GOVERNMENT OF THE DISTRICT OF COLUMBIA

Public Roundtable on

"The Department of Health Care Finance"

Testimony of

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

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Introduction

Good morning, Chairman Gray and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services and Director of the Department of Health Care Finance (DHCF). I appreciate the opportunity to provide testimony regarding the operations of DHCF, specifically the status and program plans explicitly mandated through our recently procured Medicaid managed care organization ("MCO") contracts. In addition, I will speak briefly about potential developments that might positively impact nursing home capacity in Ward 8 and the challenges evinced by the recent power outage at UMC.

Status Of Medicaid Managed Care Contracts

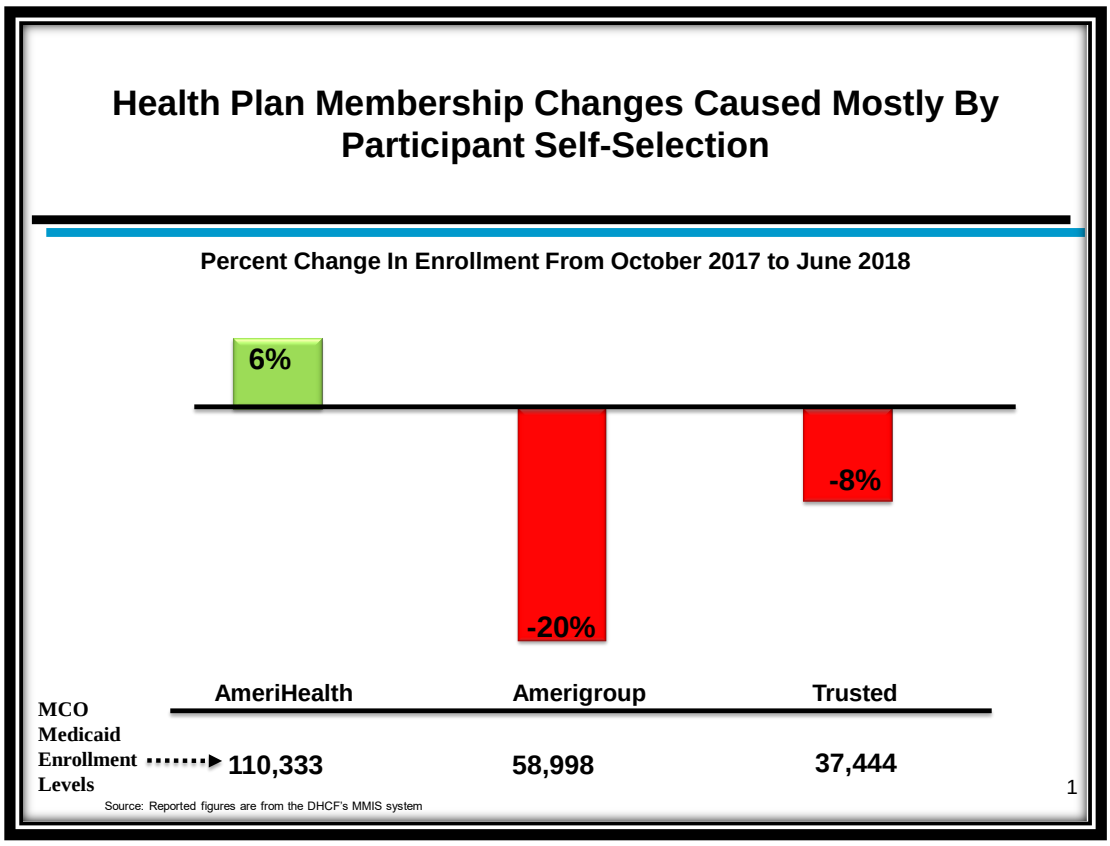
On July 16, 2020, the Department of Health Care Finance (DHCF) announced that the Office of Contracting and Procurement (OCP) submitted to the Council of the District of Columbia, a notice of intent to award three contracts for the District's Medicaid managed care program. This early procurement was occasioned by DHCF's decision not to exercise Option Year Two of the current contracts, due to problems endemic to the program that prevented compliance with basic tenants of access and actuarial soundness. It also aligns with program plans to transition designated fee-for-service (FFS) populations to managed care, particularly individuals with high-cost medical care that lacked the care coordination needed to improve health outcomes.

DHCF requires qualified, fiscally sound health plans to manage and administer an array of covered services through its managed care program, including inpatient and outpatient hospital-based services, clinic care, rehabilitation services, pharmacy benefits, and a full range of medical supplies. In the managed care environment, solvency is not only linked to the rate that companies are paid for managing and paying for the care of enrollees, but it is also directly tied to the relative

balance of enrollee risk pools. Effective risk pooling requires a diverse enrollment panel that includes a favorable combination of both high- and low-cost enrollees in the same health plan. More directly, a sufficient number of low-cost enrollees is necessary to offset the medical expenses of high-cost enrollees in a given health plan.

As you would expect, larger diverse risk pools tend to be more stable because they usually provide the optimal mix of healthy and unhealthy populations, allowing the revenue gained from low-cost enrollees to help cover the considerable medical cost of unhealthy enrollees. Therefore, the biggest threat to stable risk pools is the phenomenon of adverse selection. In Medicaid, this occurs when a disproportionate share of unhealthy individuals gravitates to a specific health plan. Enrollees in MCOs move to other plans for many reasons, but primarily to secure access to a panel of physicians unavailable to the health plan in which they are initially assigned. A sizable shift of individuals to one MCO can severely tip the balance to the point of triggering major losses for the MCO. DHCF attempts to protect against this problem in the Medicaid and Alliance programs by randomly assigning beneficiaries to avoid the disproportionate pooling of the sickest beneficiaries in one health plan. However, individuals can still switch plans for cause, thus allowing for movement to another health plan at any time during the year—even after initial enrollment closes.

Adverse Selection Problems Emerge In The District's Medicaid Managed Care Program. When new managed care contracts began in 2017, a substantial transition of enrollees from Trusted and Amerigroup to AmeriHealth occurred, the only managed care health plan in the District's Medicaid program with which MedStar Health System elected to contract. Thus, the sharpest enrollment reductions occurred for Amerigroup (20 percent), while Trusted also experienced an eight percent decline (see graph below).

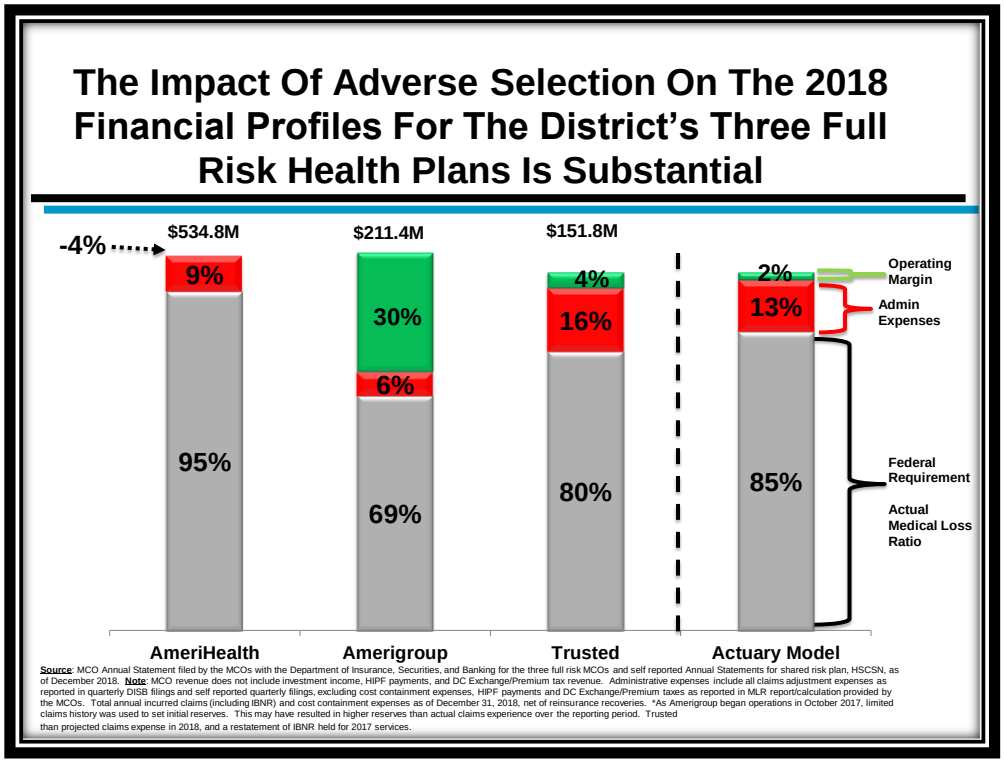


When the medical costs of the enrollees who transferred to AmeriHealth from the other two plans were examined, the data showed that these individuals had much higher medical risk and expense profiles than AmeriHealth's legacy population. On average, the medical risk levels and associated cost for those transferring to AmeriHealth were almost twice as high as the legacy beneficiaries in the plan. Thus, the impact of the transfers was to dramatically increase the health care expenses for AmeriHealth, while substantially reducing the health care costs for the other plans.

As would be expected, this markedly changed the financial profile of all three health plans. AmeriHealth was forced to spend significantly more on health care expenses than anticipated by our actuary's payment model—95 percent of health plan revenue, compared to 85 percent required by the model. This effectively wiped out AmeriHealth's historical margins of four to six percent, reducing the bottom-line outcome to a negative four percent in 2018—a 10-percentage point

change, which translated into a near $50 million financial swing. AmeriHealth was projected to lose nearly $60 million in FY2019, prompting a request for a meeting with DHCF to discuss the possible necessity of exiting the program.

Conversely, with a disproportionate number of the healthiest beneficiaries in Medicaid, neither of the other two health plans were able to meet the federally required 85 percent medical spending levels in 2018. Amerigroup, in particular, experienced a profit level heretofore unseen in the District's managed care program—a 30 percent margin, or more than $63 million, on a $211 million-dollar book of business (see graph below). Trusted's margin was likely twice as higher than shown, although it reported some profits that were paid to investors as administrative expenses, an allowable action by the DC Department of Insurance, Securities and Banking (DISB).



Without sufficient contract language to enforce the federally required 85 percent spending level for each plan, DHCF sought to redistribute payments to adjust for this fundamental flaw in the program. Accordingly, as this market shift threatened the viability of the District's managed

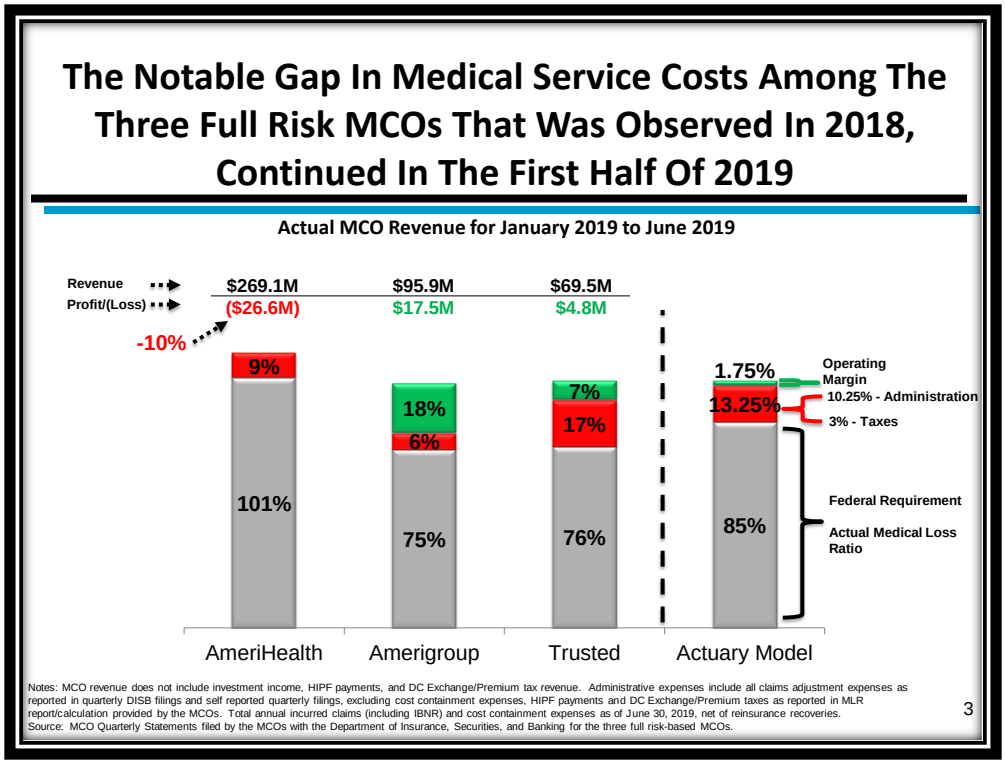
care program, we modified the existing contracts by adjusting the rates for the three health plans to slow the growing losses for AmeriHealth, while dampening the inflated profits for the remaining two health plans. However, the adjustments were limited by other existing contract language that prevented the agency from leveling the playing field for all three health plans.

Hence, the losses for AmeriHealth continued through the first half of 2019—the last period for which data is currently available—while the other two health plans were unjustly enriched (see graph on next page). Notably, Amerigroup posted an 18 percent profit in the first six months of 2019, as this health plan significantly underspent on enrollees' medical care. Similarly, Trusted underspent on medical costs at a level comparable to Amerigroup, as the health plan posted profits that were likely substantially over 10% when accounting for the payouts made to its investors.

Clearly, this financial situation was not sustainable, thus necessitating the termination of the current contracts and a re-procurement far sooner than was originally planned. As you are aware, the proposed awardees for this new procurement are AmeriHealth Caritas District of Columbia, Inc., MedStar Family Choice District of Columbia, and CareFirst BlueCross BlueShield Community Health Plan District of Columbia (formerly known as Trusted Health Plan).

The selection of these three health plans marks a major milestone in the District's efforts to reform the Medicaid program. The new contracts, which will be effective October 1, 2020, contain language to completely remedy the aforementioned problems that plague the District's Medicaid managed care program. The following three provisions of the new contracts are key:

1. The requirement that all enrollees are reassigned across the health plans using an auto-assignment process that will occur on approximately an equal and random basis. This will remove the selection bias that is deeply ingrained in the current program by eliminating the skewed distribution of high cost enrollees in one health plan.

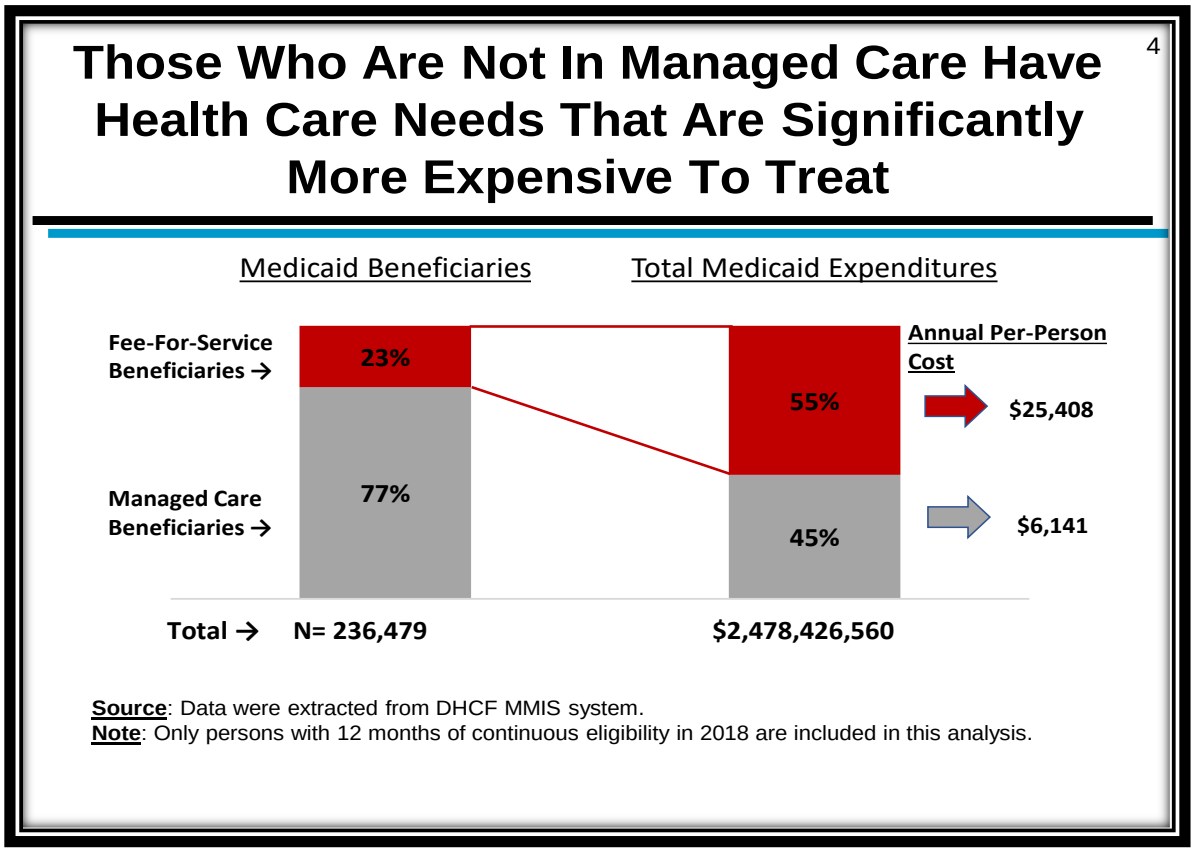


2. A provision that allows DHCF to reduce funding for any health plan in amounts that ensure the medical expenditures will be at least 85 percent of the total health plan's revenue. This is consistent with federal law.

3. A requirement that all health plans contract with each acute care hospital in the District of Columbia (and vice versa) to guarantee that enrollees are not limited in their access to these facilities. This will eliminate the necessity of enrollees moving from one health plan to another to secure access to certain hospitals.

Moving the Fee-For-Service (FFS) Population into Managed Care. Another major change reflected in the new managed care contracts is the requirement that DHCF begin the movement of FFS populations into the managed care program. One of the persistent features of Medicaid programs across the country is the disproportionate expense associated with care delivery for beneficiaries who are not in a program of managed care but, instead, receive their health care based on a FFS arrangement with Medicaid-enrolled health care providers. These providers, in turn, directly bill DHCF for health care services rendered to the FFS population but face no requirements to coordinate the care of these individuals. Partially as a result, FFS

beneficiaries represent only 23 percent of the total number of beneficiaries in the program but account for 55 percent of total program spending (see graph below). On a per-beneficiary basis, we spend roughly four times more on this population than their peers in managed care.



The potential health benefit of this strategy for this population is significant. As a group, the FFS population has high morbidity rates—six in 10 have diagnosed hypertension, roughly one-third have diabetes and high cholesterol, at least one quarter have personality disorders, depression, and asthma, and, a smaller but sizeable number are obese. Clearly, these illnesses require consistent medical attention that can save lives while reducing the cost of health care for this population.

DHCF has determined that more than $100 million of the funds annually expended on health care for these FFS beneficiaries are avoidable, spent on unnecessary trips to the emergency

room without any proven efficacy, hospital readmissions representing a lack of attention to discharge protocols, and hospitalizations that could have been prevented through proper utilization of primary or preventive care services. Accordingly, through the new managed care contracts, DHCF will undertake extensive steps to transform the Medicaid delivery system to one of quality performance and improved health outcomes for eligible populations. This move aims to transmute the managed care program into a more organized, accountable, and person-centered system that best supports the health care needs of 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. The transition will result in proportional enrollment for each of the three MCOs 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.

It is in the best interest of the District and its Medicaid program to execute these changes as soon as possible, and this new procurement makes that possible. While two protests have been lodged, we remain hopeful that the three contracts will move successfully through the DC Council, and the Contract Appeals Board will uphold the work of DHCF's technical evaluation panel (TEP) in a timely manner.

Nursing Home Developments in Ward 8

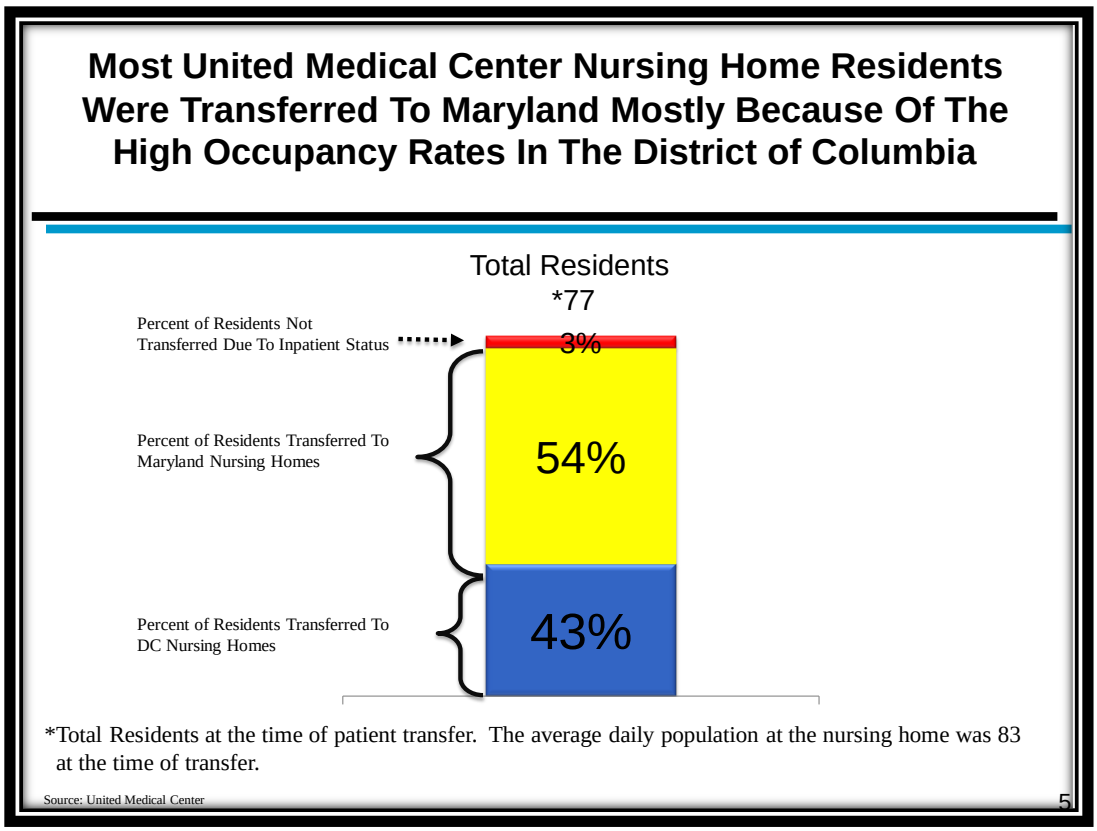
Mr. Chairman, at this time, I would like to discuss recent developments that impact nursing facility capacity in Ward 8 of the city. As you recall, on April 13, 2020, the United Medical Center Board approved the temporary transfer of all patients in the hospital's skilled nursing home as a preventative measure to decrease the potential spread of COVID-19 among the facility's residents,

while concomitantly supporting the Mayor's efforts to expand hospital capacity in the event of a surge in COVID-19 patients.

The patient transfers were initiated on April 29 and completed on May 19, before the predicted COVID surge for the District. Prior to the transfers, each nursing home patient was tested for COVID-19 to ensure that the receiving facility and its residents were not comprised. The graph on the following page summarizes the results from the transfer process. As shown, a total of 77 residents were housed in United Medical Center's Nursing Home when the transfer was initiated, except three patients who were being treated in a hospital inpatient setting. Because of the District's occupancy rate for nursing homes—the highest in the nation—most residents (54 percent) were relocated to Maryland, while 43 percent selected and were granted an in-District placement.

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, plans are underway to replace this capacity rather than reopen the nursing home in UMC. At least one provider has expressed an interest in expanding its nursing home footprint in Ward 8 to address some of the increasing demand for nursing home facilities in the District. We will watch this development closely over the coming months and keep the Committee abreast of any progress.

Importantly, as news on the possible expansion of nursing home beds in Ward 8 materializes, UMC Board Chairperson LaRuby May has committed to working with those planning a new facility or expansion, to ensure that residents who were transferred to protect them from COVID, are made aware of the possibility to return to Ward 8.



Challenges at the United Medical Center (UMC)

Mr. Chairman, I will close my testimony today by highlighting the recent challenges experienced by UMC in managing conditions during the heat wave of the past two weeks. In the midst of this extremely hot weather spell, the hospital significantly struggled with keeping the facility cool as temperatures inside the building came perilously close to exceeding levels considered safe by DC Health. The source of this problem is the hospital's two chillers. While one is in better condition than the other, both have been in use for nearly 40 years and are now at the point of obsolescence.

Last week, after an especially intense storm, the hospital lost power due to an issue with Pepco and was forced to rely on several generators to power the facility. When UMC experienced difficulty consistently powering the generators, temperatures in the hospital spiked, prompting the

staff to transfer patients who were in the intensivist department to other hospitals, while less critical patients were moved to the lower floors.

When the power was completely restored, the historical difficulties with cooling the hospital reemerged, highlighting the need for the replacement of at least one and maybe both of the chillers. On an emergency basis, hospital management is proceeding with the purchase of at least one chiller. Moreover, CEO Colene Daniels recently outlined to the Finance Committee, the capital requirements for UMC and the cost of addressing those needs. This information has been shared with the full Board which will ultimately make recommendations for moving forward as management urgently corrects the cooling system issues in the immediate future.

Eventually, the Board's goal is to approve a plan of repair to ensure that all patient health and safety needs, which are explicitly tied to requirements for capital improvements, will be expeditiously addressed. I would be remiss, however, if I did not note that these capital needs may exceed the hospital's budget, thereby necessitating an infusion of funds from the city. On that point, we will work with the Committee on Health with any funding request approved by the City Administrator and the Mayor.

Mr. Chairman, this concludes my testimony and I am happy to address any question that you or other members of the Committee might have.