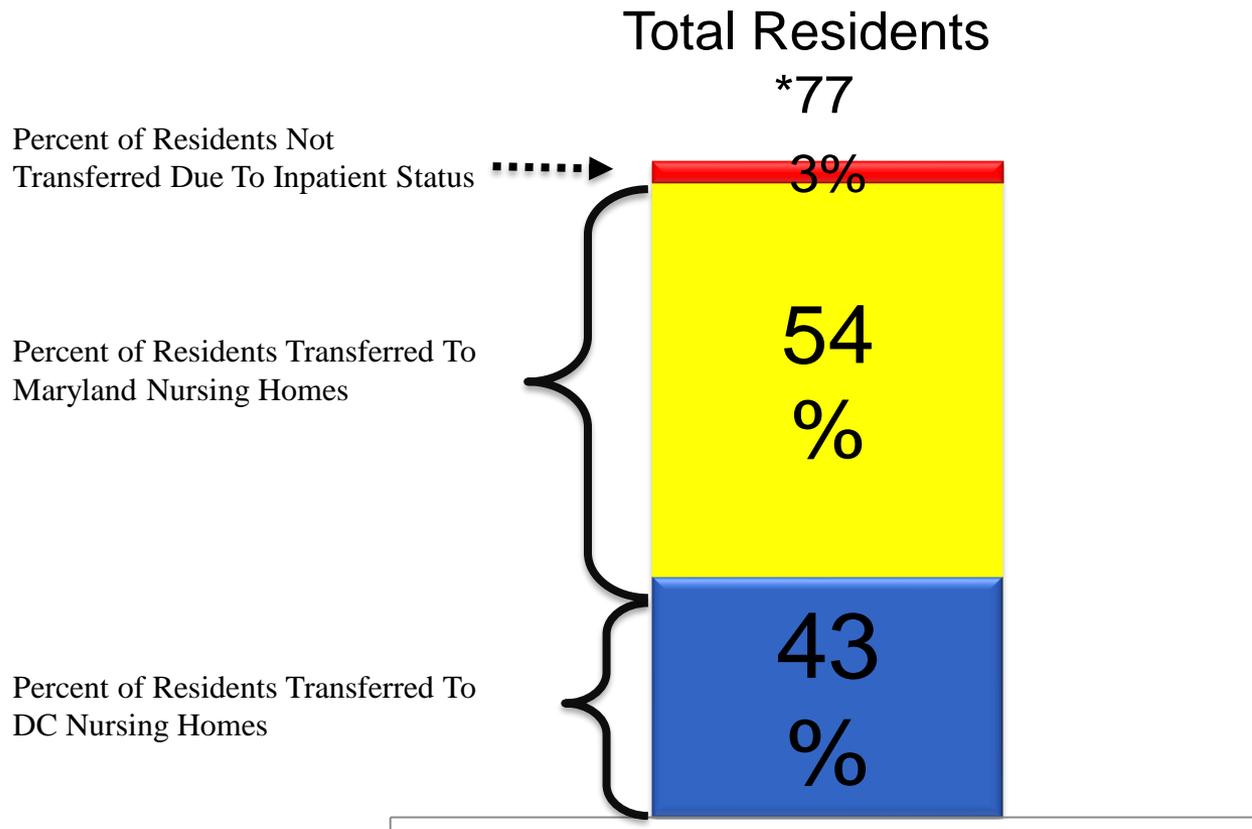
General Occupancy Source: Based on data published by DCHCA [here](#).

- Out of 16 facilities:
 - 14 were updated in 2020 (8 in July 2020)
 - 1 updated in 2019
 - 1 updated in 2018

The Movement Of United Medical Center Nursing Center (UMNC) Residents

- ❑ In view of the current COVID-19 pandemic, UMC worked with the Mayor's Surge Capacity Task Force to increase hospital capacity to prepare for a possible surge of COVID-19 positive individuals in our community
- ❑ To ensure UMNC residents are in safe environments and not placed at further risk of infection, the Board approved the temporary transfer of all residents to facilities in the District of Columbia and Maryland.
- ❑ UMC staff worked with DC Health, CMS, and the DC Long Term Care Ombudsman
 - Guidance provided
 - Daily touchpoints with DC Department of Health Care Finance
- ❑ UMC has maintained constant communications with all residents and their responsible parties/guardians with detailed placement information
 - Residents were notified of appeal rights

Most United Medical Center Nursing Home Residents Were Transferred To Maryland Because Of The High Occupancy Rates In The District of Columbia



*Total Residents at the time of patient transfer. The average daily population at the nursing home was 83 at the time of transfer.

Given The Reality Of The Pandemic, UMC's Board Decided To Permanently Close The Nursing Center

- ❑ With unanswered questions about the length of the nationwide pandemic and the expected closure of United Medical Center in 2024 when the new hospital opens, the UMC Board announced the closure of the nursing center on June 24, 2020
- ❑ Now, plans are underway to replace this capacity rather than reopen the nursing home in UMC
 - One provider has expressed an interest in expanding its nursing home footprint in Ward 8
- ❑ We will watch this development closely over the coming months and keep the Committee abreast of any progress

Timeline Of Events Surrounding UMC Power Outage

Thursday, July 23

- ❖ 8:55PM Hospital lights and monitors flickered
- ❖ 9:30PM UMC Facilities Director notified
- ❖ 10:00PM DC Health notified
- ❖ 10:04PM UMC's CEO Daniel and COO notified

Friday, July 24

- ❖ 12:58AM Update provided to DC Health
- ❖ 2:31AM Lights went out and staff reported loud banging
- ❖ 2:43AM Lights still out with no emergency power. UMC begin moving patients
- ❖ 3:10AM DC HSEMA onsite and speaks to PEPCO
- ❖ 4:24AM PEPCO dispatched
- ❖ 4:27AM Chair May and DM Turnage notified
- ❖ 5:02AM DC Health arrives onsite
- ❖ 7:03AM PEPCO confirms that Maryland feeder has NO power, so chillers are not effective
- ❖ 9:07AM PEPCO confirmed that both transformers blew
- ❖ 10:11AM Full power restored

Significant Repairs Will Be Needed On Hospital's Cooling And Heating System Before UMC's Closure

UMC's Heating And Cooling Costs For FY20-FY21

Repairs and Replacements

\$5,843,000

Required Annual Maintenance

\$805,000

These Additional Capital Costs Are Not In The May 2020 Board-Approved Spend Plan

	Available on Oct 1, 2019	May 2020 Proposed Spend Redistribution Plans - under EOM/OBP/DHCF Review	Projected Balance on Sept 31, 2020 (if approved by DHCF/EOM/OBP)
Prior Years	\$16,900,000.00	\$16,867,398.42	\$32,601.58
FY17	\$2,335,218.99	\$2,335,218.99	\$-
FY18	\$7,950,579.09	\$7,950,579.09	\$-
FY19	\$4,500,000.00	\$4,500,000.00	\$-
FY20	\$4,500,000.00	\$4,500,000.00	\$-
Totals	\$36,185,798.08	\$36,184,495.08	\$32,601.58

Next Steps For Review Of Capital Plan

July – Aug 2020 – Initial drafts of recent capital spend and a capital needs assessment are currently under Finance Committee and Board review

August 2020 – UMC to revise its capital spend plans and major project reports

Sept – Oct 2020 – Finance Committee, Board, DHCF, and OBPM reviews

October 2020 – FY2021 Transmittal to COH

Questions

And

Comments