DC Fiscal Policy Institute

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DC FISCAL POLICY INSTITUTE

At the Public Hearing on the
Fiscal Year 2014-2015 Performance Oversight Hearing
For the DC Department of Health Care Finance
District of Columbia Committee on Health and Human Services
March 9, 2015

Chairwoman Alexander and other members of the committee, thank you for the opportunity to testify today. My name is Wes Rivers, and I am a Policy Analyst at the DC Fiscal Policy Institute. DCFPI engages in research and public education on the fiscal and economic health of the District of Columbia, with a particular emphasis on policies that affect low- and moderate-income residents. I am also the chair of the Medical Care Advisory Committee (MCAC).

I am here today to applaud and thank the Department of Health Care Finance for their part in providing access to healthcare for the District's lowest-income residents. DC has led the nation in implementing the Affordable Care Act, and DHCF continues to improve the scope and reach of DC's Medicaid program. I would also like to commend the Department on their recent award of a State Innovation Model planning grant. I have met with the staff working on innovation, and I am excited by the prospects of addressing payment in primary care and delivery for high needs/high utilization populations.

I am also here to share a few areas where I believe the Department can improve its performance and outcomes – including the eligibility and enrollment processes for Alliance and Medicaid beneficiaries, evaluation and oversight of the Managed Care Organizations, and information sharing with consumers and the community.

Eligibility and Enrollment

As you know, in October of 2013, the District began an overhaul of its entire public benefits IT system. This process included implementation of the sweeping changes to the Medicaid eligibility and enrollment processes. Three agencies are overseeing this transition -- Health Care Finance, the Health Benefits Exchange Authority, and the Economic Security Administration of the Department of Human Services. While this process has been relatively successful when compared to many states, the District has faced some challenges that have affected residents seeking services. IT glitches, delayed implementation timelines, and inadequate staffing resulted in Medicaid and Healthcare Alliance consumers facing problems and delays when applying for or renewing benefits.

However, I am happy to say there were some important successes this year. First, about half of MAGI (income-based) Medicaid Renewals have been able to passively renew through the new

system – meaning these beneficiaries never had to complete any paperwork or visit a service center to maintain their Medicaid eligibility – the system simply bumped their eligibility information against federal and local data sources to confirm eligibility. This simplified process is a win both for the agency in reduced staff time needed for processing renewals of this type but also for consumers who avoid producing onerous documentation annually. Second, recent collaboration between ESA, advocates, and the managed care organizations strengthened outreach efforts – including robocalls and mailings -- to help Medicaid beneficiaries maintain their benefits if they were unable to passively renew. DHCF staff are also leading efforts to resolve some IT problems with the Medicaid renewal process that require significant manual processing.

Still, there is work to be done. First, close to 1,000 households were cut off of Medicaid in February, due to not completing the new renewal paperwork. Anecdotal evidence suggests that some beneficiaries coming into health centers are very confused by a 17-page renewal form that asks for tax information, among other things. More outreach is needed to ensure that no one who needs benefits is left out of this new system. Health Care Finance should continue and expand its collaboration with the MCOs for outreach help and learn from other experienced states, like Oregon, to track down those who have missed their renewal deadline. The Department can ensure that the maximum number of beneficiaries remain enrolled, if MCOs and authorized representatives can get information far in advance about residents who need to fill out renewal documents.

Second, the DC Healthcare Alliance 6-month in-person eligibility requirement continues to be an undue burden on residents and on service center capacity. Up to 67 percent of monthly Alliance recertifications are terminated due to the process, and the added volume continues to lead to long wait-times, delayed processing of applications, and wrongful denials. Health Care Finance should pursue changes to the program expeditiously – including adjusting the recertification period to a year and allowing health centers to help with applications and renewals.

Managed Care Organizations

I am very happy that Health Care Finance is now issuing a report on MCO performance, and I hope that the Department will actively engage the MCAC and other stakeholders when deciding on the data elements and information to be presented in its quarterly performance newsletter and mechanisms to improve overall care delivery.

Performance metrics and specific outcome goals are critical in the area of MCO performance given the current results shown through the MCO reports are quite troubling. One of the consistent take-aways is that all three MCOs contracted by the city need to improve performance by doing a better job of connecting residents on Medicaid with basic health services, coordinating care, and reducing avoidable costs. Each quarterly report shows the same trends – primary care visits are down among adults, and fewer than 5 percent of beneficiaries are in case management for chronic conditions – a figure far too low given our health indicator data on level of chronic conditions. What's worse, the MCOs spent $34 million dollars on costs related to low-acuity emergency room visits and potentially avoidable hospital admissions and readmissions – all markers of a failure to coordinate patient care. These costs will affect how much the District pays the MCOs in the future. We all have our wish lists for $34 million – the District could fund school-based mental health clinicians in every school, a fully expanded maternal and child health home visiting program in every ward, and expansion of the DC Healthcare Alliance program. I probably would never have to testify at a DHCF Budget hearing again!

The Department has identified these problems and with one year's worth of data, staff will move forward to create benchmarks for success. Even though these MCOs are only a year into their contracts, these trends are not new to the District or to managed care. This means that strong benchmarks should be developed in a thoughtful but expedited way, and that the Department should step up its oversight and enforcement role immediately seeking real performance improvement and outcomes. Performance metrics should reflect the MCO's value to improving the health of beneficiaries, especially for those in need of case management.

Information Sharing

I am pleased that DHCF has made some progress this year in increasing the transparency through various reports. I urge the Department to continue to expand its transparency and collaboration with key community stakeholders, including MCAC. The MCAC is developing requests for the department on these two efforts. The MCAC seeks to improve how the agency presents information on enrollment trends and utilization data and on and how it seeks stakeholder input to improve health outcomes. We will share these recommendations with the department this summer and hope that we can work together to improve the lives of those served through these critical programs.

Thank you for the opportunity to testify, and I am happy to answer any questions.