DISTRICT OF COLUMBIA
PRIMARY CARE ASSOCIATION

To: The Honorable Vincent Gray, Chair, Committee on Health
Members of the Committee
From: Tamara Smith, President and CEO, DC Primary Care Association
Re: Performance and Oversight of the DC Department of Health Care Finance
Date: February 6, 2019

The DC Primary Care Association (DCPCA) works to ensure a high quality, integrated health system that gives every District resident a fair shot at a full healthy life. We welcome the opportunity to offer testimony on the performance and oversight of the DC Department of Health Care Finance (DHCF.) DCPCA appreciates DHCF's partnership in our work to achieve health equity. Our testimony will address the Department's efforts in the areas of health information exchange (HIE), substance use disorder treatment, finance, access, and maternal health.

Health Information Exchange

DHCF is a leader in its commitment to health information exchange, working to coordinate across the system, build tools to improve patient health, and support effective provider utilization. The Department's investment in HIE, EHR adoption, and HIT meaningful use is critical to the District's health system, and essential to achieving the improvements in health outcomes we all seek.

In 2018, DHCF released the State Medicaid Health IT Plan (SMHP) which defines the goals for HIT/HIE and articulates the roadmap to achieve those goals. DHCF engaged in deep analysis of the current HIE gaps and capacity and extensive stakeholder engagement to identify needs and potential for HIT/HIE to address the District's most pressing health challenges. In particular, the SMHP focused on the following specific use cases:

1. Transitions of Care
2. Social Determinants of Health
3. Population Health Management
4. Public Health

DCPCA concurs that the chosen use cases identify the most important opportunities to leverage health information to improve health outcomes and health equity. In particular, **we support DHCF's focus on "collection, exchange, and use of SDOH data (to) maximize interventions to support individual health, reduce barriers to access, and improve the efficiency of person-centered care."** We applaud the Department's commitment to determine current clinical and

community collection of SDOH data, stakeholder needs in terms of SDOH data exchange, and exploration of technical platforms to support these endeavors.

DCPCA is concerned that behavioral health information remains excluded from the District's health information exchange. We appreciate DHCF's frank assessment of the needs and capacity of this critical sector of our health system. The SMHP rightly prioritizes investment in building a behavioral health foundation of electronic patient records, but providers need implementation guidance for how to legally share this information across the system.

Substance Use Disorder Treatment

In our testimony at last week's Opioid Roundtable, DCPCA articulated some DHCF's work to increase access to opioid use disorder (OUD) treatment. We **welcome the decision to expand the capacity for community health centers to offer high quality office-based OUD treatment.** We also urge the following:

- DHCF should rapidly promulgate regulations to lift all prior authorization restrictions for MAT in the District of Columbia. We highlighted the
- DHCF should work with advocates to make peer recovery specialists, community health workers, and OUD navigators sustainable through Medicaid reimbursement
- DHCF should eliminate the $1 copay some Medicaid patients must pay for MAT prescriptions.

Additionally, DCPCA recommends that DHCF **consider a Medicaid 1115 demonstration to improve OUD treatment**. The Centers for Medicare and Medicaid Services (CMS) encourages applications aimed at making significant improvements on the following goals and milestones:

Goals:
1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

Milestones:
1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care;

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

In addition, DCPCA continues to advocate for specific behavioral health "Z" codes, which document the toxic stressors and negative social determinants that our patients routinely experience. In order to de-stigmatize important behavioral health interventions, it is important that we do not rush to label patients with a psychiatric diagnosis. Often patients are experiencing symptoms such as anxiety, insomnia, elevated blood pressure due to loss, trauma, instability, and financial and other domestic stress among other examples. We consider new ICD10 codes which capture "persons with potential health hazards related to socioeconomic and psychosocial circumstances" to be an appropriate diagnostic documentation for some of the behavioral health services our health centers provide.

Finance

DCPCA appreciates DHCF's continued partnership in a solutions-focused effort to streamline provider payments. Clearly, DHCF has made significant progress in addressing configuration and matching problems since the implementation of new billing rules associated with positive changes in the FQHC payment rule. But DHCF, the FQHCs, and DCPCA may still need to consider other options to further rationalize the payment system. DHCF has been open to problem-solving in the past, and we know we can count on their open minds as we continue to address billing challenges.

Similarly, DHCF has worked with DCPCA and our FQHC members to implement a consistent and fair payment methodology that accurately identifies and reimburses FQHC costs. We welcome leadership commitment to open dialogue about needed changes to the methodology that will improve timelines of cost reports and address issues that may result in lower-than-sustainable rates. In particular, we hope to work with DHCF to **eliminate the cap on administrative expenses.** Medicare eliminated such caps, and the use of them in the District's FQHC payment methodology results in increased burden on FQHCs in terms of what staffing and services are defined as "administrative." In addition, the challenges of the new billing system over the past several years has certainly increased administrative costs as currently defined by DHCF, resulting in a sort of double jeopardy for the health centers. They will be penalized for the increased costs they incur when attempting to be properly paid.

Lastly, as indicated in the section addressing SUD, DCPCA hopes to work with DHCF to **identify opportunities for Medicaid reimbursement of community health workers, peer support personnel, and patient navigators.** All are critical to meeting the District's most pressing health challenges including efforts to address persistently poor maternal health outcomes, alarming OUD deaths, and high rates of uncontrolled other chronic illness.

Alliance

DCPCA joins with our colleagues in multiple health advocacy organizations to again call on DHCF to implement legislation that moves to **12-month recertification for Alliance** beneficiaries. "Churn" on and off insurance coverage is associated with disruptions in physician care and medication adherence, increased emergency department use, and worsening self-reported quality of care and health status.

TeleHealth

DCPCA supports **expansion of telehealth** to empower patients as partners in their health care. In particular, telehealth shows promise in addressing inequity in access to maternal fetal medicine specialists, psychiatry, and SUD treatment, all pressing challenges in the District of Columbia. The DC Health *Health Systems Plan* identifies the need to increase availability of high-quality medical specialty services for low income residents. We hope to work with DHCF to **leverage telehealth in all its modalities to tackle persistent inequities** that deepen along racial and socio-economic lines in the District including:

- asynchronous store and forward services
- remote patient monitoring, and
- originating site payments

DCPCA Connected Care Network

DCPCA supports DHCF's continued investment in care management and care coordination, and its focus on value-based care. As the MyHealth GPS program proceeds toward value payment, we know analysis of the program model, its lessons, and collaboration with providers on modifications will be essential to sustain progress. The 7 District FQHCs that have joined together to form a clinically integrated care coordination entity (the Connected Care Network, or CCN) seek partnership with the District Medicaid managed care organizations, as well as directly with DHCF to improve health outcomes, contain costs, and increase health equity.

In closing, DCPCA wishes to acknowledge the Department of Health Care Finance leadership and staff for their expertise, their collaboration, and their commitment to building a health system driven to improve health outcomes and increase health equity. We are grateful for ongoing partnerships across many departments and levels. We share DHCF's drive to do right by every District resident in need of safety net care. I am happy to answer any questions the Committee may have.