GOVERNMENT OF THE DISTRICT OF COLUMBIA
Executive Office of Mayor Muriel Bowser

Office of the Deputy Mayor for Health and Human Services

COMMISSION ON HEALTHCARE SYSTEMS TRANSFORMATION

July 30, 2019
1152 15th Street NW, Suite 900
10:00 am – 12:00 pm

Commission Members

Name	Affiliation/ Designation	Attendance	Designee	Attendance
David Catania	Co-Chair	Present		
Sister Carol Keehan	Co-Chair	Present		
Kimberly Russo	George Washington University Hospital	Present		
Kevin Sowers	Johns Hopkins Medicine, Sibley Memorial Hospital	Present		
Oliver Johnson	MedStar Health	Present		
Dr. Malika Fair	United Medical Center	Present		
Dean Hugh Mighty	Howard University Hospital	Present		
Corey Odol	Psychiatric Institute of Washington			
Denise Cora-Bramble, M.D.	Children's Hospital	Present		
Marc Ferrell	Bridgepoint	Present		
Don Blanchon	Whitman-Walker Health	Present		
Kim Horn	Kaiser Foundation Health Plan	Present		
Maria Harris Tildon	CareFirst BlueCross BlueShield	Not present	Colette Chichester	Present
David Stewart	University of Maryland, Family Medicine	Present		
Kelly Sweeney McShane	Community of Hope	Not present	Melissa Millar	Present
Maria Gomez	Mary's Center	Not present		
City Administrator	City Administrator	Not present	Ben Stutz	Present

Rashad Young				
Deputy Mayor Wayne Turnage	Deputy Mayor for Health and Human Services	Present		
Dr. LaQuandra Nesbitt	D.C. Health	Not present		
Dr. Barbara Bazron	Department of Behavioral Health	Present		
Melisa Byrd	Department of Health Care Finance	Present		
Dr. Faith Gibson Hubbard	Thrive by Five	Present		
Chief Gregory Dean	Fire and Emergency Medical Services	Present		
Councilmember Vince Gray	Council of the District of Columbia, Committee on Health	Not Present	Eric Goulet	Present
Tamara Smith	D.C. Primary Care Association	Present		
Jacqueline Bowens	D.C. Hospital Association	Present		
Dr. Gregory Argyros	Washington Hospital Center	Not present	Dr. Jeffrey Dubin	Present

Additional District Government

Name	Role	Office or Agency
Rayna Smith	Staff	Office of the Deputy Mayor for Health and Human Services
Amelia Whitman	Staff	Office of the Deputy Mayor for Health and Human Services
Fern Johnson-Clarke	Staff	DC Health
Lauren Ratner	Staff	DC Health
Sharon Lewis	Staff	DC Health
John Coombs	Staff	Fire and Emergency Medical Services
April Grady	Staff	Department of Health Care Finance
Noah Smith	Staff	Department of Health Care Finance
Alice Weiss	Staff	Department of Health Care Finance
Melanie Williamson	Staff	Department of Health Care Finance
Aviana Cooper	Staff	Department of Health Care Finance
Raessa Singh	Staff	Department of Behavioral Health

Public Attendees

Name	Role	Organization
Justin Palmer	Public	D.C. Hospital Association
Roderic Woodson	Public	Parker Poe
Regina Knox Woods	Public	MedStar
Calvin Smith	Public	Bridgepoint
Eric Wolff	Public	DLA Piper
Feseha Woldu	Public	MedStar
Dr. Raymond Tu	Public	Medical Society of DC
Robert Hay, Jr.	Public	Medical Society of DC
Michael Crawford	Public	Howard University
Patrick Canavan	Public	IdeaCrew
Lisa Fitzpatrick	Public	Grapevine Health
Kevin Wrege	Public	Pulse Advocacy
Karen Dale	Public	AmeriHealth Caritas DC
Vincent Keane	Public	Unity Health Care
Dr. Gloria Wilder	Public	Core Health and Wellness Cener

Agenda and Minutes

1. Call to Order — Commission Co-Chairs

- Co-Chair David Catania called the meeting to order at 10:02 am.
- Co-Chair Sister Carol Keehan introduced herself and shared her priorities for the commission.

2. Commission Administration — Commission Co-Chairs

- Co-Chair Catania informed the Commission that Karen Dale, Dr. Raymond Tu, and Vincent Keane have been added to the Commission as non-voting members.
- Co-Chair Catania introduced Eric Wolff who has offered his assistance with data collection and analysis
- Co-Chair Catania circulated a draft report for subcommittees to use. He indicated that the goal was to create a consistent template for all subcommittees to fill out.
    - Dr. Barbara Bazron requested clarity about whether each subcommittee is expected to do a sustainability plan.
        - Co-Chair Catania indicated that this item was to encourage subcommittees to think about different types of sustainability – financial, environmental, infrastructure – as the recommendations are developed.
    - Co-Chair Catania requested members send any additional feedback after the meeting.
- Co-Chair Catania shared that subcommittees are already having robust conversations and indicated that the relationships formed during this process is one of the biggest benefits to these conversations. He hopes that these relationships continue beyond the Commission's time.

3. Presentation by the Department of Health Care Finance DHCF

- Deputy Mayor Wayne Turnage introduced his presentation as a foundation setting presentation by the core parts of our government, focusing on what the problems are from a government perspective. He worked with DC Health, Department of Health Care Finance, and the Deputy Mayor's office to provide a high-level overview of the system, including patient utilization, structure, and challenges faced by Medicaid and providers. Medicaid is a focus at the end due to its significant impact on the system.

The District Of Columbia's Hospital Sector Is A Nationally Recognized System of Care But Most Beds Are Concentrated In The North West Quadrant Of The City [4]

Hospitals	Licensed Capacity	Operating Capacity	Beds In Use	Location	Percent of Total Beds
Tertiary Hospitals					
George Washington	365	365	365	NW	
Georgetown – MedStar	609	425	425	NW	61%
Howard	470	225	225	NW	
Washington Hospital Center – MedStar	912	745	745	NW	
			1760		
Secondary Community Hospitals					
Sibley	282	194	194	NW	14%
United Medical Center	210	210	210	SE	
			404		
Specialty Hospitals					
Children's National	313	313	313	NE	
Psychiatric Institute of Washington	130	130	130	NW	25%
St. Elizabeths	292	292	292	SE	
			735		

Note: This list excludes Hospital for Sick Children (merger with Children's National), Bridgepoint's sub-acute hospitals which provide rehabilitation and nursing home care, and the MedStar National Rehabilitation Center which specializes in rehabilitation care.
Source: Information on District of Columbia health facilities' total numbers of operating and licensed beds was collected by the District of Columbia Hospital Association and shared with the State Health Planning and Development Agency (SHPDA) in January 2019

- Hospitals are a focus of any health care system. In the District, a substantial portion of the beds reside in the NW quadrant of the city. 14% of the beds belong to secondary hospitals and 25% are specialty beds.
- We use two capacity measures for hospital beds – licensed and operating – and these two are not always equal.

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Compliments To Hospital Care

- In addition to its hospital assets, the District health care system offers the following:
  - More than 50 primary care clinics and 34 are community health centers hat accept walk-in patients with at least half of these facilities offering evening and weekend hours
  - Seven of these clinics are federally qualified health centers that offer primary care, dental, mental health and substance abuse services
  - On a per-capita basis, the highest number of active physicians, direct patient care physicians, specialty, and primary care doctors in the United States

- DHCF recently redesigned payment methodology for FQHCs

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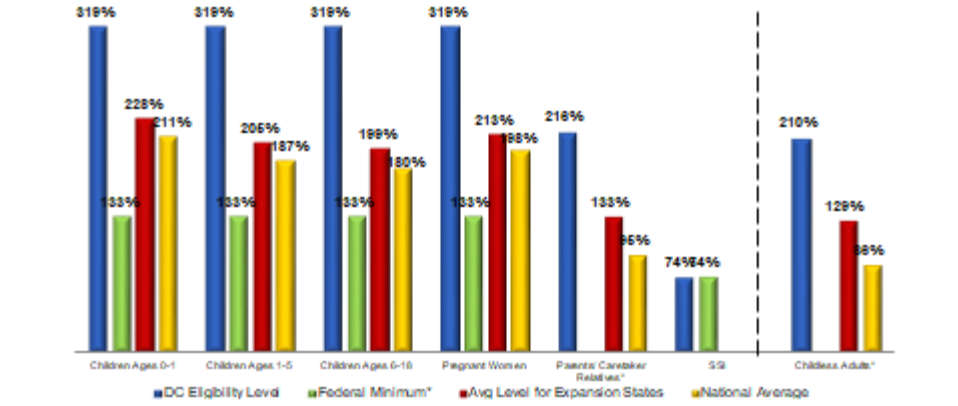
Insurance Coverage Is Not A Problem In The District of Columbia

- District has embraced the view that health care access is a right
- Leveraged partnership with federal government and was an early expansion State
  - Aggressive set of policies to expand Medicaid insurance coverage for its residents
  - High functioning insurance exchange that mandates coverage and facilitates access to federal premium tax credits for commercial coverage
  - Result = 97% of residents have health insurance - 2nd in the Nation
- Virtually same coverage as Medicaid for approximately 15,000 residents who are not citizens

- Insurance coverage isn't a problem in the District. We were an early entry into Medicaid expansion and implemented an aggressive set of policies to expand coverage for as many residents as we could. In addition, we initiated a high functioning health insurance exchange and have since implemented a mandate despite federal changes.
- Because of Medicaid expansion and the Exchange, 97% of residents in the District have insurance. We also provide coverage to non-citizen residents.

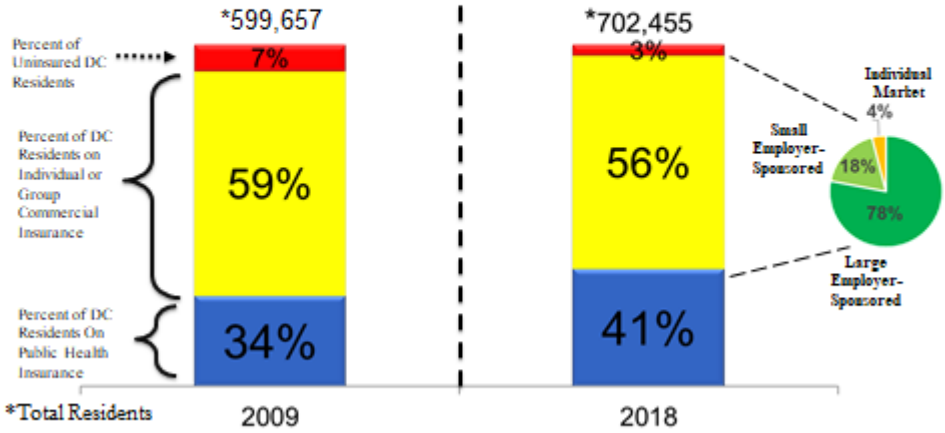
The District's Eligibility Levels Exceed Federal Requirements And Statewide Averages



Source: Centers for Medicare and Medicaid Services State Medicaid and CHIP Income Eligibility Standards, updated June 2016.

- This slide compares the District to rest of country, with the blue bars representing the District. We compare favorable to the rest of the country in terms of insurance.

Though Most DC Residents Have Commercial Coverage, Nearly Four in 10 District Residents Rely on Public Health Insurance – This Has Payment Implications For Providers



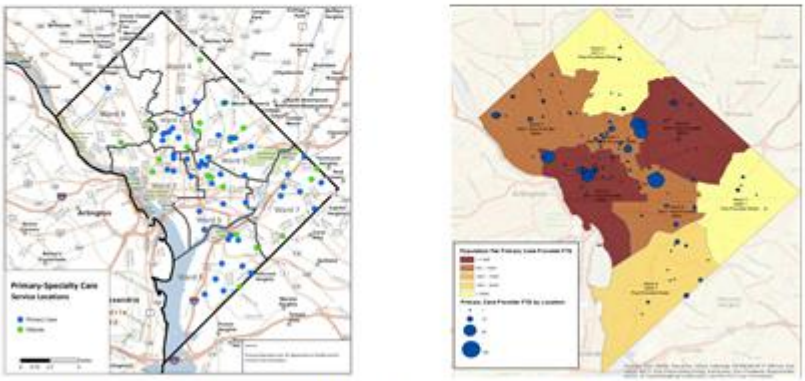
Source: District population estimate from 2009 and 2018 United States Census Bureau
Commercial insurance data is as of July 2019
Medicaid and Alliance data reported from DHCF's Medicaid Management Information System (MMIS).
Note: These data exclude some District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated.

- The impact of these policies is that policies is that Medicaid coverage has grown and uninsured rates have decreased between 2009 and 2018.
- On the commercial insurance side, a majority of the coverage is large employer, with smaller percentages of small employers and individual through the exchange.

- There is interplay between commercial insurance and Medicaid – with expansion to approximately 83,000 childless adults, we have taken the most expensive people of the commercial pool.

Primary Care Services Are Heavily Located In Two Wards But Generally Available Across The City [12]

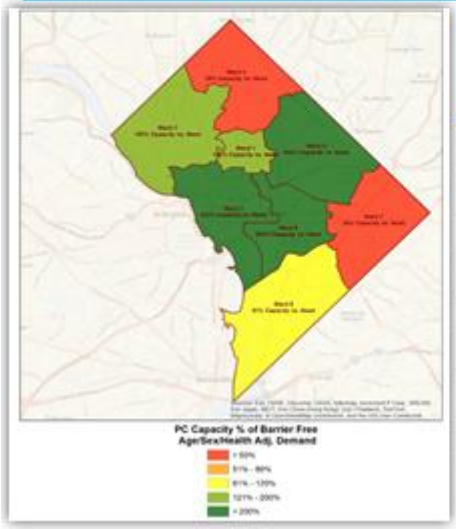
- *DC = 240 Active Primary Care Physicians/100,000
- *US rate = 91 Active Physicians/100,000



Source: July 1, 2016, population estimates are from the U.S. Census Bureau (released December 2016). Physician data are from the 2017 AMA Physician Masterfile (December 31, 2016). Reported in 2017 State Physician Workforce Data Report Section 1: Physician Supply

- Primary care is spread across the city, but heavily concentrated in Wards 2 and 5
- The second map indicates capacity for a given location – in Wards 3, 7, and 8 there is evidence of primary care operations, but they are not as numerous or as big.

For Residents in Three Wards, The Capacity For "Barrier Free" Primary Care Visits Relative To Need Is Sufficient But Among The Lowest In The City [13]



Geography	Population per PC Provider FTE	Capacity as % Barrier-Free Visits
Ward 1	884	160%
Ward 2	262	523%
Ward 3	822	165%
Ward 4	3,271	39%
Ward 5	378	338%
Ward 6	503	264%
Ward 7	4,358	30%
Ward 8	1,610	81%
DC Total	667	197%

- This slide shows the capacity of primary care operations against potential need, if everyone in a ward went to a primary care visit at least once a year in their ward.
    - Barrier-free visits are very high in wards 1 and 2, and low in wards 4, 7, and 8. This demonstrates that if everyone went to the doctor as recommended, there would be stress on the wards with low capacity.
        - Would be stress on the wards low– seeks to

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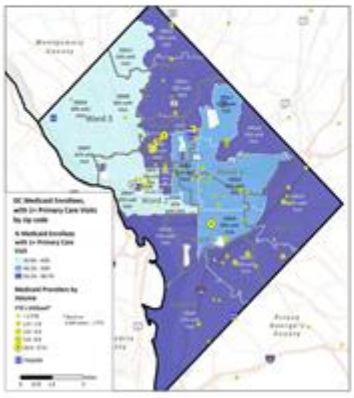
Primary Care Engagement By DC Medicaid Enrollees -- Including Well Child and Preventative Care -- Is Low, Falling Just Below 60 Percent Overall



Source: The annual EPSDT report (form CMS-416).

- Medicaid seeks to increase patient engagement with primary care.

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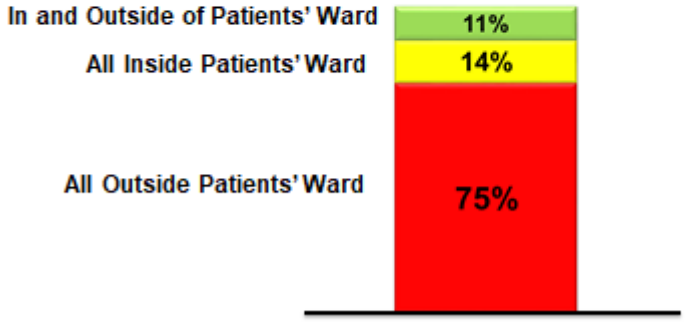
Neither Is Primary Care Usage Defined By Geography Or Travel Time For Medicaid Patients

Where Was Primary Care Received?



Source: DC Health

- This slide shows where Medicaid patients receive their care. Usage is not defined by geography as 75% of beneficiaries get their care outside of their ward.

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Key Primary Care Takeaways

- DC Network consists of well-distributed FQHCs, hospital-based, private, and primary care practices
- DC has the highest rate of primary care physicians in the nation
- Isolated gaps may exist but clinic capacity is not a leading issue
- At 60 percent, primary care engagement is low for Medicaid enrollees
- Medicaid recipients opt to travel significant distances to access primary care services, despite the fact that there are access points in their communities

There Are 3,161 Licensed Beds In The City's Acute Care Health Care System (Excluding Providence), But Only Three Hospitals Have Their Full Complement Of Beds In Service

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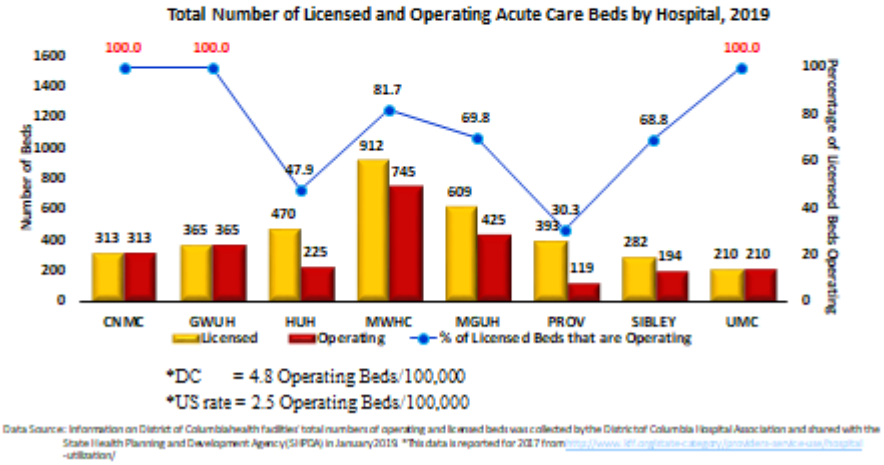
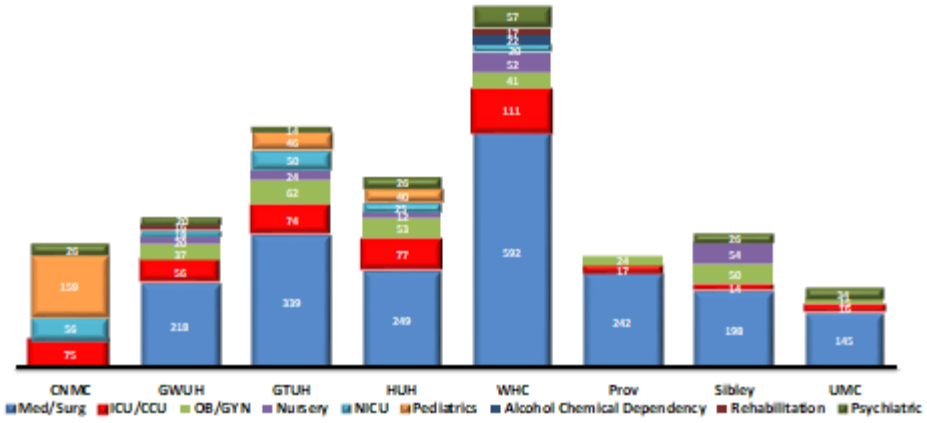


Data Source: Information on District of Columbiahealth facilities' total numbers of operating and licensed beds was collected bythe District of Columbia Hospital Association and shared with the State Health Planning and Development Agency(SHPDA) in January2019. *This data is reported for 2017 from http://www.ahrf.org/state-data-by-topic/conditions-services/hospital-utilization/

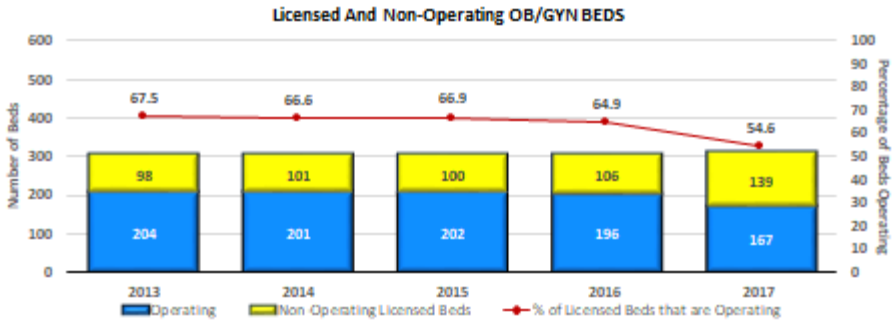
- This slide shows licensed beds compared to the operating beds in hospitals across the city. There are a total of 3,161 licensed beds, but only three hospitals have their full complement of beds online: Children's, George Washington, and UMC.

For Most Hospitals, The Critical Care Service Line Accounts For The Largest Portion Of Their Licensed Specialty Beds



Data Source: Health Regulation and Licensing Administration, DC Health Data as of 8/6/2018

With The Closure Of Providence, The Termination Of The OB/GYN Service Line At UMC, And Business Decisions By Other DC Hospitals, The Proportion Of Licensed OB/GYN Beds In Operation Has Declined By Almost 20 Percent



Data Source: Information on District of Columbia health facilities' total numbers of operating and licensed beds was collected by the District of Columbia Hospital Association and shared with the State Health Planning and Development Agency (SHPDA) in January 2019.

For Similar Reasons, The Proportion Of Operating Psych Beds Have Also Declined

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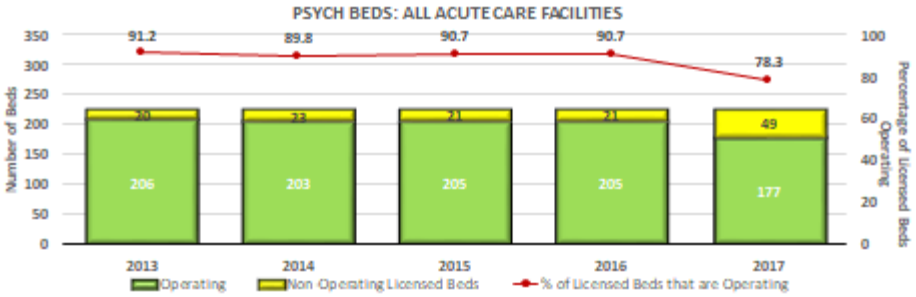

Data Source: Information on District of Columbia health facilities' total numbers of operating and licensed beds was collected by the District of Columbia Hospital Association and shared with the State Health Planning and Development Agency (SHPDA) in January 2019.

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- The decline in psych beds is a critical issue when we look at the incidence of people dealing with behavioral health issues that require treatment for psychiatric care.

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However, Except For UMC, Distances Patients Are Traveling For Hospital Services Are Similar And Are Comparable To National Patterns

FIGURE 11: DC HOSPITAL DISCHARGES – DESTINATION AND PREFERENCE % BY ZIP CODE ORIGIN

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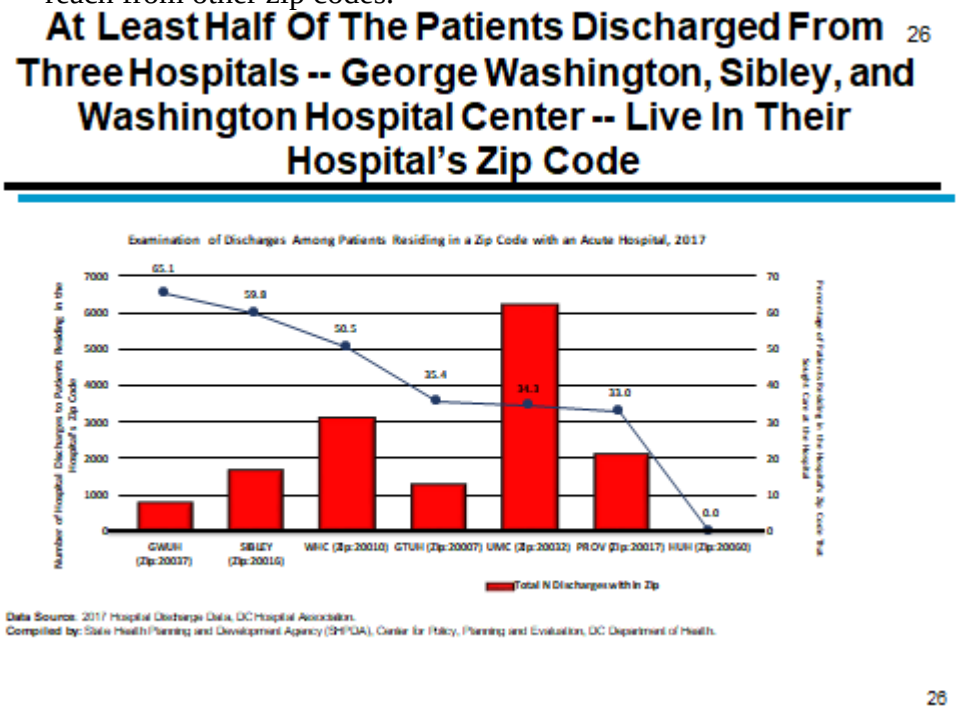
- Hospitals are concentrated in the NW quadrant of the District, and with the exception of UMC, the distances people are traveling for care is similar to the national pattern.
    - The lines of this map represent a starting point of where people live and then go for hospital care. The thicker the line, the higher the volume coming from that zip code.

- There are not many lines around UMC, suggesting UMC does not have much reach from other zip codes.



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- This slide shows hospital care to patients in the zip code in which they are located, based on discharges.
    - At least 50% of discharges from GW, Sibley, and Washington Hospital Center (WHC) come from the zip code in which the hospital exists.
    - Howard didn't have any immediately in their area, which suggests a substantial opportunity to engage patients around them.

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Key Takeaways On Capacity

- District hospitals have significant amounts of unused licensed bed capacity
- Operational bed capacity in DC is nearly twice the national average
- Medical/Surgical beds account for nearly half of all hospital beds and critical care beds represent the largest share of specialty beds
- Recent market place changes and associated capacity reductions have created challenges for two key specialty areas – psychiatric and OB/GYN services

Utilization Of DC Health Care System Is Hospital Centric, Ranking 1 in The Nation On Key Metrics

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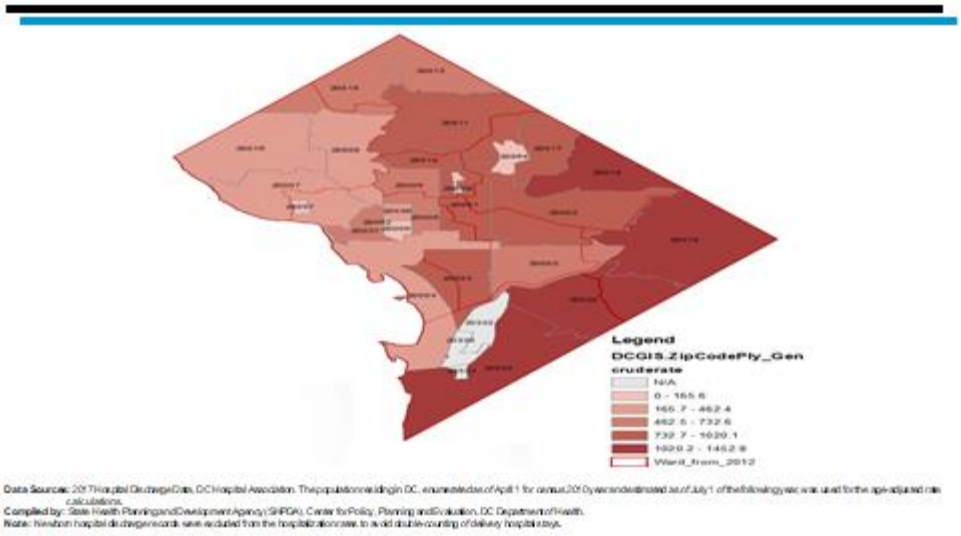
Hospital Metric	National Rate (per 1,000 population)	District Rate (per 1,000 population)	District's National Ranking
Hospital Operational Beds	2.5	4.8 (+92%)	1
Hospital Admissions	105	187 (+78%)	1
Emergency Room Visits	455	698 (+53%)	1
Inpatient Days	572	1,293 (+126%)	1

Note: This data is reported for 2017.
Source: http://www.kff.org/state-category/providers-service-use/hospital-utilization/

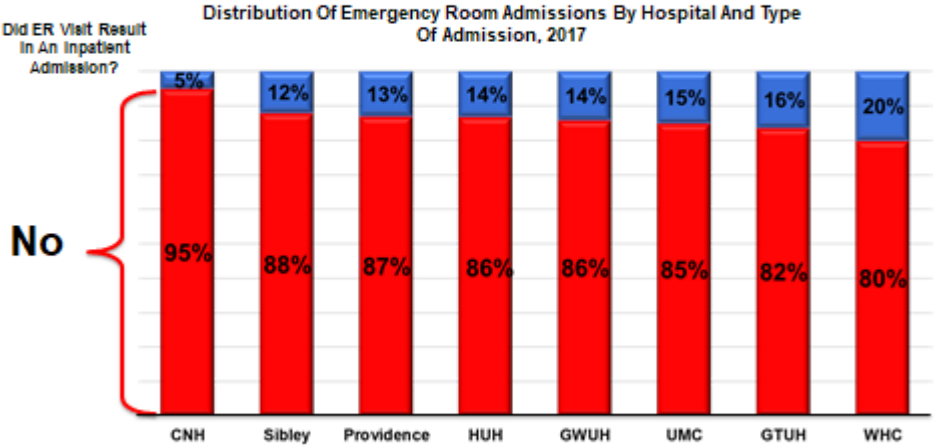
- The District's health care system quite hospital centric, ranking number 1 by a long shot.

Hospitalization Rates (Per 10,000 Population), Are Highest In East End Of The City, 2017

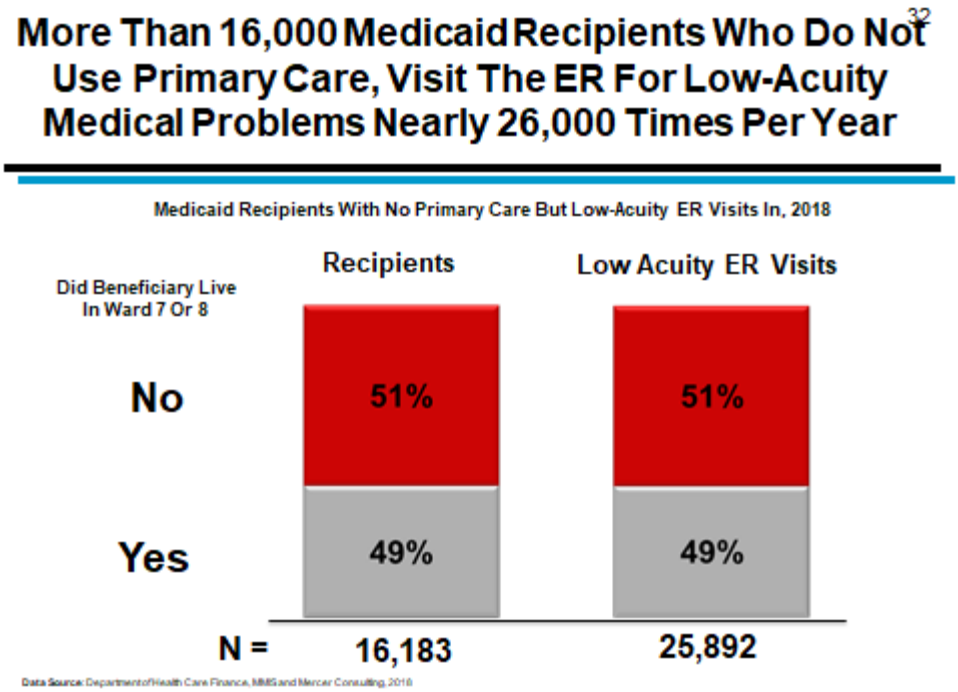


- This slide shows hospitalization rates across the city, with darker areas, representing higher hospitalizations. The east end of the city has highest rate of hospitalizations.

Notwithstanding The High Levels Of ER Use, Most Such Visits Do Not Require Or Result In An Inpatient Admission

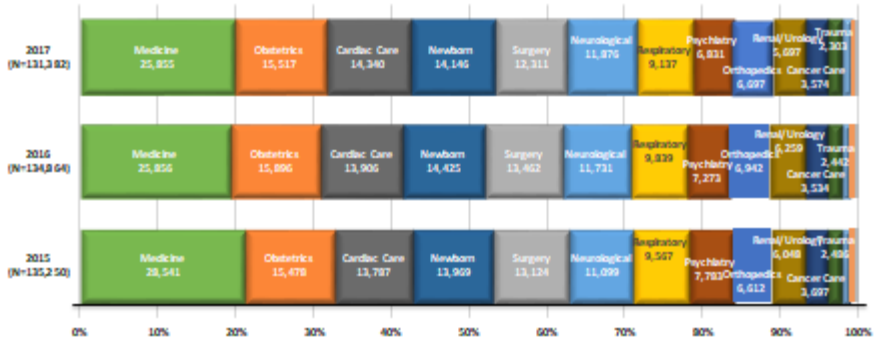


- There is heavy use of ER, but ER use does necessarily result in high rate of inpatient admissions. 85-95% of ER visits do not result in inpatient admission. WHC has highest conversation rate; and Children's has the lowest.
    - This indicates that a lot of the traffic going to emergency room should be diverted to address systemic problems.



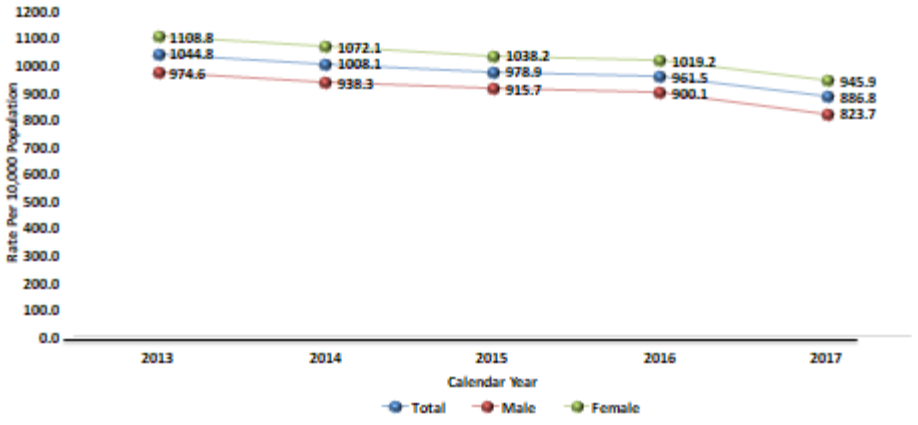
- DHCF looked at if there are Medicaid patients who have no primary care physician (PCP) relationship, but go to ER for low-acuity medical problems. It is fine if people are going to the ER for a broken bone, but issues arise when they are going for issues that should be addressed by a PCP.
    - DHCF found that here are 16,000 Medicaid recipients who did not visit PCP, but went to ER for low acuity medical problem. This accounts for almost 26,000 ER visits that likely should have been seen at one of the primary care clinics.
    - 50% of these beneficiaries live in ward 7 or 8 where there is sufficient, underutilized primary care.

Broadly Speaking, Four Service Lines Account For More Than Half Of All Hospital Discharges



Data Source: 2015-2017 Hospital Discharge Data, DC Hospital Association.
Compiled by: State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health.
Note: The figure includes all inpatient hospital discharges. Medicine means Medical-Surgery

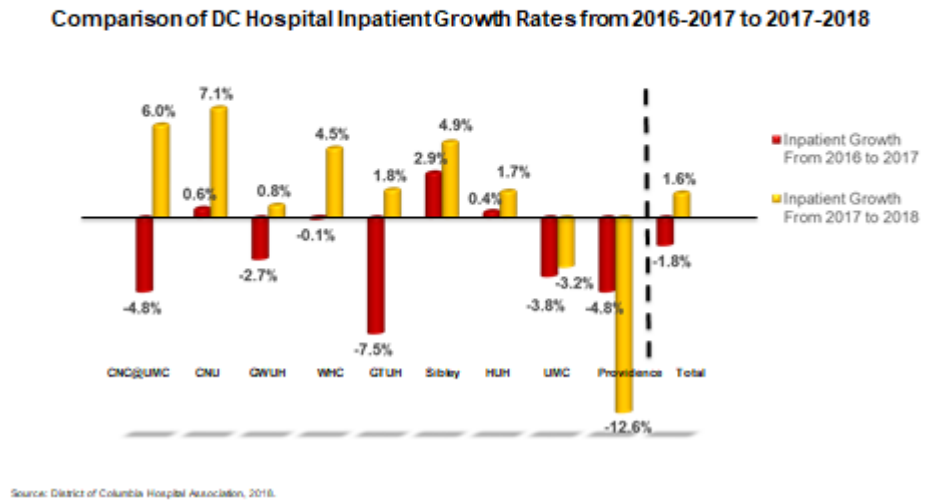
Yet, Age-Adjusted Hospitalization Rates Show A Declining Trend In Hospital Discharges, Overall And For Men and Women, 2013-2017



Data Sources: 2013-2017 Hospital Discharge Data, DC Hospital Association. The population residing in DC, enumerated as of April 1 for census 2010 year and estimated as of July 1 of the following year, was used for the age-adjusted rate calculations.
Compiled by: State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health.
Note: Newborn hospital discharge records were excluded from the hospitalization rates to avoid double-counting of delivery hospital stays.

- There was a steady decline in inpatient admissions between 2013 and 2017.

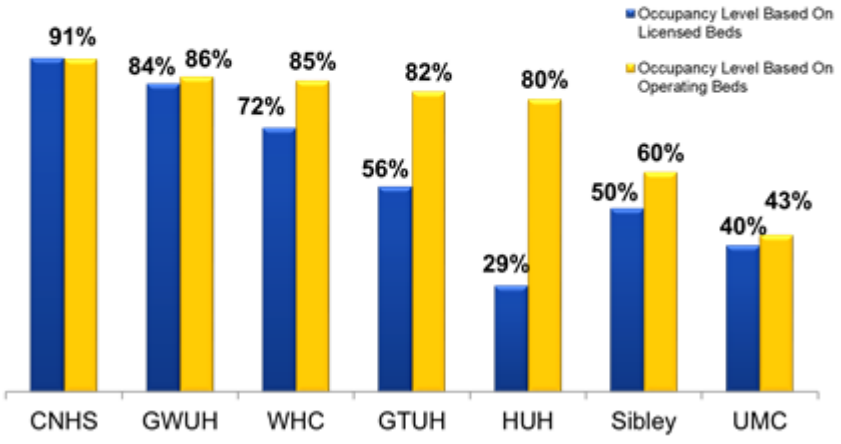
However, The Announced Plans For The Closure Of Providence In July 2018, Appears To Have Pushed Segments of That Market To Washington Hospital Center, Sibley, And Children's National [36]



Source: District of Columbia Hospital Association, 2018.

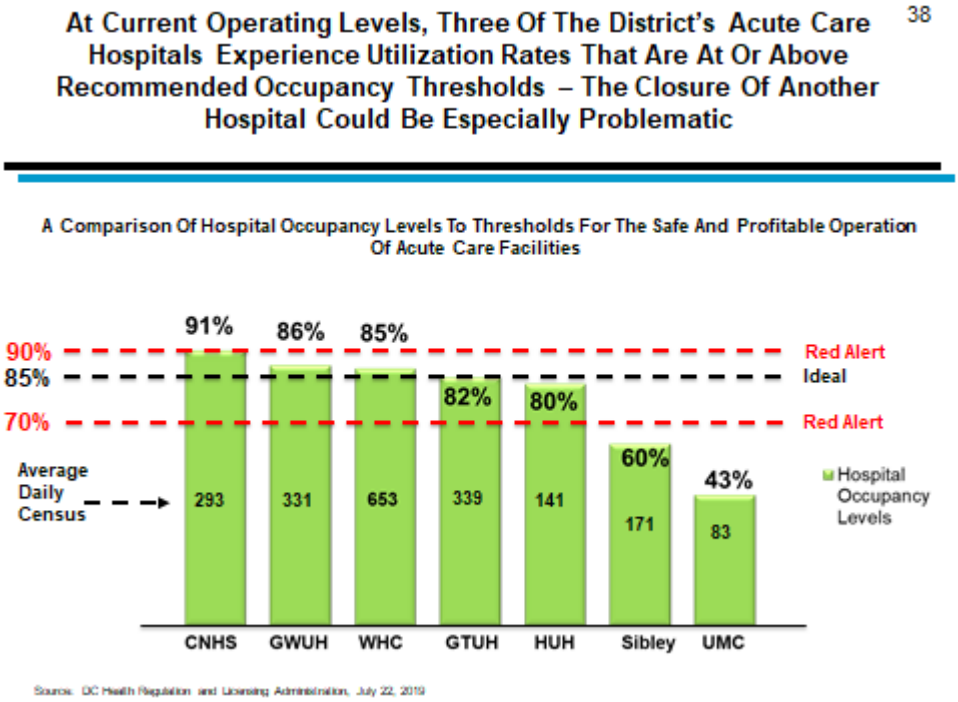
- When Providence closed, admission numbers flipped for several hospitals. There was an increase at Children's, UMC, and WHC, as well as a slight increase at GW.
- Total inpatient growth was only 1.6%, but there is a maldistribution of patient care with respect to inpatient admissions, which has resulted in some hospitals experiencing overcrowding.

Data Examined Since The Providence Closure, Show That Hospital Occupancy Rates For Some Facilities Vary Significantly Based On The Metric Of Licensed Versus Operating Beds [37]



Source: DC Health Regulation and Licensing Administration, July 22, 2019

- Looking at occupancy levels for both licensed and operating beds since Providence closure:
    - Children's and GW have no difference because all their licensed beds are operating.
    - WHC, Geogetown, and Howard have a big difference in their occupancy rates due to the gap in licensed vs. operational beds.
    - UMC doesn't have a big gap, but they also do not have a lot of inpatient admissions.



- Hospitals should have an occupancy rate around 85%. If it is above 90%, hospitals should be concerned about their ability to manage patients, while if it is below 70% hospitals should be concerned about losing money.
    - Three hospitals have rates at or above the recommended threshold. If we have another closure in the city, it could be especially problematic due to these occupancy rates.

Also, As A Part Of The Market Shift From The Providence Closure, PIW Now Faces Increased Demand For Beds To Treat Persons Who Have Been Involuntarily Committed

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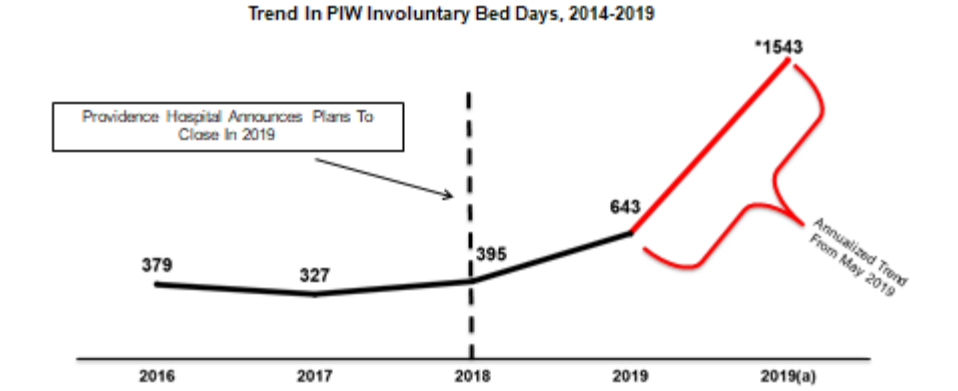

*Notes: This figure is an annualized estimate using actual data through May 12, 2019.
Source: PIW Hospital

- When Providence announced their closure, inpatient bed days at PIW began to spike. If they continue at the same pace, we project they will have 1,500 bed days by the end of this year.
    - There is also a challenge of payment for adults in Medicaid, which DHCF is working to fix as the operating expense for PIW is growing immensely.

Similar Shifts Are Evident When PIW Psychiatric Stabilization Encounter Data Are Examined

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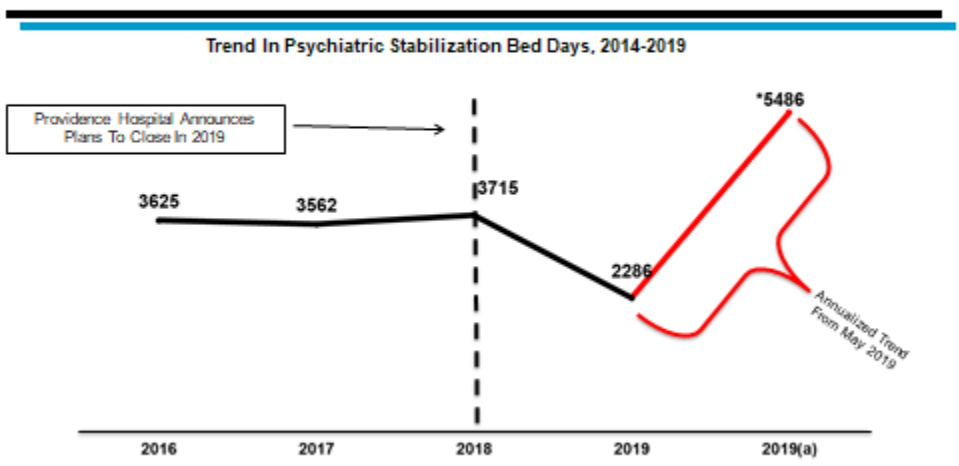

*Notes: This figure is an annualized estimate using actual data through May 12, 2019.
Source: PIW Hospital

- Similarly, PIW is projected to hit 5,486 psychiatric stabilization encounter bed days by the end of the year.

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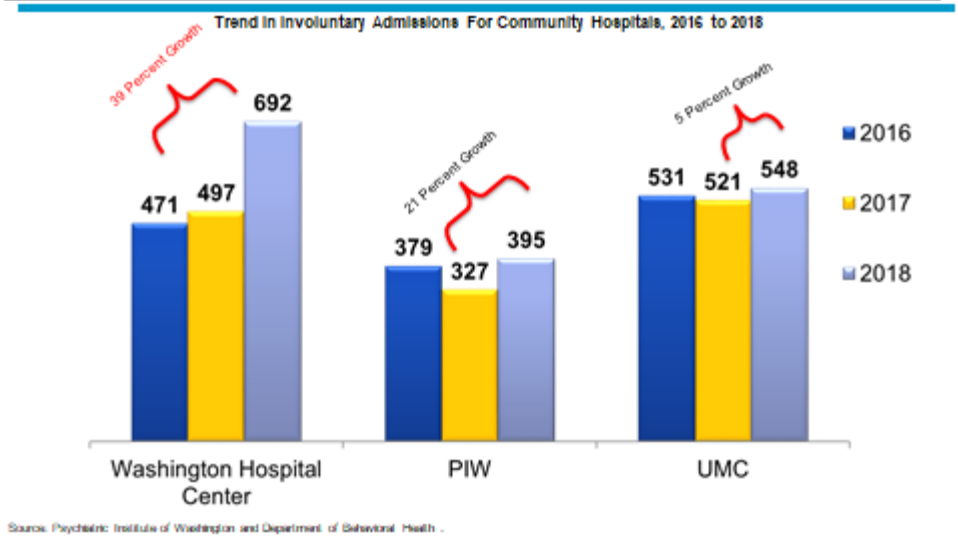
Washington Hospital Center Witnessed A Precipitous Increase In The Number Of Involuntary Admissions Following The Closure of Psychiatric Beds At Providence



Source: Psychiatric Institute of Washington and Department of Behavioral Health .

- WHC witnessed a precipitous increase in the number of involuntary admissions following the closure of psych beds at Providence. Through the 1115 waiver, we are trying to purse a model to move out of DRG hospitals and move into CPEP type operations across city.

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Key Inpatient Takeaways

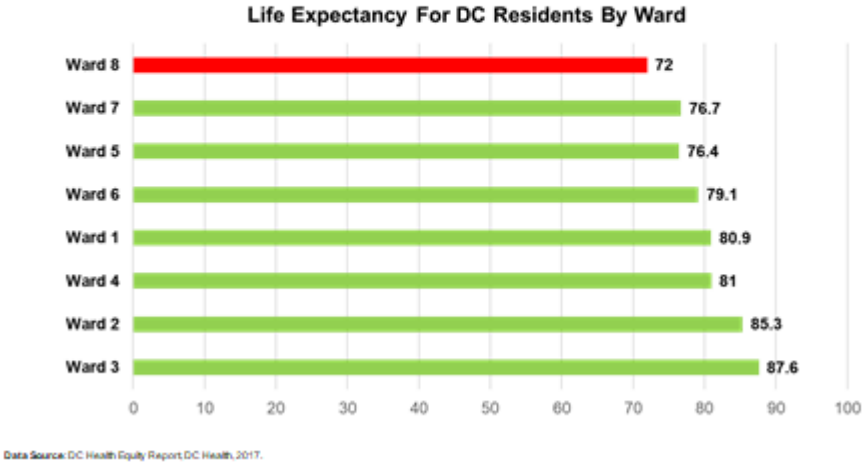
- DC residents are profligate consumers of hospital-based services, ranking the District first in the nation against every major metric of hospital use
- In the process, many residents eschew the use of primary care treatment, instead choosing to use the emergency room as their entry point for health care, even for low-acuity illnesses
- Still, hospital inpatient growth trends are relatively flat, but the closure of Providence and historically low volumes at UMC, have spawned maldistribution problems for several hospitals, most of which have chosen to operate at less than their licensed capacity
- In part, because of decisions by most DC hospitals to operate at less than their licensed bed capacity, several acute care operations have occupancy rates that fluctuate beyond the ideal capacity level of 85%
    - As a result, the hospital market could not easily absorb the closure of another acute care facility at current operating capacities

Sharp Differences In Health Outcomes Exist in DC Wards 7 and 8[44]

- African-Americans are disproportionately impacted by chronic diseases like high blood pressure, diabetes, and asthma
- Rates of preventable and early detectable cancers (breast, cervical, lung, colon, and liver) are higher in African-Americans, Latino residents, and residents in Ward 5, and, most especially, in Wards 7 and 8
- There is an established association between nine key drivers and health outcomes in DC – Education, Employment, Income, Housing, Transportation, Food Environment, Medical Care, Outdoor Environment, and Community Safety
  - Ward 7 and 8 residents typically compare unfavorably on these measures to their peers citywide

- When we look at key drivers for health outcomes, residents in wards 7 and 8 compare unfavorably on measures by a large margin compared to their peers citywide.

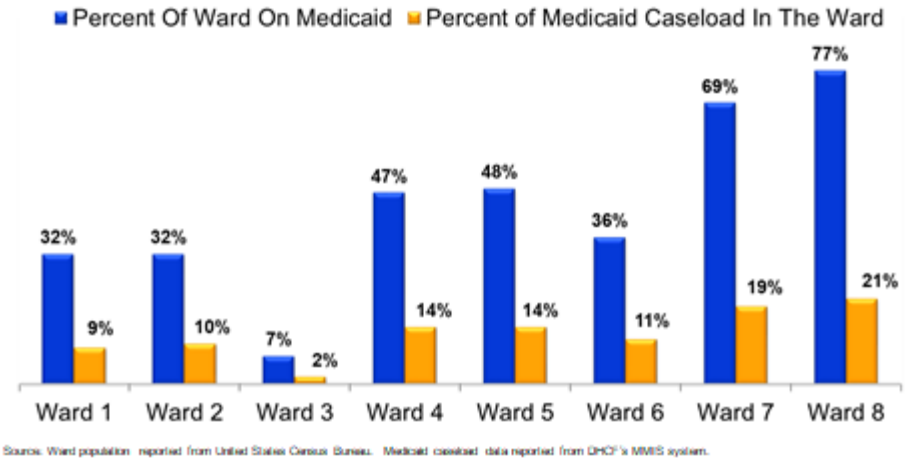
The Impact Of These Disparities Is A Significantly Reduced Life Expectancy For The Residents Of Ward 8[45]



Data Source: DC Health Equity Report,DC Health, 2017.

Medicaid Enrollment Levels -- A Proxy For Poverty Thresholds Within Each Ward Of The City -- Reveal The High Concentrations Of Poverty In Wards 7 & 8, And Have Direct Implications For Provider Payments

46



Source: Ward population reported from United States Census Bureau. Medicaid caseload data reported from DHCF's MMIS system.

- Using Medicaid eligibility as a proxy for poverty, Wards 7 and 8 are almost entirely captured in poverty – nearly 80% in Ward 8 and 70% in Ward 7. This has implications for the health of residents, but also for providers seeking to provide care in these Wards.
    - Medicaid rates are limited by an upper payment limit, and while managed care plans negotiate with hospitals, there is recognition that they are public plans in these negotiations.

47

Although The Residents Of Wards 7 & 8 Have The Highest Morbidity Levels In The City, They Do Not Have Access To An Organized And Integrated System Of Care

- The absence of a system of care in Wards 7 and 8 has undermined the operation of the area's only acute care hospital

- No referral network from primary, urgent or specialty care providers.
    - This echoes through the hospital's finances, making if difficult for UMC to operate without the benefit of a public subsidy

- When combined with the hospital's other challenges -- brand issues, aging and obsolete infrastructure, no outpatient business model -- UMC continues to struggle with issues around patient volume

- One of the biggest tragedies of health care system is summarized on this slide: Wards 7 and 8 have the highest morbidity levels and do not have access to an organized and integrated system of care.
    - There is no real referral network, which echoes through finances of UMC. UMC also has brand issues, an aging and obsolete infrastructure, and no outpatient business model.
    - The subsidy UMC has received since the time it was created is massive.

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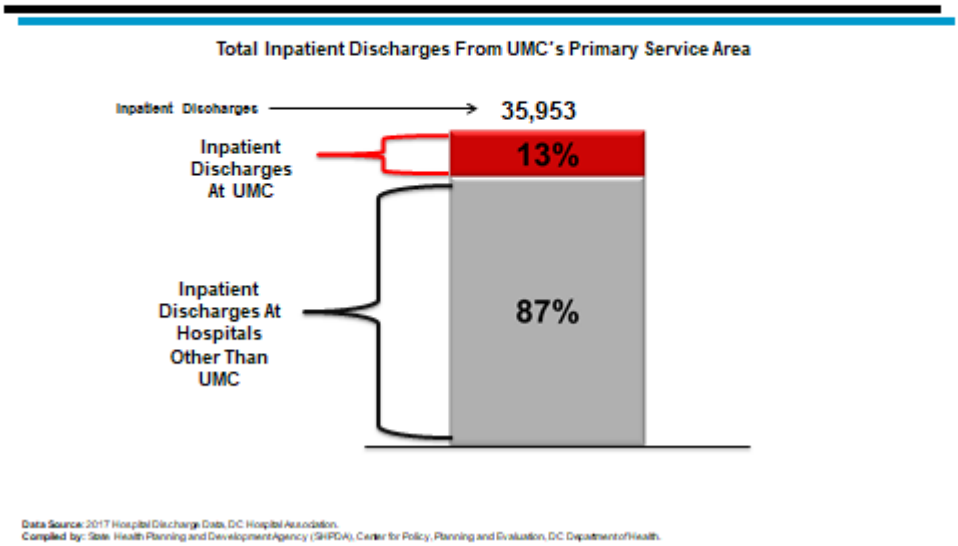
Presently, As A Result, UMC Only Draws 13% Of The Discharges From Its Primary Service Area



Data Source: 2017 Hospital Discharge Data, DC Hospital Association.
Compiled by: State Health Planning and Development Agency (SHPDA), Center for Policy, Planning and Evaluation, DC Department of Health.

- UMC only has 13% of the discharges from their primary services area.

With An Underperforming Hospital And No Outpatient Specialty Care In East End, This Means Most Medicaid Spending On Secondary And Tertiary Care For Residents In Wards 7 & 8 Escapes UMC

49

Note: Medicaid and Alliance spending are included in these totals and they reflects payments made to providers in CY2018 for managed care and fee-for-service members for inpatient, outpatient, and non-primary care physician services.
Source: Medicaid Management Information System (MMIS) and United Medical Center Not-For-Profit Hospital unaudited cost report CY2018 from OCFO

- Medicaid has spent almost $600 million on residents of ward 7 and 8 health care, but UMC has only received 6% ($34m) of this – almost all of this spending went to other hospitals.

Key Takeaways Regarding Health Care In The City's East End

50

- ❑ Although home to the District's sickest residents, there is not workable system of care in Wards 7 and 8
- ❑ This causes many to seek health care outside of their neighborhoods in large numbers and often in a very inefficient manner, thus exacerbating the present challenges in the District's health care system
- ❑ Moreover, those who remain and seek care from the hospital, typically rely upon on Medicaid to pay for their care, reducing the per-person payments UMC can expect relative to patients with commercial insurance
- ❑ These problems must be directly addressed in any effort to build a reliable and sustainable system of integrated care in the East End of the city.

50

Key Takeaways Regarding Health Care In The City's East End

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52

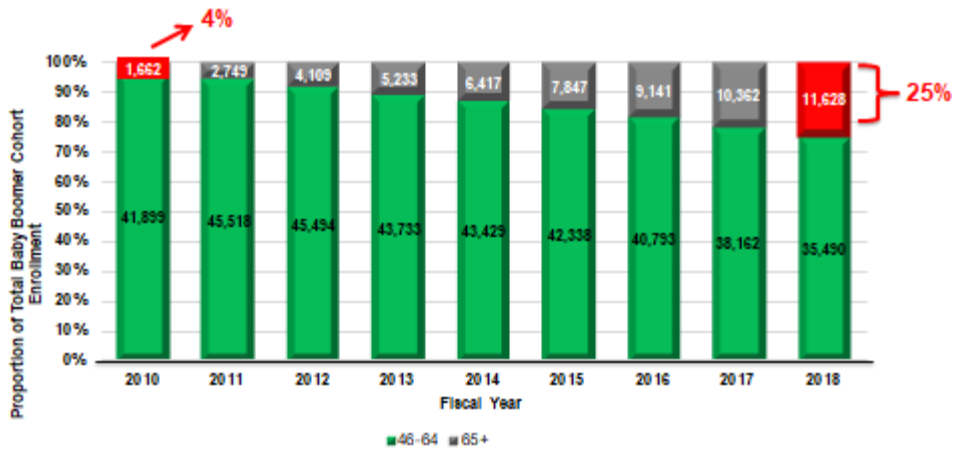
Medicaid Overview And Challenges

- DHCF has set 3 priorities for the Medicaid/CHIP, Alliance and Immigrant Children programs:
  - Build a health system that provides whole person care
  - Ensure value and accountability
  - Strengthen internal operational infrastructure
- Key Challenges:
  - Aging of Medicaid and Alliance Populations
  - Fee-for-Service members with chronic health challenges and inappropriate use of health care resources
  - Behavioral health needs
  - Alliance cost growth and demographic changes

- Medicaid has three major priorities, listed on this slide, under the leadership of Melisa Byrd. There are also several key challenges facing the Medicaid program.

55

Baby Boomer Generation Are A Growing Share Of The Medicaid Program And They Will Require More Comprehensive Care

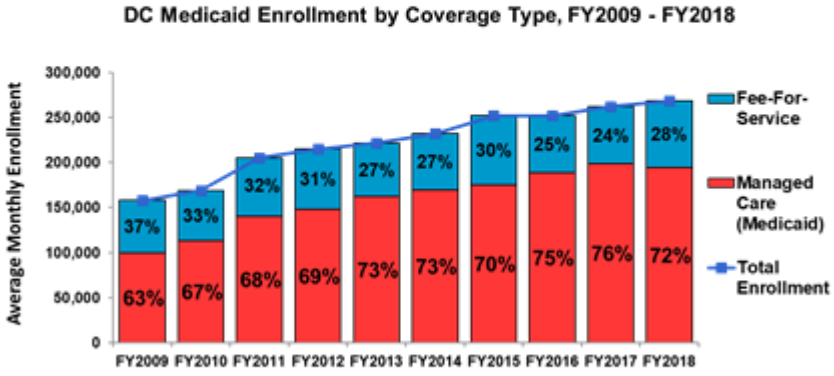


Source: DC Medicaid Management Information System (MMIS) beneficiary data extracted March 2019.
Note: Beneficiary age was calculated as of September 30 each fiscal year.

- The Baby Boomer population within the Medicaid program has increased by a factor of seven.

16

Nearly Three-Fourths of Medicaid Enrollees Are In The Managed Care Program But Plans Are To Grow This Number To Near 100 Percent



Source: DC Medicaid Management Information System (MMIS) beneficiary data extracted February 2019.

- Medicaid is increasingly becoming a managed care operation. The goal is to make completely managed care, and it is well on its way. A large proportion of current fee-for-service beneficiaries will be moved by 2022, then we hope to tackle long-term care members by 2023.

Despite Managed Care, Most Medicaid Visits To The Emergency Room Made By Health Plan Members Are For Low Acuity, Non-Emergency Conditions

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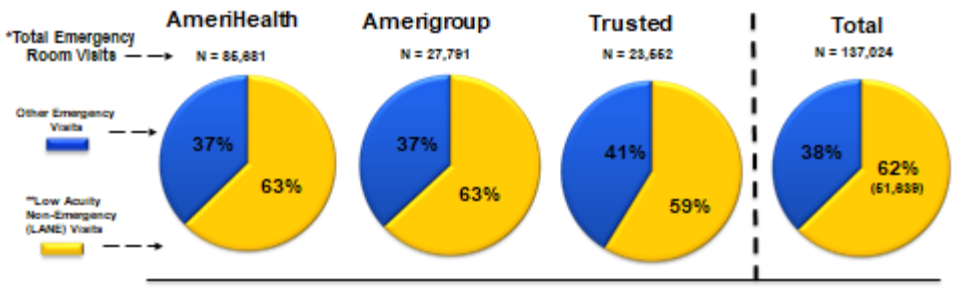

*Total emergency department visits consists of all visits to the emergency room regardless of diagnosis which did not result in an inpatient admission. **Low acuity non-emergency (LANE) visits are emergency room visits that could have been avoided based on a list of diagnosis applied to outpatient data.

Source: Encounter data submitted by managed care plans to Department of Health Care Finance

- In 2018, Medicaid members had 137,000 emergency room visits, 60% of which were low acuity. This needs to be addressed.

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

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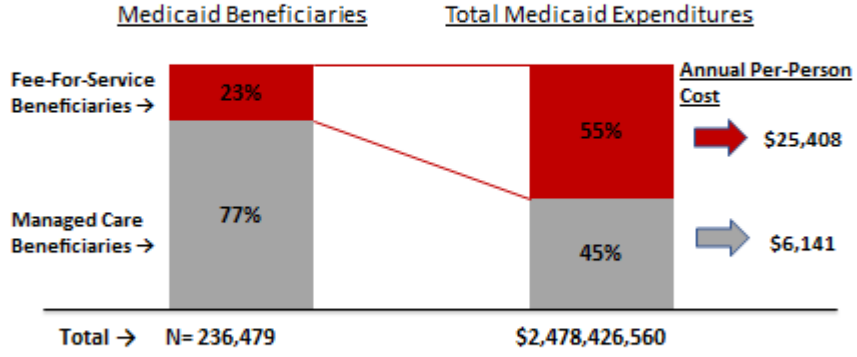

Source: Data were extracted from DHCF MMIS system.
Note: Only persons with 12 months of continuous eligibility in 2018 are included in this analysis.

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Top Ten Chronic Conditions For Fee-For-Service Beneficiaries Include Hypertension and Behavioral Disorders

Top Ten Chronic Conditions For FFS Children And Adults, FY18

Condition	Percent of total	Condition	Percent of total
Hypertension	53%	Behavior Disorder	18%
Hyperlipidemia	28%	Asthma	13%
Diabetes	28%	Allergy	12%
Depression	25%	Depression	7%
Personality Disorder	25%	Obesity	5%
Asthma	21%	Personality Disorder	5%
Osteoarthrosis	20%	Congenital	3%
Obesity	18%	Anxiety	3%
Peripheral Atherosclerosis	17%	Sickle Hypertension	1%
Other heart disease	14%		

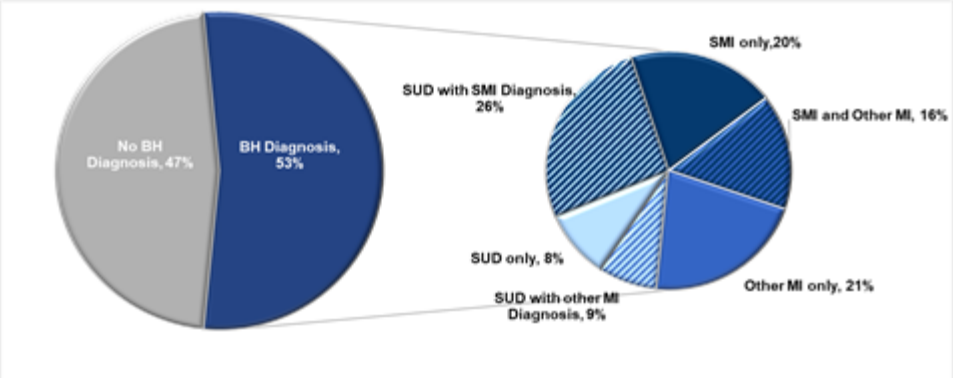
Source: DC Medicaid Management Information System (MMIS) data extracted in January 2019.

Note: FFS beneficiaries were identified as those with at least three MTM payments and no MCO payments in FY18. Children are defined as under age 21. Adults are at or above age 21. Examples of behavior disorders include eating disorders, conduct disorders, and attention deficit disorders.

60

More Than Half of Fee-For-Service Beneficiaries Have A Behavioral Health Diagnosis

Distribution Of Behavioral Health Diagnoses Among Fee-For-Service Beneficiaries, FY18



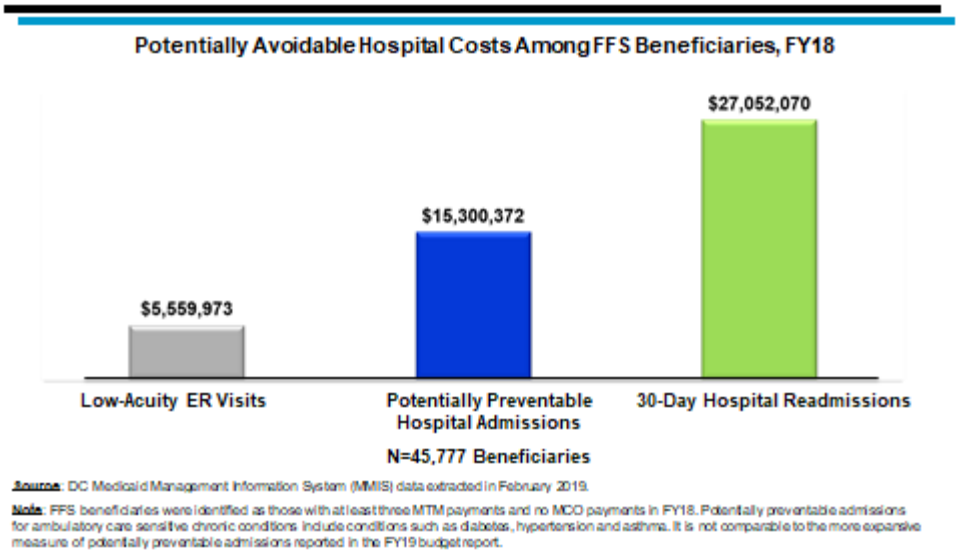
Source: DC Medicaid Management Information System (MMIS) data extracted in February 2019.

Note: FFS beneficiaries were identified as those with at least three MTM payments and no MCO payments in FY18. Behavioral Health Disorder (BH), Severe Mental Illness (SMI), Substance Use Disorder (SUD), Mental Illness (MI).

- More than half of fee-for-service beneficiaries have a behavioral health diagnosis. These patients are dealing with a system that is fragmented and difficult to understand.

61

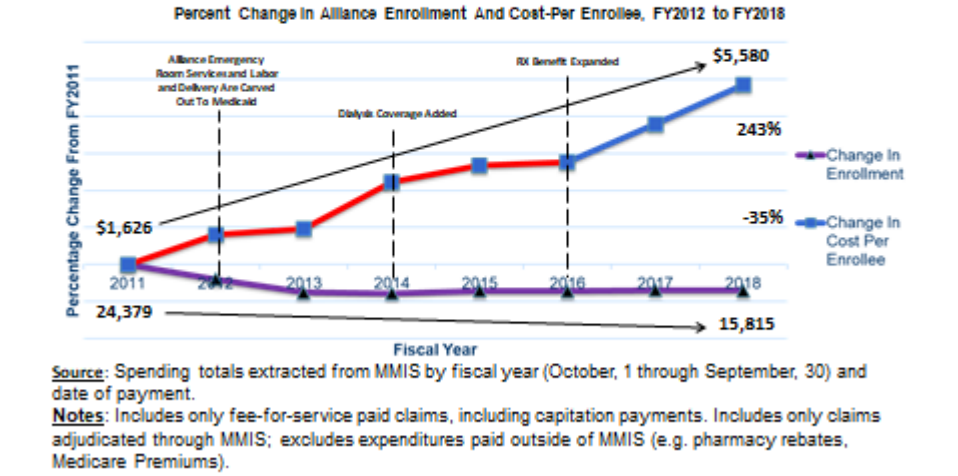
Nearly $50 Million Of The Medicaid FFS Costs Incurred In FY2018 Were Avoidable



- This slide shows the dollars we would have not spent if people used the system correctly – it was nearly $50 million in 2018.

62

Alliance Enrollment Growth Has Been Flat, The Cost Per-Enrollee Has Sharply Spiked



Source: Spending totals extracted from MMIS by fiscal year (October, 1 through September, 30) and date of payment.
Notes: Includes only fee-for-service paid claims, including capitation payments. Includes only claims adjudicated through MMIS; excludes expenditures paid outside of MMIS (e.g. pharmacy rebates, Medicare Premiums).

- While enrollment has decreased in Alliance, costs have increased. While some of this is due to coverage expansion, it does not explain all of the increase. The aging population is also an issue here. This is not sustainable, especially given that it is all local dollars.

Every Resident Should Have Access To An Integrated System Of Care, Regardless Their Zip Code

- Goal - create a streamlined, seamless coordinated system that delivers high-quality, high-value care, regardless of the point-of-entry in the system
- Elements of the Integrated System
  - Acute care hospital
  - Ambulatory specialty care facility on the campus with the hospital
  - Several urgent care facilities in the network of care
  - Contractual or referral agreements with primary care clinics in the PSA
  - Nexus to a nationally renown Level I Trauma Center
  - Modern IT platform to seamlessly link the elements of the system for patient management;

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- We believe that no matter where you live you should have access to integrated system of care. This includes the elements listed above.

Key Questions For Subcommittees

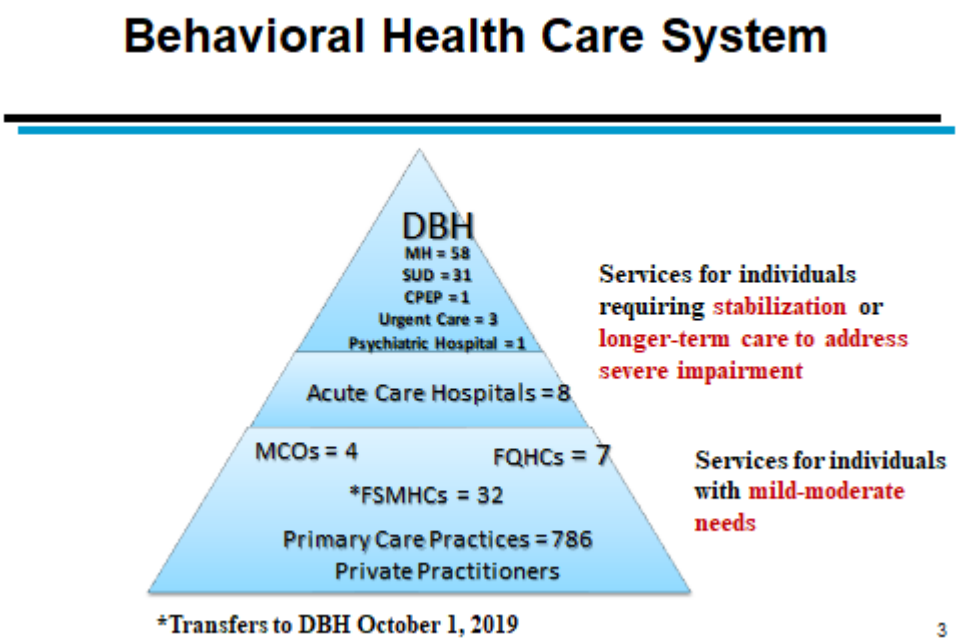
- What are the facilitators/barriers to the creation of integrated healthcare delivery systems in the District of Columbia relative to the work of your subcommittee?
- How can the issues addressed by your subcommittee facilitate access to an integrated healthcare delivery system for every resident of the District of Columbia?
- What factors internal to the healthcare delivery system pose the greatest risk of success to the recommendations from your subcommittee?
- What factors external to the healthcare delivery system pose the greatest risk of success to the recommendations from your subcommittee?

65

- This lists the key questions we believe subcommittees should consider as they develop their recommendations.

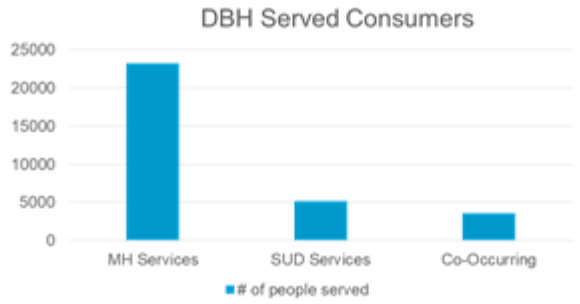
4. Presentation by the Department of Behavioral Health **DBH**

- Dr. Bazron stated that this presentation will provide a brief overview of system, individuals served, and issues that need to be addressed.



- Within DBH, we have mental health service providers, substance use providers, a crisis program, urgent care clinics, and one psychiatric hospitals
    - In addition, eight acute care hospitals accept patients for psychiatric crises stabilization, and managed care organizations (MCOs), Federally Qualified Health Centers (FQHCs), Free Standing Mental Health Clinics (FSMHC), and primary care practices also serve providers with mild-moderate problems
        - We need the system to provide good care coordination and linkages
        - FSMHCs will move to DBH October 1
    - When children's experience crises only Children's and PIW are available to them. Children often end up boarded in ERs and not admitted. This needs to be addressed and we are working with colleagues to try to open up access points.
        - Currently, we have to send children across the border to Maryland or to other states to get care.
    - DBH treats individuals regardless of ability to pay.

Residents Receiving Behavioral Health Services through DBH



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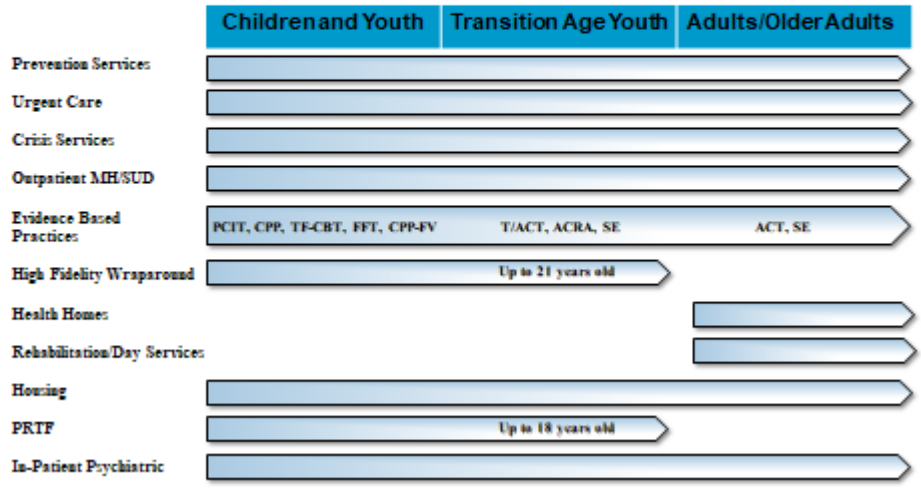
- DBH serves about 30,00 people throughout the system of care, about 16% of which have co-occuring disorders.

Range of Services Provided



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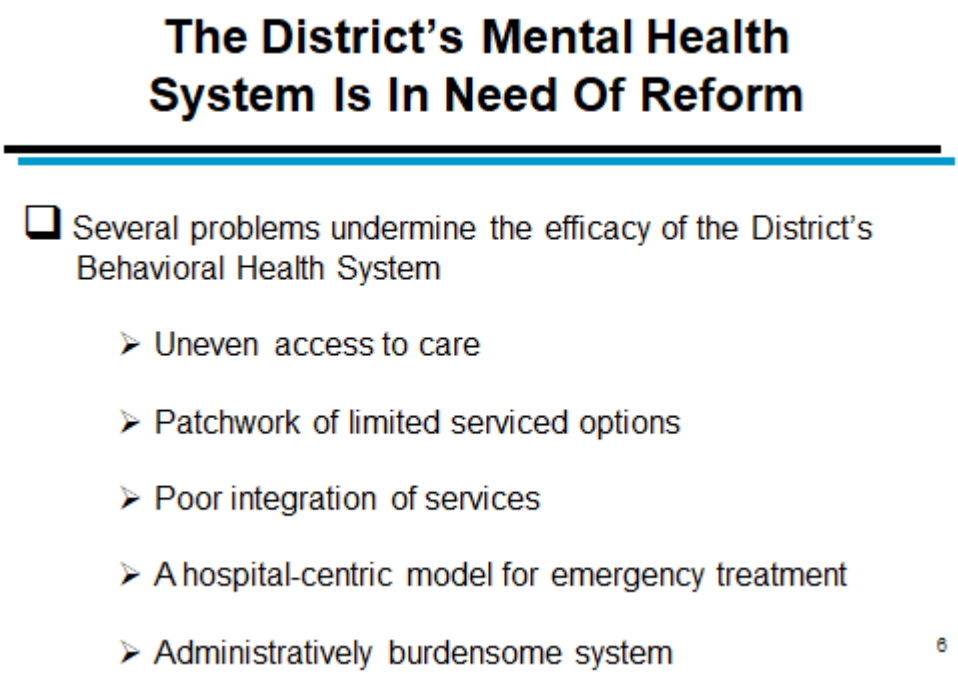
- DBH's goal is to promote recovery, respect, cultural and linguistic competence, choice-driven care. People must agree to come in to service delivery system, with the exception of those who are committed or FD-12 because they are a danger to self or others.
  - This means that, in terms of engagement, other barriers must be addressed.

- Services must be tailored to meet the needs of families, as well as individuals.
  - Young people exist within context of families and we can't treat children without thinking about families.
  - There are a range of services offered, from prevention through inpatient. We are looking at how we increase urgent care services and crisis services to decrease individuals using the ER as their service provider.



- There are several areas in need of reform, and we have made limited progress on this.
  - Uneven access to care: We need to get services where people are and accessibility across the network. With regard to this, we have made progress in the school-based mental health program. We are in 52 schools now, and will expand to 67 more next year.
  - Patchwork of service limited options: Need to get trauma informed services to people who need them, keeping in mind the needs of the entire family.
  - Poor integration of services: Since 2014 we have been working towards true integration, but we are still somewhat working in silos. Our goal is that every provider can assess and refer clients appropriately, and eventually that all providers will be able to provide whatever services people need.
  - Hospital-centric model: Many people end up in ER for psychiatric disorders. We are attempting to expand the array of services.
    - As of July 1, DBH's new crisis response team, a team of clinicians out in the community to address individual as well as community crisis, is operational.

Significant Gaps Exist in the Behavioral Health Delivery System

- Services within the District's behavioral health system are often provided in silos and needed services are not Medicaid-reimbursed
  - In FY18, ~3,000 Medicaid adult beneficiaries had stays in detox and IMD residential treatment at a cost of at least $11.2M in local funds. These services are not Medicaid-reimbursed under the "IMD Exclusion"
  - Other locally funded services, including peer counselors, recovery supports, and crisis services are not Medicaid-reimbursed
  - Despite Medicaid coverage of Medication Assisted Treatment (MAT), access to MAT and accompanying recovery support services is limited and often disconnected.

7

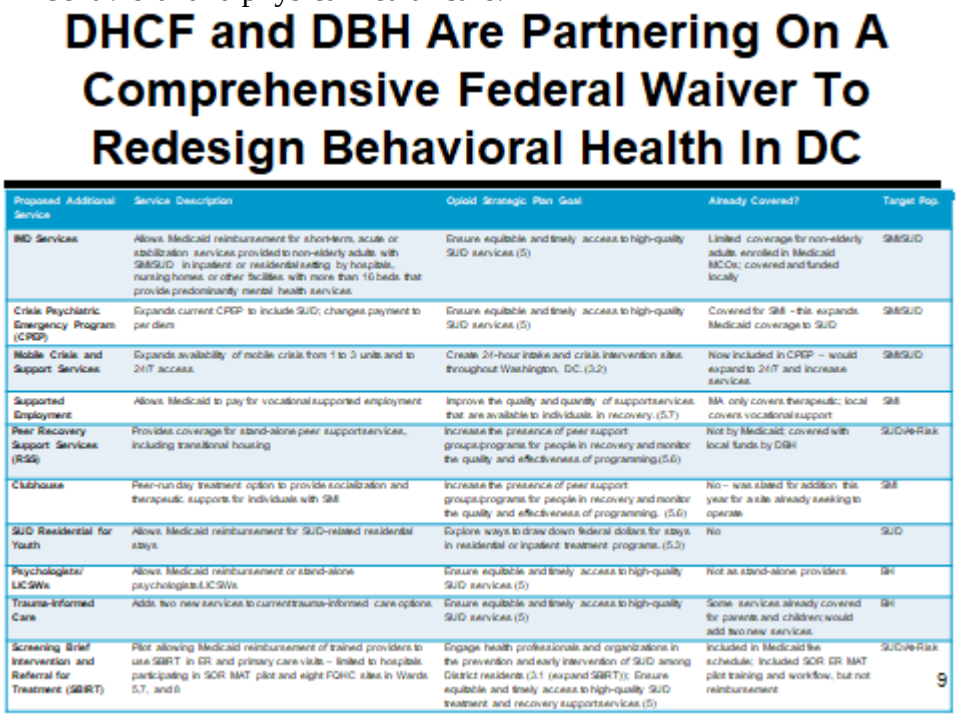
- DBH and DHCF submitted an 1115 waiver. In terms of Medication Assisted Treatment (MAT), it will remove the $1 copay.
  - We seem to have sufficient capacity to meet needs for methadone; Vivitrol is administered by PIW; Buprenorphine is on an uptick and there are 175 providers in community.
  - The Department of Corrections is beginning to provide all three types of MAT.

Significant Gaps Exist in the Behavioral Health Delivery System (cont'd)

- Gaps in coverage increase health risks for beneficiaries. This results in individuals with SUD and/or mental illness:
  - Not being diagnosed early in the course of their disease
  - Not receiving needed care
  - Utilizing emergency rooms for care
  - Experiencing poor physical and behavioral health outcomes; and
  - Having an increased risk of overdose deaths

8

- Individuals are not being diagnosed early enough. If someone is showing symptoms when they are child and they are not seen in the sysmte until they are 30, their treatment will be more severe and more costly.
    - Within the SUD population, the people most affected are older males 50 and older that have been using for 20 or more years.
    - We are moving to have SBIRT screening in schools, hopsitals, and private offices to begin to identify people earlier.
    - The DC Hospital Association has begun an overdose outreach program to try to connect to care
    - We are using a lot of funds to decrease emergency room utilization and integrate behavioral and physical health care.



DHCF and DBH Are Partnering On A Comprehensive Federal Waiver To Redesign Behavioral Health In DC

Proposed Additional Service	Service Description	Opioid Strategic Plan Goal	Already Covered?	Target Pop.
IMD Services	Allows Medicaid reimbursement for short-term, acute or stabilization services provided to non-elderly adults with SMI/SUD in inpatient or residential setting by hospitals, nursing homes, or other facilities with more than 16 beds that provide predominantly mental health services.	Ensure equitable and timely access to high-quality SUD services.(5)	Limited coverage for non-elderly adults enrolled in Medicaid MCOs; covered and funded locally	SMI/SUD
Crisis Psychiatric Emergency Program (CPEP)	Expands current CPEP to include SUD; changes payment to per diem	Ensure equitable and timely access to high-quality SUD services.(5)	Covered for SMI - this expands Medicaid coverage to SUD	SMI/SUD
Mobile Crisis and Support Services	Expands availability of mobile crisis from 1 to 3 units and to 24/7 access.	Create 24-hour intake and crisis intervention sites throughout Washington, DC. (3.2)	Now included in CPEP – would expand to 24/7 and increase services.	SMI/SUD
Supported Employment	Allows Medicaid to pay for vocational supported employment	Improve the quality and quantity of supportservices that are available to individuals in recovery. (5.7)	MA only covers therapeutic; local covers vocational support	SMI
Peer Recovery Support Services (RSS)	Provides coverage for stand-alone peer supportservices, including transitional housing	Increase the presence of peer support groups/programs for people in recovery and monitor the quality and effectiveness of programming.(5.6)	Not by Medicaid; covered with local funds by DBH	SUD/At-Risk
Clubhouse	Peer-run day treatment option to provide socialization and therapeutic supports for individuals with SMI	Increase the presence of peer support groups/programs for people in recovery and monitor the quality and effectiveness of programming. (5.6)	No – was slated for addition this year for a site already seeking to operate	SMI
SUD Residential for Youth	Allows Medicaid reimbursement for SUD-related residential stays.	Explore ways to draw down federal dollars for stays in residential or inpatient treatment programs. (5.3)	No	SUD
Psychologists/ LICSWs	Allows Medicaid reimbursement of stand-alone psychologists/LICSWs	Ensure equitable and timely access to high-quality SUD services.(5)	Not as stand-alone providers	BH
Trauma-Informed Care	Adds two new services to currenttrauma-informed care options.	Ensure equitable and timely access to high-quality SUD services.(5)	Some services already covered for parents and children; would add two new services.	BH
Screening Brief Intervention and Referral for Treatment (SBIRT)	Pilot allowing Medicaid reimbursement of trained providers to use SBIRT in ER and primary care visits – limited to hospitals participating in SOR MAT pilot and eight FQHC sites in Wards 5,7, and 8	Engage health professionals and organizations in the prevention and early intervention of SUD among District residents.(3.1 (expand SBIRT)); Ensure equitable and timely access to high-quality SUD treatment and recovery supportservices.(5)	Included in Medicaid fee schedule; included SOR ER MAT pilot training and workflow, but not reimbursement	SUD/At-Risk

9

- This slide lists the array of services under the 1115 waiver. We hope to receive notice by CMS that it is approved by October 1and begin implementation by January 1.

District Seeking to Expand Coverage, Combat Opioid Epidemic, and Integrate Care

- Three primary goals for District waiver:
  1. Cover a broader continuum of Medicaid behavioral health treatment for individuals with serious mental illness (SMI)/serious emotional disturbance (SED) or a substance use disorder (SUD)
  2. Advance the goals of the District Opioid Strategic Plan by improving outcomes for individuals with Opioid Use Disorder and other SUDs
  3. Support Medicaid's movement towards more integrated medical and behavioral health care to better coordinate prevention and treatment
- Two phases for Behavioral Health Transformation Demonstration Initiative:
  - Phase I: Focus on IMD services and ancillary community services and supports
  - Phase II: Broader Medicaid behavioral health system and service reforms

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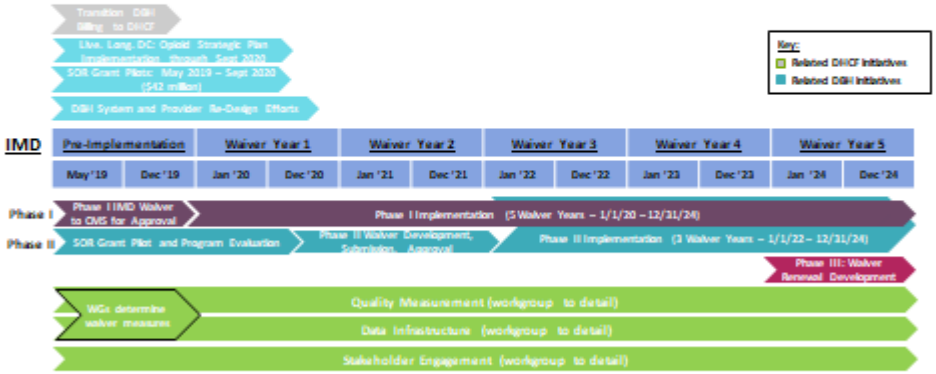
- The comment period for the 1115 waiver will end soon. The goal of the waiver is to address opioids, provide services, and integrate care.

An Aggressive Timeline Is In Place To Secure Federal Approval Of The IMD Waiver



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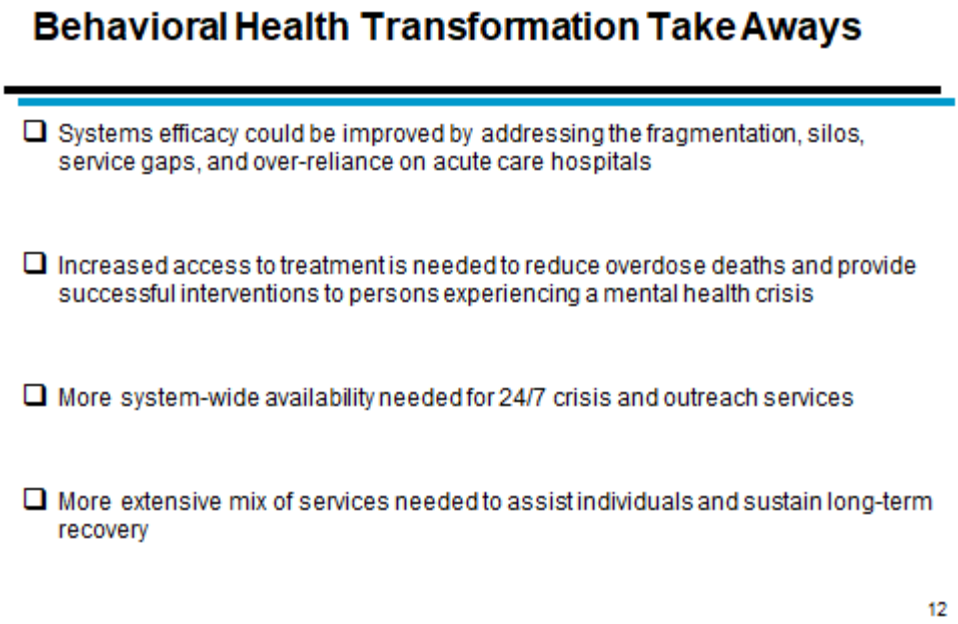
- This slide shows the schedule for IMD waiver. We are seeking a five year waiver.



Questions from Commissioners regarding both presentations:

- Co-Chair Catania thanked Deputy Mayor Turnage and Dr. Bazron.
- Jackie Bowens stated that we all share goal of efforts to change behaviors and ensure people are getting right care at the right place at the right time. We need to look at issues impacting what was presented, such as staffing and infrastructure. A complete picture will help people get a better understanding of what is driving decisions.
    - Co-Chair Catania suggested having a 15 minute presentation from DC Hospital Association and DC Primary Care Association on these issues. There were no objections.
- Marc Ferrell asked about geriatric payment and psychiatric services add-on payments and whether they are working. In addition, he stated that he thinks the DBH mobile crisis team initiative is a fantastic idea.
    - Melisa Byrd stated that on the nursing facility side, Medicaid added two new add-on payments, one for geriatric care and one for behavioral health. The last she looked we have not seen as much utilization as we would like to see, but they are continuing to work with nursing facilities to increase use. However, they believe it is working.
    - Dr. Bazron indicated that here is no upper limit for age for DBH Care.
- Kim Horn requested that the slides be sent to everyone. In addition, she requested a deeper diver into primary care because and its impact on ER usage – what is going on here, what could be enhanced or augmented to reduce inpatient stays.
- Karen Dale said that there is an opportunity to coordinate better – a challenge exists for MCOs if someone is seeking services and they don't know. In addition, in terms of MCOs, they have latitude to be more creative, and she believes that the sooner that we can connect with DBH and coordinate, the better we can leverage other tools

    - Dr. Bazron stated that she is making rounds now because she believes care coordination and coordination of care. We need to make connections smooth and easy.
    - Ms. Dale stated that there is a policy opportunity to use peer specialists and community health workers more.
    - Dr. Bazron stated that peer specialists will be reimbursable under the 1115 waiver. However, we need consistent job descriptions to understand roles and responsibilities, as other places have seen disaster when this hasn't happened. Peers have also shared with DBH that they need to be paid at a reasonable rate, so that they can live.
- Kevin Sowers stated that it would be good to know how much primary care has been converted to concierge primary care, to examine capacity vs. accessible capacity.
- Kim Russo stated that the District is blessed with the infrastructure and systems we have, but there is a gap in knowledge of what resources are available, which results in use of higher cost care. We have to focus on communication and knowledge to redirect behaviors. GW is investing in community health workers and behavioral health social workers. If they providers don't know what resources are available, they can't direct people to the resources and there is a currently a knowledge gap about what resources are truly available.
- David Catania stated that when we lost the public benefit corporation and we lost its integrated system, we were left with a challenge of recreating a well-functioning integrated system.
- Dr. Cora bramble stated that she heard things wasn't aware of in Dr. Bazron's presentation. She requested that we work on better ways to share new services.
- Kim Russo stated that we need to increase CRISP utilization. We are duplicating care because not all providers are using CRISP to understand care in the community.
    - Dr. Bazron added that behavioral health needs to be in CRISP too.
- Sister Carol asked whether we have any data on why people still choose to go to the ER rather than primary care.
    - DM Turnage indicated that DHCF has contemplated a study to get at this. Anecdotally and from national studies, people go to the ER because they are smart. If they a job that is demanding, they want to get care all at once, and they are on Medicaid, cost isn't an issue. They want to go somewhere they can see a doctor, a specialist, get their medicine and leave. It would be interesting to look at in DC. We have made investments in FQHCs, they are where care is needed, and many could use more patients.
    - Tamara Smith stated that there has been qualitative data. Some of it indicates exactly what DM Turnage said, but some of it is a lack of knowledge and some of it is many years of behavioral patterns – it's accessible and convenient. Children's did research on this and people are saavy consumers – they know what wait times are, when to go, etc. We need to reconfigure primary care so people know about it and it's accessible.
- Vincent Keane asked if any information has been gathered relative to Minute Clinics and CVS. Have they been included in calculations of clinics in city? In addition, when he travels around he notices hospitals are advertising how long their wait is, but that is not happening here.

    - DM Turnage indicated that on the primary care side, if they are a licensed clinic, they should be included. The data included primary care and urgent care.
- Dr. Raymond Tu stated the slide with the arrows showing people coming in and the dearth of arrows going to UMC, is in part due to the fact that UMC cannot include plans from Maryland and Virginia. It prevents UMC from getting into those markets and capturing those patients.
- Kim Russo stated that it is very important that we are looking at DC specific data. Unlike Maryland and Virginia, whose hospitals can go on diversion and send patients to DC, DC does not allow their hospitals to do this.
- Co-Chair Catania stated that there could be conflicts between the city CFO, generally not referring to any specific past or present CFO, being in charge of the UMC finances, as well as a gap in knowledge about hospital financials.
- Kim Horn stated that as we look at data, we are only looking at residents in the District, but we need to look at what is overflowing to Maryland or Virginia. Maryland hospitals would say they have been impacted by closures.
- Jackie Bowen asked about changing health seeking behaviors.
    - Dr. Bazron stated that she did not look at data, but that DBH is looking at cultural responsiveness and what this means in terms of accessibility and patterns of use.
- Jackie Bowens asked how we improve communications and paint a whole picture. People know how to get treated when they go to certain places so they choose where to go, in part based on that.
- Co-Chair Catania stated that it has been 13 years since we did a deep dive, comprehensive survey. If we did, he expects that there would be gaps in men vs. women and other demographics.

5. Subcommittee Updates **Subcommittee Chairs**

- Co-Chair requested that staff create a central place where information is posted about all subcommittees so Commission members can go to other subcommittee meetings if they would like. Staff – central place where info is posted – so you can go if you (we need to send to everyone)
    - Rayna Smith indicated that it would be posted on the DMHHS website and sent to Commission members.
- Subcommittee co-chairs did not have updates at this time.

6. Public Comments **Public**

- No public members presented comments.

7. Adjournment **Commission Co-Chairs**

- Prior to adjournment, Co-Chair Sister Carol Keehan provided her new email address and phone number.
- The meeting was adjourned at 11:50.