GOVERNMENT OF THE DISTRICT OF COLUMBIA

Public Roundtable
On
The Medicaid Managed Care Contracts

Testimony of
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and
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Before the
Committee of the Whole
Council of the District of Columbia
Before The Honorable Phil Mendelson, Chairperson

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WebEx Virtual Platform
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

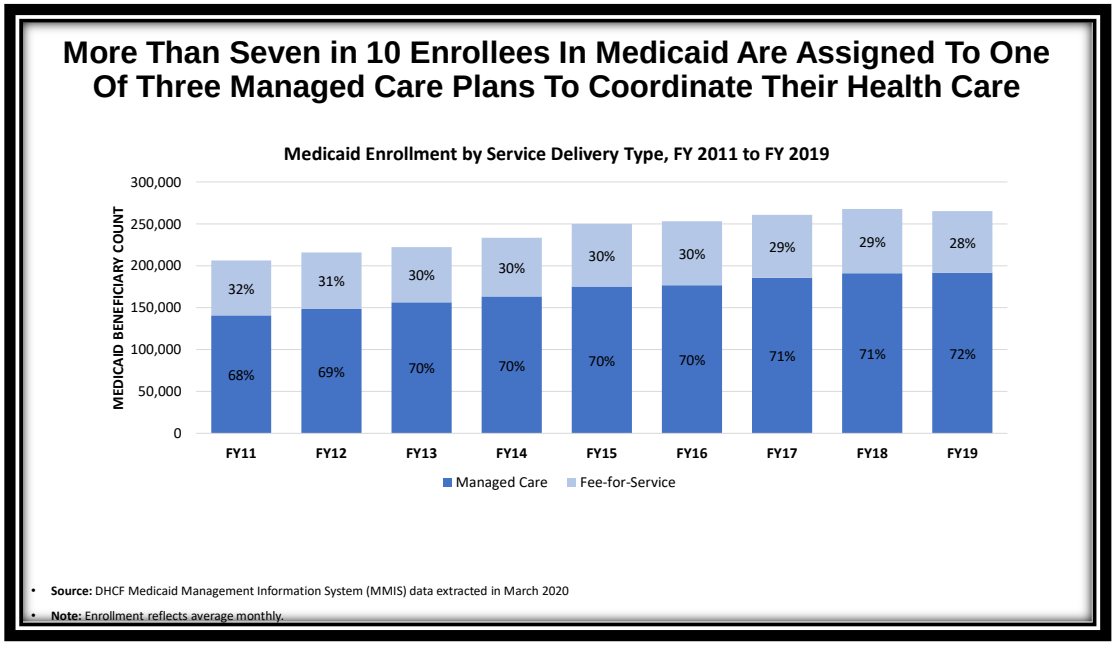
Good morning Chairperson Mendelson, Councilmember Kenyan McDuffie, and other members of the Committee of the Whole. I am Wayne Turnage, Deputy Mayor for Health and Human Services and the Director of the Department of Health Care Finance (DHCF). I am joined today by George Schutter, Chief Procurement Officer at the Office of Contracting and Procurement (OCP), and Kristi Whitfield, Director of the Department of Small and Local Business Development (DSLBD). I appreciate the opportunity to offer remarks on the three Medicaid managed care contracts presently before the Council for consideration of approval.

My very brief remarks will outline the importance of these contracts to the District's Medicaid program, the landmark reforms that are incorporated therein, and the consequences associated with a disapproval that would, in effect, require DHCF to extend the current contracts through Fiscal Year 2021. Although my colleagues and I stand ready to answer any questions you have, I would like to assure you at the outset that we are — in no uncertain terms — confident the proposed awardees were selected properly, and in full accordance with the applicable laws and regulations.

Importance of Medicaid Managed Care Contracts

Medicaid is the District's public health insurance program for residents who live on the economic margin, a significant minority of whom struggle with complex medical problems or disabilities. This program plays an integral role in the District's health care system, by funding the delivery of preventative, diagnostic, acute, and complex medical care for roughly 40 percent of all District residents. In terms of funding, the Medicaid program has a budget of more than $3 billion in total funds and the managed care contracts comprise in excess of $1 billion of this amount. Each time these contracts are competitively bid, they represent the largest procurement in the District.

As a strategy for ensuring the delivery of health care to the District's most vulnerable residents, the managed care program has, over time, assumed a prepotent position in our program. Since 2008, the number of enrollees in Medicaid managed care has grown from 68 to 72 percent (see graph below). This means that, on average, more than seven of every 10 enrollees in the Medicaid program rely upon the three managed care programs to help them negotiate the challenges that are endemic to health care service delivery across the city.



The importance of this fact cannot be understated. Enrollees who are assigned to managed care, receive a range of care coordination services that are not available to their counterparts in what is known as the Fee-For-Service (FFS) program. These services can be especially beneficial in helping residents schedule appointments, seek care in the appropriate environment, execute hospital discharge protocols, and manage their medications. By comparison, persons in the FFS program receive virtually none of this assistance on a routine basis, but instead, must negotiate these issues without the benefit of a third party. This has been especially problematic for this population because, as DHCF has consistently found, FFS

members are significantly sicker, more expensive to care for, and frequently engage with the health care system in a manner that is almost always episodic, rarely planned, and inefficient – potentially undermining the effects of the health care services they need and receive.

Reforms Incorporated in the New Contract

Mr. Chairman, I would like to spend a brief moment explaining why these new contracts are so important to the District's Medicaid program as we approach FY2021. Most notably, there are significant gaps in the current contracts that have spawned certain detrimental actions among enrollees and providers that have significantly destabilized this $1 billion program. Notably, the current contract was not sufficiently comprehensive to mitigate problems which saw Medicaid's sickest members disproportionately enrolling with one of the three health plans as a means to secure access to a fuller panel of hospitals. This created adverse selection issues and unresolvable financial pressures. Nor does the current contract provide a vehicle to allow DHCF to address significant managed care underspending on enrollees' health care observed in two of the three plans – a problem that spiked health plan profits to levels never previously witnessed in a public health insurance program that I can recall.

In response, when the new contracts were developed, DHCF made changes to the program. Specifically, the new contracts, which will be effective October 1, 2020, if approved, contain language to completely remedy these problems. Three provisions are key:

1. The requirement that all enrollees be reassigned across the MCOs 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 MCO.

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

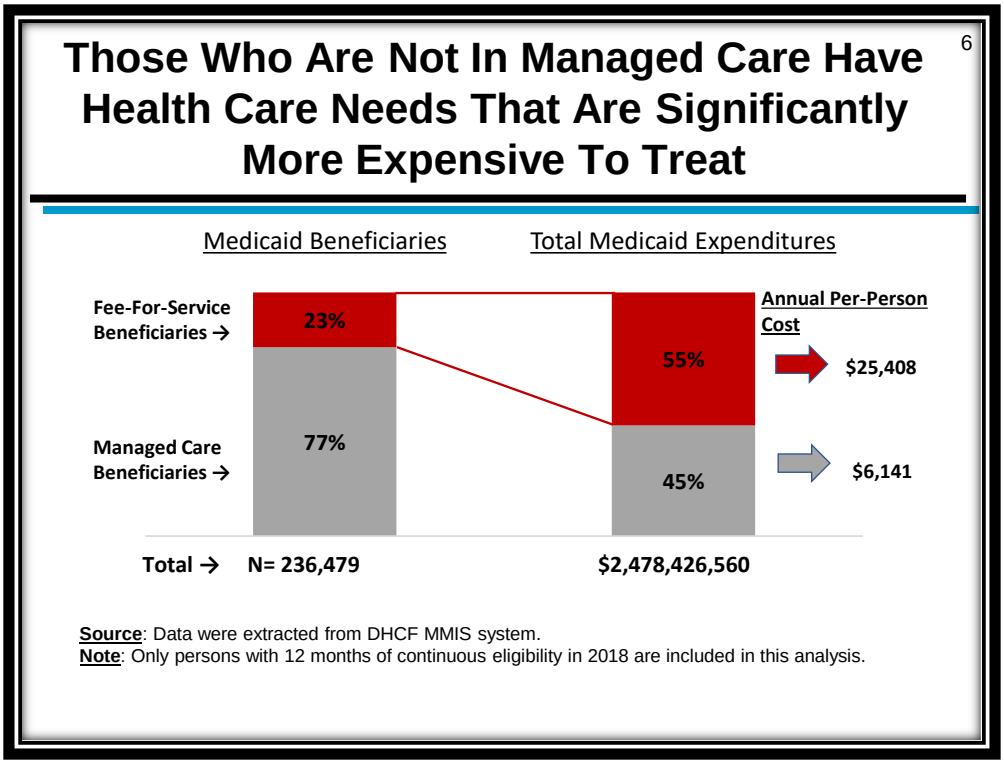
3. A requirement that all MCOs contract with each acute care hospital in the District of Columbia to guarantee that its beneficiaries are not limited in their access to hospitals.

Together, these changes will erase the severe problem of enrollee adverse selection that pushed the program to the precipice of insolvency, allowing DHCF to recapture funds from health plans that underspend on enrollees' health care. This will stifle any prospect of unjust profits and ensure that enrollees have universal access to all acute care hospitals, public clinics, and large physician practice plans in the District, regardless of the plan to which they are assigned. This type of health care access for poor people has never before occured in the District and frankly, is a rare policy — if it exists at all — in Medicaid programs across the country.

Finally, it should also be highlighted that the new contracts contain language that allow DHCF to move nearly 20,000 FFS members into managed care. 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 health care providers, who, in turn, directly bill DHCF for the health care services provided to this population.

In the District, this problem is especially acute. Currently, FFS beneficiaries who have been enrolled in Medicaid for 12 consecutive months, represent only 23 percent of the total number of beneficiaries in the program but account for 55 percent of total program spending (see graph on next page). On a per-beneficiary basis, we spend roughly four times more on this population than their peers in managed care.

The consequences of further delaying the movement of the FFS population into a program of managed care are significant. As a group, this 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. As we now know, many of these diseases are underlying risk factors that are especially problematic in this pernicious pandemic which has claimed the lives of more than 600 DC residents, a disproportionate number of whom are African Americans.

Clearly these illnesses require consistent medical attention that can save lives while having the added virtue of 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 from lack of attention to discharge protocols, and hospitalizations that could have been prevented with a proper plan of primary care.

Accordingly, with these new contracts, DHCF is undertaking extensive steps to transform the Medicaid delivery system to one of quality performance and improved health outcomes for a more expansive population of enrollees. 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. This change, along with the others mentioned, will result in proportional beneficiary enrollment in 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.

Mr. Chairman, I close my remarks by stating that each of the agencies involved in the procurement of the managed care contracts have welcomed your well-reasoned review of this process. I should note that the DHCF technical team responsible for the evaluation of the proposals can boast of almost five decades of managed care experience. Moreover, having reviewed many of the same documents that are now in your possession supporting the work of each agency in this process, there is no doubt in my mind that the relevant agencies carefully followed the laws governing both the District's procurement activity and the Certified Business Enterprise (CBE) program.

Accordingly, my earnest and respectful request is that following today's Roundtable, the Disapproval Resolution be lifted to immediately approve the contracts, allowing for further scrutiny by the Contract Appeals Board while DHCF continues to move forward with its federally required 90-day readiness review activities in preparation for the new contract year.

This concludes my remarks. I will be happy to take any questions you have about the managed care program, leaving other queries about the application of CBE preference points and the procurement process to the relevant agencies that are represented at this Roundtable.

Thank you.