

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Fiscal Year 2015 Performance Oversight Public 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, Room 412

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Introduction

Good morning Chairwoman Alexander and members of the Committee on Health and Human Services. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and I am pleased to be here today to offer a status report on the critical work of the agency. Assisting me in my efforts are members of both DHCF's Executive Management Team as well as key members of my senior staff. As a group, these individuals boast of significant experience in health care policy development, program management, and financial analysis making them well equipped to confront the frequent and significant challenges that accompany our efforts to manage a budget of over \$3 billion.

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. The leadership at DHCF works closely with the Deputy Mayor along with the Mayor and her executive team to pursue the priorities and goals established for this agency. We undertake this challenge with a heavy reliance on data analytics to inform our program implementation decisions, policy development choices, and our ongoing efforts to evaluate the efficacy of the initiatives we have established.

As you may know Madam Chair Alexander, on January 11, 2016, Mayor Muriel Bowser released her first annual Accountability Report, which shows the progress the Bowser Administration is making to help our city achieve its full potential. In alignment with the Mayor's goals and priorities, DHCF maintained efforts to improve the health of women, children, and families in the District.

My testimony today is drawn from the work we have conducted for the time period encompassing FY2015 through January of 2016. As in past years, I have structured my testimony to provide a high level summary of the major issues and challenges that DHCF faced

over this time period as well as outline the progress we continue see from a few initiatives that were put in place in the years preceding this time. I specifically discuss four primary projects underway at the agency:

1. DHCF's continued efforts to improve the delivery of managed care services;
2. The agency's success in building a collaborative partnership with the Department of Behavioral Health (DBH) to improve health outcomes while reducing cost for persons with serious mental illness;
3. The sweeping changes under way in DHCF's very important long-term care program; and,
4. The very significant changes we continue to make to our provider reimbursement program to ensure that the rates we pay are prudently grounded in sound payment principles, while nested in a structured methodology designed to encourage the delivery of efficient and quality health care services.

As my testimony will demonstrate, these projects have produced policies that offer a sharp departure from historical practices in the District's Medicaid program. This, as expected, has created some disagreements with the provider community. Nonetheless, the proposals that we advanced and subsequently executed are necessary to modernize the District's approach to Medicaid reimbursement while reducing the probability that we will experience significant disallowances.

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 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. It is estimated that more than 35 percent of all District residents receive their health care through either the Medicaid or Alliance programs costing DHCF nearly \$3 billion annually in FY2015.

Though the agency's annual budget is funded through a combination of local dollars, dedicated tax revenue, special purpose funds, and federal dollars that facilitate the provision of health care coverage to the District's low-income adult residents and children, the majority of DHCF's funding is allocated to the Medicaid program which is generally supported with a 70 percent federal subsidy.

DHCF's day-to-day work continues to be guided by the four major priorities established in 2015 to support the agency's broadly defined mission. These priorities are: (1) improve patient outcomes and reduce health care spending through the use of care coordination strategies; (2) strengthen program integrity efforts; (3) reform DHCF's long-term care program; and (4) support the District's public safety net hospitals. The projects and initiatives discussed in my testimony support at least one or more of these priorities.

DHCF's Major Focus in FY2015

DHCF's Managed Care Program. Madam Chairwoman, first allow me to turn your attention to the work we continue to pursue with our managed care program. DHCF's managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid and Alliance health insurance programs. There is a monthly average of approximately 188,000 Medicaid beneficiaries and just over 15,000 Alliance members who are assigned to one of the four following Managed Care Organizations (MCO):

- AmeriHealth Caritas DC (AmeriHealth)
- MedStar Family Choice (MedStar)
- Trusted Health Plan (Trusted)
- Health Services for Children With Special Needs (HSCSN)

Three of these health plans -- AmeriHealth, MedStar, and Trusted -- offer comprehensive benefits and operate under full risk-based contracts with the District. We share the risk with the fourth plan, HSCSN. In FY2015, the District spent more than \$983.9 million on MCO services with a little more \$828.4 million of this amount accounted for by the full risk-based contracts signed by AmeriHealth, MedStar, and Trusted.

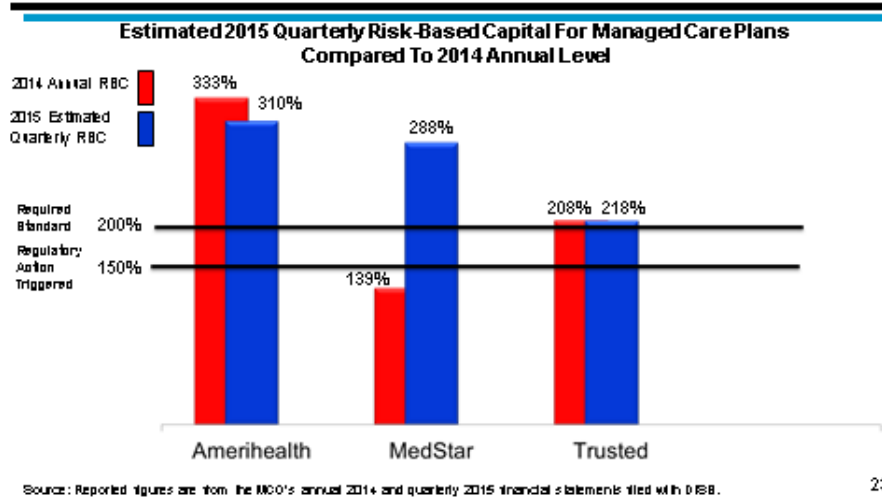
For a number of years, DHCF worked to rebuild a program that was beset by problems and under heavy scrutiny by our regulator, the Centers for Medicare and Medicaid (CMS). To address the myriad of problems during the period from FY2013 through FY2014, DHCF staff selected three new health plans, established clearer and more enforceable contract language, and, in the process, brought much needed stability to the program. This allowed the agency to more sharply focus on the performance of the new health plans which we now regularly evaluate across four domains - financial condition, administrative performance, medical spending, and care coordination activities.

Through quarterly performance review reports, DHCF evaluates the financial stability of the health plans and determines whether they are meeting the standards we set for them using a wide array of metrics such as Risk-Based Capital position, monthly cash reserves, and a comparison of company assets to liabilities.. The results of these reports have generally been very positive. Our analysis covering the time period of January 2015 through June 2015 shows the three full-risk health plans to be in strong financial condition while receiving high marks for managing the administrative responsibilities of a health plan, including the timely payment of provider claims.

Two graphics provided in this testimony illustrate these points. The first reveals the health plan's Risk-Based Capital (RBC) positions. RBC can be seen as a proxy for whether a

health plan has the assets to pay claims. The threshold for an acceptable RBC level is 200 percent. As shown below, three health plans have RBC positions that were above this required level. MedStar’s RBC level in 2014 was substantially below the 200 percent threshold due to significant enrollment growth and the plan’s much higher inpatient and physician cost. MedStar officials addressed this problem with a \$15 million infusion to the health plan assets in 2015, effectively increasing the RBC to 288 percent.

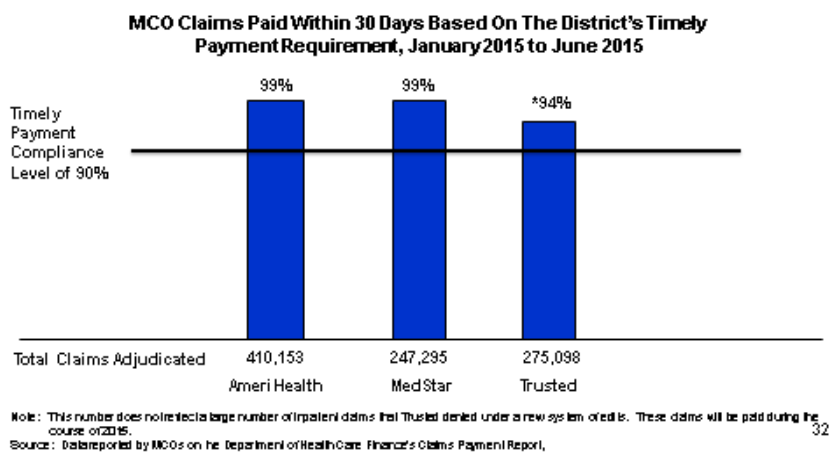
Currently All Three Health Plans Report Risk Based Capital Levels That Exceed The Required Threshold



Administratively, the health plans face justifiable expectations of timely payments from the providers who actually deliver the beneficiaries’ health care services. District law requires that 90 percent of clean claims must be paid within 30 days. As shown below, this standard was surpassed by all three plans in the first six months of 2015, following similar success experienced in 2014.

Madam Chair, you raised a question during DHCF’s Oversight Hearing in 2015 about the MCOs handling of denied claims which, as such, are not subject to the 30-day timely

Over The First Six Months Of 2015, The Three Health Plans Continue To Pay Claims In Compliance With The District's Timely Payment Requirement



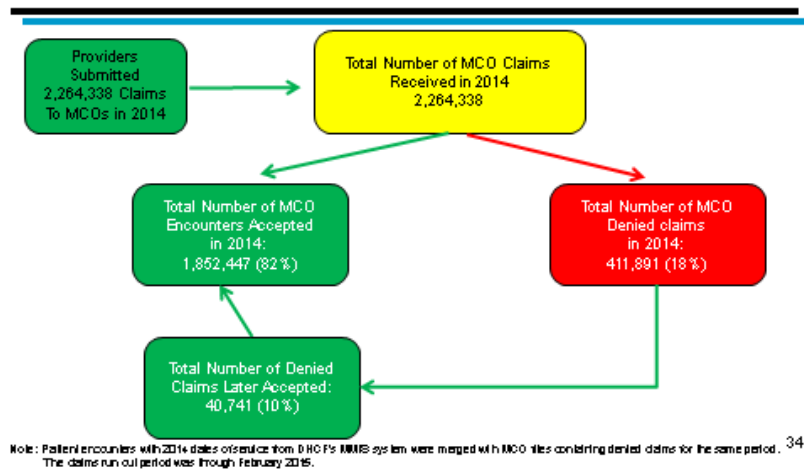
payment rule. Accordingly, we promised to expand the reach of our evaluation efforts to assess whether this was in fact a problem.

Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers have expressed concerns that managed care plans are unjustifiably denying a high rate of claims as a cash management strategy. Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the health plans' networks, and potentially cause access to care issues for beneficiaries in the Medicaid and Alliance programs.

As shown on the next page, in 2014, less than two of every ten claims submitted by providers to the MCOs were denied. This provides clear evidence that the MCOs are not manipulating the claims adjudication process by using it as a vehicle for cash management.

Equally instructive, we conducted additional research on those claims that were denied. The results from this work showed that almost 80 percent of the denied claims were

Less Than Two Of Every Ten Claims Submitted For Payment To The District's MCOs Are Denied



subsequently paid within 30 days from the date of the initial denial. We will continue to track the health plans' performance in this area on an annual basis

Notwithstanding this progress and the fact that the health plans continue to spend at least 85 percent of payments on beneficiary medical care as contractually required, all three MCOs consistently struggle in their efforts to execute effective care coordination strategies for the subset of their beneficiaries whose health conditions mark them as prime candidates for more intense management.

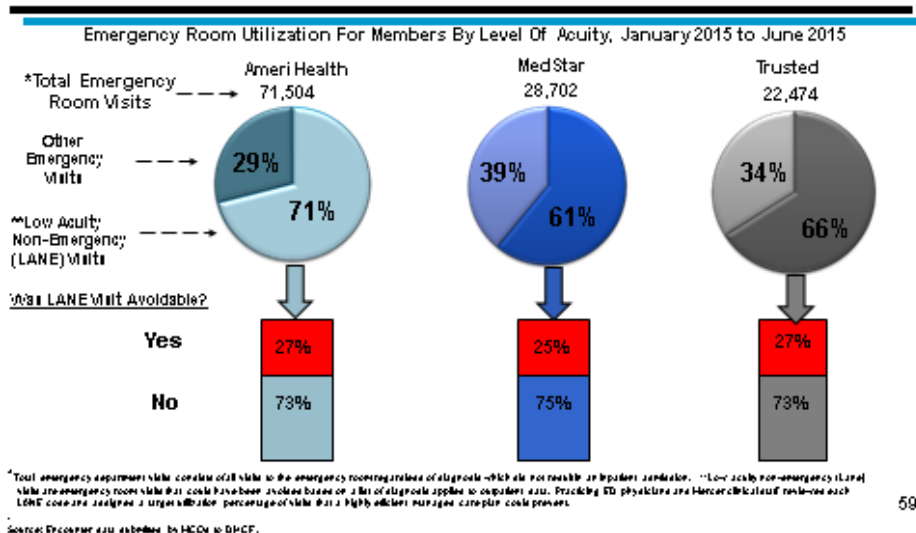
To assess the MCOs' care coordination efforts, we closely examine the following patient outcomes for each of the District's three health plans:

- Emergency room utilization for non-emergency conditions;
- Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care; and
- Hospital readmissions for problems which prompted a previous and recent -- within 30 days -- hospitalization.

Our analysis revealed the MCOs are experiencing problems with each of these metrics. The graphic on the next page highlights the health plans' performance related to one of these

metrics - beneficiaries' use of the emergency room for non-emergency conditions that could be delivered in a clinic-based setting. Across the three MCOs, the proportion of members who rely upon the emergency room for non-emergency care ranges from a low of 61 percent to a high of 71 percent.

The Beneficiaries For All Three MCOs Use The Emergency Room For Low Acuity Diagnosis At A High Rate And Nearly Three in 10 Of These Visits Are Avoidable



The financial consequences of the health plans substandard performance in the three areas in which their efforts are tracked are not insignificant. We estimate that if the health plans were to successfully address the utilization problems for just a subset of the relevant members, annual health care spending for Medicaid alone would be reduced by \$30 million in total funds, \$10 million of which are local dollars.

In response to this problem, beginning in February 2016, DHCF's three full-risk MCOs will be required to meet performance goals in order to receive their total capitated payment rate. These performance goals will require the MCOs to reduce the incidence of the three previously described patient outcomes based on a formula under development by DHCF.

We have designed this program so that it is funded through a two-percent withhold of each MCO's actuarially sound capitation payment for the corresponding period. The goal of the program is to require the health plans to show measurable improvement against benchmarks for the aforementioned indicators or face the loss of up to 2 percent of their capitated payment. This withhold amount is the profit margin factored into the MCOs' base per-member, per-month payment rate. We will rely on claims data to measure the MCOs performance in this system. Since some time must be allowed to ensure a more complete picture of claims activity, payments for successful performance will likely occur 4 to 6 months after the annual measurement period closes. It will be the responsibility of the health plans to build the required nexus with the provider community in support of more enhanced care coordination efforts.

Care Coordination for the Fee-For-Service Population. Madam Chair, as we reported in FY2014, the problems associated with excessive and expensive utilization of health care resources extends beyond the beneficiaries in the MCOs and to the Medicaid recipients who participate in the District's Medicaid fee-for-service program (FFS). Recall that 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. This allows the beneficiaries complete independence in choosing among the existing pool of Medicaid-eligible providers rather than from a network prescribed by the plans.

However, when you juxtapose this circumstance -- no system of care coordination for FFS beneficiaries -- against the empirically demonstrated reality revealing this population to be sicker with more expensive health care needs, a troubling paradox is created.

We took steps to address this problem in FY2013 when DHCF submitted and CMS approved our application for technical assistance and grant funds to assist the District in its

efforts to design a Health Homes benefit to manage persons with complex medical problems. While the program does not explicitly exclude beneficiaries who are in the MCOs, we applied for the opportunity with the full expectation of using this initiative to begin to address, predominantly, the care coordination problems experienced by beneficiaries in the FFS program

As a reminder, the concept of health homes calls for the use of an interdisciplinary team in the selected facilities to integrate and coordinate all primary, acute, behavioral health, long-term care services, and related supports for persons who are enrolled in the program. Thus, working in a partnership with the Department of Behavioral Health (DBH), the two agencies jointly developed the design of this program in FY2013 with intentions to rollout the project on October 1, 2014. For a number of reasons, we were not successful and in some instances were forced to revisit major aspects of the program design.

I am pleased to now report that through the combined efforts of the two agencies and the provider community, we received approval from CMS and launched this program on January 1, 2016 with eight certified health homes. By the end of this month the program will have an additional 5 entities certified by DBH to manage the health care for persons with serious mental illness and high levels of health care utilization.

Over the coming months, my team will be searching for opportunities to expand this concept in separate initiatives to other target groups of beneficiaries. In the meanwhile, through the performance review process being established, we will report on the progress of this particular project throughout the year, with plans to deliver a more comprehensive report at next year's oversight hearing.

Reform of Long-Term Care. Madam Chair, I would now like to briefly discuss the efforts of DHCF to bring much needed reforms to our system of long-term care. Presently, we

are spending about 34 percent of the nearly \$3 billion in total Medicaid funds on long-term care services. Due to long-standing problems with the program and the policy reforms ushered in by a national focus on long-term care for the poor and disabled, the Medicaid-funded programs in the District are in a period of significant change from both a policy and programmatic perspective.

Over the past four years, DHCF has worked in partnership with the Department on Disability Services, the DC Office on Aging, the Department of Health, and the Department of Human Services to address a number of issues. Specifically, this group has focused on stabilizing waiver services for Intellectual and Developmental Disabilities (IDD), Elderly and Individuals with Physical Disabilities (EPD), improving nursing home transitions through the “Money Follows the Person” Demonstration, implementation of the Adult Day Health Program, and reducing the fraud, waste and abuse among providers of Personal Care Assistance (PCA) services.

In FY2015, working closely with the Office of the Deputy Mayor for Health and Human Services (DMHHS), we initiated a plan for major and systemic program reforms to improve the quality and the delivery of long term care services and supports to District residents and their families. In order to succeed in these reform efforts -- many of which are mandated by federal law -- DHCF will focus on three major areas: 1) organizational restructuring; 2) programmatic evolution; and 3) quality improvement.

Organizational Restructuring. In August 2014, the agency undertook an organizational review after observing numerous dysfunctions in the response to the February 2014 FBI raids and subsequent suspension of home health agencies. The review revealed a number of issues, including lack of clear and consistent operating policies and procedures; a paucity of staff

training; and an almost complete absence of trust among staff and between staff and management.

In response, we moved to strengthen the leadership of our growing long-term care operations and improve staff performance by creating a blueprint to establish three new divisions specifically aligned by program function. When this plan is fully implemented, staff will be organized into these separate divisions according to whether their primary job duties are classified as operations, beneficiary access to services, or program oversight. Working within this new structure and with an entirely new management team -- persons who came to DHCF with years of experience in long-term care -- staff will operate with a clearer understanding of their roles and the importance for seamless communications. Moreover, it has been made clear to all persons involved in this enterprise that we have entered a new era that focuses on performance and accountability.

At the same time, DHCF is working with Deputy Mayor Donald and her team on broader organizational changes. Recognizing that the path to long-term care services for too long has been complicated by a confusing and unnecessary set of processes, we are looking to further collaborate with the Aging and Disability Resource Center (ADRC) at the DC Office on Aging (DCOA) to more efficiently connect District residents to long-term care services.

Program Evolution and Redesign. A major focus of our long-term care reform is focused on strategies to improve the quality and the delivery of long term care services and supports to District residents and their families. While completion of the reform will take some time, steps were taken in FY2015 to improve the delivery of long-term care services in the following ways:

- Establishing a No Wrong Door (NWD) Access System in partnership with both the DC Office on Aging (DCOA) and the Department on Disability Services (DDS). This streamlining of the eligibility process will allow ADRC to assume responsibility for providing all pre-eligibility assistance to applicants for long-

term care supports and services. DHCF will eventually procure a new case management system to facilitate the efficient implementation of the NWD approach;

- Building a uniform assessment process across long-term care supports and services;
- Continued work with the Department of Human Services to build an automated eligibility process through the DC Access System (DCAS);
- Establishing person-centered planning across all programs;
- Constructing a completely rebuilt conflict free case management services system; and,
- Laying the ground work for the District's first participant-directed community support program in the EPD waiver.

Due to the breadth and scope of changes that must be implemented, DHCF has organized a SWAT team if you will, that is composed of key agency staff across relevant divisions to ensure that these efforts receive the intensity of focus warranted by the importance of the underlying issues.

Quality Improvement. Finally, in FY2015, DHCF initiated plans to improve its quality oversight of long-term care programs and services. Frankly, this has been a significant shortcoming in the agency and our historic failures in this area drew substantial criticism from our regulator, CMS. Thus, a major goal of the realignment is to reorganize and strengthen quality oversight by bringing all quality reviewers together in one unit.

We believe this will allow the successes and progress of the IDD Waiver oversight to be shared seamlessly with the other programs within the Long-Term Care Administration while facilitating coordination and program-wide planning for quality improvement. Accordingly, DHCF is undertaking a number of actions to improve quality, including:

- Establishing the authority to apply intermediate sanctions on providers to address substandard performance;

- Collaborating with the Department of Health to identify ways to bring high quality providers into DC; and
- Improving the EPD waiver provider readiness and review process.

Although initiated in FY2015, this work will extend beyond FY2016 and into FY2018 before it is completed. Surely there will be difficult challenges and setbacks along the way. However, when the work is completed, the District will have a modernized approach to long-term care that will be on par, if not above, with any system in the United States.

Improvements to Provider Reimbursement Systems. Madam Chair, I would like to use the final portion of my presentation to address the improvements to the payment systems that we continued to pursue for a number of our major providers in FY2015. As rule, CMS grants the State Medicaid Agency significant flexibility in the types of methodologies that can be used to reimburse providers for the care they deliver. Under a general restriction that the payments must be based on reasonable cost, questions as to how States will establish reimbursements levels are largely left to the wisdom of the State Medicaid agency.

In FY2015, we completed the work necessary to validate the soundness of the payment models for hospitals, established formal cost reporting requirements and a rate rebasing plan for personal care services, and developed a new methodology to replace the antiquated rate model that had been used since 1999 -- without major alteration -- to reimburse Federally Qualified Health Centers.

Several of these efforts deserve further discussion. With respect to hospitals, as we reported at last year's oversight hearing, DHCF began work on new payment methodologies for inpatient and outpatient services as well as for the specialty care provided by several District acute care facilities. In general, our goal was to find ways to use the payment system to more directly reward hospitals for the delivery of patient care in the most efficient manner possible.

For the inpatient model, our goal was to alter the incentives in the payment system through two policy changes. First, we decided that the base payment for hospitals would be calculated on a district-wide, rather than a hospital-specific basis. Second, we redirected a portion of the hospital-specific -- so called add-on payments -- toward the district-wide base price. This was designed to reduce payments to hospitals for costs that had little to do with patient quality and access, while increasing the payments for direct patient care.

DHCF accomplished this goal by capping hospital payments for capital cost, Direct Medical Education (DME), and Indirect Medical Education (IME). At the time, reimbursements for capital and DME were paid as add-ons based on per-patient discharges, while IME was added to each hospital's base rate.

For outpatient care, the goal was to move from a system that paid a flat rate to hospitals for outpatient care to a methodology that reflected the specific health care needs of the patient being treated. We executed this approach by establishing a reimbursement methodology that allowed hospitals to bill DHCF for the patient-specific diagnosis, reflecting of course, documented differences in the acuity level of the beneficiaries who were treated.

I am pleased to report that in FY2015, CMS approved the State Plan Amendments establishing each of these new methodologies and the first-year implementation results are quite favorable. Notably, for inpatient care, the payment system has produced the desired impact. As shown in the Table on the next page, the aggregate payment received by the industry under the new methodology, is almost 100 percent of the cost for the services provided to Medicaid Fee-For-Service patients.

Medicaid Payments Compared To Cost For Hospitals That Provide Health Care Services To Beneficiaries in The District's Fee-For-Service Medicaid Program

Hospital	Total Charges	Total Cost	Total Paid	Medicaid Payment To Cost Ratio
Children's National	\$38,370,642	\$15,243,601	\$15,558,644	102%
George Washington Hospital	\$131,306,225	\$31,746,116	\$34,820,002	110%
Georgetown University Hospital	\$70,906,347	\$22,336,172	\$18,718,971	84%
Howard University Hospital	\$82,323,681	\$46,190,857	\$40,438,564	88%
Providence Hospital	\$45,272,890	\$18,847,374	\$23,205,286	123%
Sibley Memorial Hospital	\$5,159,265	\$2,445,832	\$1,985,035	81%
United Medical Center	\$36,560,375	\$14,384,220	\$16,520,221	115%
Washington Hospital Center	\$218,202,456	\$60,818,770	\$59,861,889	98%
Total	\$628,101,880	\$212,012,941	\$211,108,612	99.6%

Notes: Cost is based on FY14 cost report factors applied to year-to-date FY15 claims, assuming 94% completion through October 2015.

Source: Xerox Consulting Services, January 2016.

Equally important, hospitals with lower costs are no longer automatically penalized because, as previously described, the base payment rate is a district-wide average rather than a hospital-specific measure. Thus, lower cost hospitals benefit from a relatively higher district-wide base payment which increases their payments to levels that exceed 100 percent of their reported cost. As the previous Table shows, this methodology proved especially beneficial for Providence, Washington Hospital Center, George Washington Hospital, United Medical Center, and Children's National.

As for outpatient results, the analysis of payments in FY2015 clearly indicates that hospitals are being rewarded more appropriately for the increasingly more complex care that is delivered on an outpatient basis. And, because the model was adjusted to pay a higher portion of the cost incurred in this setting, the Medicaid payments received by each hospital are more in line with the expenses incurred for these very important services.

Madam Chair, the other major payment reform we pursued in FY2015 was for the District's eight Federally Qualified Health Centers (FQHCs). These ambulatory clinics play a critical role in the delivery of preventative and primary care for low-income populations in the District. Based on federal law, since 1999, States have been subject to specific federal requirements when building a rate methodology for these providers.

Particularly, for the purpose of setting a minimum payment level for FQHCs, Congress mandated a Medicaid per-visit payment rate to guarantee FQHCs a certain level of payment for services provided to Medicaid beneficiaries. This payment floor was derived through the use of what is commonly known as a Prospective Payment System (PPS) which, in this case, was defined as the FQHCs' reasonable cost per visit. This same law required States to adjust these per-visit rates annually for inflation. Moreover, States were permitted to increase the PPS if the FQHCs reported an increase in the scope of services provided.

Since 1999, payments to the District's FQHCs were based on this model except that no changes were initiated to address the clinic's service expansion or the entry of new health centers into the District's market. Thus, in FY2015, DHCF initiated plans to revise the FQHC payment model to capture the cost of service expansion while incorporating features that rewarded both efficiency and quality in the delivery of health care services.

Through the use of audited cost reports, we updated the base payments the clinics would receive, thereby raising the federally mandated minimum floor, and enhanced this rate through the use of a bonus payment. Also known as an Alternative Payment Methodology, FQHCs will only receive this enhanced or bonus payment if they meet certain program requirements and achieve specific patient outcomes.

We are presently working with the FQHCs to finalize the system of performance measures upon which the enhanced payments will be made. While we intend to allow a transition period, when the system is implemented in January 1, 2017, FQHCs will be required to produce results that show measurable improvements in patient outcomes in order to receive 100 percent of the enhanced payment.

With this new payment model for FQHCs, the changes made to how hospitals are reimbursed, the pay-for-performance system established for MCOs, and the cost reporting requirements we have established for several other provider groups, we continue our efforts to enhance the integrity of the District's reimbursement policies.

Conclusion

Madam Chair, while this concludes my testimony for today, this discussion only partially addresses the many projects we managed in FY2015 that will continue to receive our attention in FY2016. Under the guidance of Mayor Muriel Bowser and the general direction of Deputy Mayor Donald, we plan to aggressively pursue those plans which hold the promise of an improved service delivery system for beneficiaries in the Medicaid and Alliance programs.

As always we operate with complete transparency and I will ensure that the communication channels with your staff remain open and productive. This concludes my presentation and my staff and I are happy to address your questions as well as those of other Committee members.

Thank you.