GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2021-105
September 1, 2021

SUBJECT: Health Care Resources Emergency

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia pursuant to section 422 of the District of Columbia Home Rule Act, approved December 24, 1973, Pub. L. 93-198, 87 Stat. 790, D.C. Official Code § 1-204.22 (2016 Repl.), and section 5 of the District of Columbia Public Emergency Act of 1980, effective March 5, 1981, D.C. Law 3-149, D.C. Official Code § 7-2304 (2018 Repl.), it is hereby **ORDERED** that:

I. BACKGROUND

A. The District contracts for the provision of health care services to more than 250,000 District residents who are covered by the Medicaid and DC Health Care Alliance ("Alliance") programs through contracts with three managed care organizations ("MCOs")—AmeriHealth, CareFirst, and MedStar. Each of these contracts (base year plus four options years) was awarded by the Office of Contracting and Procurement ("OCP"), on behalf of the Department of Health Care Finance ("DHCF"), pursuant to a contract solicitation issued by the District in 2020. Each of the contractors has performed satisfactorily during the base year.

B. MedStar's contract with the District will expire on September 30, 2021, and, because of a decision by the Contract Appeals Board, the MedStar contract may not be extended under the 2020 solicitation. The AmeriHealth and CareFirst contracts are also scheduled to expire on September 30, 2021, but the District intends to exercise option year extensions for each of those contracts.

C. Because the District has a small and concentrated health care market, the ability of the MCOs to ensure access to adequate health care for the District residents participating in their plans depends significantly on each plan being able to provide access to the same networks of health care providers. This equality in network access has been achieved in the District's Medicaid and Alliance MCO system through agreements between each of the MCOs. These agreements allow any MCO enrollee to have access to all three of the MCOs' acute care hospitals, large physician practice plans, and federally qualified health centers, regardless of the specific MCO in which the individual is enrolled.

D. In small health care markets, such as the District, the failure of each MCO to build the same provider networks can result in a disproportionate share of unhealthy individuals gravitating to a given MCO, usually to secure access to a panel of

physicians unavailable to the health plan to which they belong. Such plan shopping behavior by enrollees with high morbidity levels can trigger major losses for the final destination MCO. This situation, frequently referred to as a "death spiral," can easily financially destabilize an entire managed care program operating in a small or concentrated health care market, such as the District.

E. The importance of having a functional MCO system for the District's Medicaid and Alliance programs, with complete and universal networks, is underscored by the income and health challenges faced by the members for whom the MCOs purchase health care. To qualify for the managed care benefit under the District's contracts, an adult must have income that is no more than 221% of the federal poverty level; for children, the income limit is 324% of the federal poverty level. Additionally, available program data demonstrate that eight in ten of those who are enrolled in the Medicaid or Alliance programs are persons of color. Over 75% are African Americans who live disproportionately in Wards 7 and 8.

F. Moreover, a recently completed analysis by DHCF revealed that 31% of all District residents insured by Medicaid and the Alliance have health conditions that place them at substantial risk for an adverse outcome if they become infected with COVID-19, which has separately occasioned a public emergency due to its significant health impacts. At least 25,000 of these persons are enrolled in the managed care program and they struggle with asthma, chronic kidney and/or lung disease, diabetes, heart ailments including high blood pressure, obesity, and problems with compromised immune systems. When severe illness results in hospitalization, the impact on the District's health care delivery system is significant.

G. Unfortunately, the data also show that these same persons are substantially less likely to be vaccinated against COVID-19. Vaccination data available on most persons enrolled with the three MCOs revealed that only 24% of slightly more than 195,000 members for whom DHCF has vaccination data were fully vaccinated as of June 2021—significantly lower than the rate for residents on a Districtwide basis, who are vaccinated at an overall rate of 59%.

H. Apparently as part of the planning associated with the expected termination of its MCO contract due to the Contract Appeals Board decision, Medstar notified the other MCOs that it intends to cancel or modify the network-sharing agreements described in paragraph C above. On August 20, 2021, MedStar sent AmeriHealth a notice that it intends to terminate all medical services that AmeriHealth currently purchases from MedStar. The notice has an effective date of November 18, 2021. MedStar's contract with CareFirst expires on September 30, 2021, and MedStar has informed CareFirst that it does not intend to continue the contract on the existing terms. As noted in paragraph B, above, MedStar's own Medicaid and Alliance MCO contract with the District will expire on September 30, 2021.

I. If the current contracts MedStar has with both AmeriHealth and CareFirst expire

without renewal, no enrollee in the District's managed care program will have access to any non-emergency services at MedStar's hospitals in the District, inclusive of Georgetown University Hospital, Washington Hospital Center, and MedStar National Rehabilitation Hospital in the District; nor will they have access to any MedStar clinic, cancer care center, pharmacy, or urgent care center, to MedStar's extensive network of physical therapy and other rehabilitation facilities, nor to MedStar's expansive specialty care suite of physicians. The only services that will be available through MedStar will be qualifying emergencies that are handled through the emergency departments at MedStar facilities.

J. Because the MedStar health system, relative to any other single health care entity in the District, accounts for the largest share—31%—of total paid claims for the Medicaid and Alliance programs—both in the managed care and fee-for-service population, the negative impacts that will result from this lack of access to the MedStar system are particularly high.

K. In the District's Medicaid and Alliance managed care program for inpatient and outpatient claims, MedStar provides for more than 20% of the utilization overall in the system, and over 30% of the utilization by adults. Moreover, the percentage for specialty services can be even higher; for example, in the last four years, there have been more than 9,500 births among parents on Medicaid, and the MedStar health system was the destination for delivery for nearly 40% of these mothers.

L. The reverberations from the loss of MedStar from the managed care program will echo through the District's entire health care system with a significant and pernicious impact. The remaining providers will face the unplanned challenge of absorbing a substantial share of the Medicaid and Alliance market with no time to increase capacity. This will occur precisely at a time when all medical facilities are struggling with staff shortages. District residents will almost certainly face waiting periods in crowded hospital emergency rooms that could exceed 24 hours. There will also be difficulty securing primary care visits, and lengthy three- or four-month delays for specialty care appointments. In a system where MedStar is essentially taken offline for the non-emergency care services required by more than 250,000 District residents, the remainder of the system will be congested with patient demand that will manifest as system choke points in crowded hospitals, outpatient clinics, and emergency rooms. The result will be increases in the complexity of untreated chronic illnesses, and otherwise avoidable deaths

M. Moreover, there will likely be suppression of utilization, causing an increase in morbidity levels and possibly an increase in the number of deaths of those in the Medicaid and Alliance MCO program, as residents delay seeking care—especially for prevention and diagnostic services. This will prevent physicians from the early and timely detection of diseases before the problems become more difficult, complex, and costlier to treat.

N. In addition, the complex care that thousands of members in the Medicaid and

Alliance MCO program are presently receiving from the MedStar health system would be disrupted. One of the current MCOs (not MedStar) estimates that of its 20,000 enrollees who received care at a MedStar health facility, approximately 2,000 have complex medical needs. These enrollees have three or more hospital re-admissions, five or more emergency room visits, and diagnoses such as cancer, diabetes, hypertension, kidney failure, and heart disease. Any disruption to their ability to timely access care at a MedStar facility will likely result in health-harming consequences as the District's healthcare delivery system does not have the ability to immediately absorb the urgent care needs for this volume of members. DHCF can plan for the possibility of MedStar's exit from the MCO program, which may occur if MedStar decides not to pursue a contract with the District or if it is not awarded a contract by the District in the competitive procurement process, but a smooth transition cannot be accomplished without sufficient time to plan for the impact of such a development.

O. The presence of the fourth wave of COVID-19 will only exacerbate the problems caused by the expected disruptions to the MCO program. Data from the early months of the pandemic indicated that low-income minority populations were especially susceptible to COVID infections, severe hospitalization, and deaths. The MCO managed care population is precisely the group that is now most at-risk for future infections because of their low COVID-19 vaccination rate. Should infections among these Medicaid and Alliance enrollees continue to grow with a decline in their available health care options, the attendant problems for these residents and those of the larger health care system in the city as well, could reach crisis levels.

II. PUBLIC EMERGENCY AND EMERGENCY MEASURES

A. Based on the circumstances described in Section I of this Order, a public emergency is declared in the District of Columbia, effective immediately.

B. The City Administrator, Deputy Mayor for Health and Human Services, Director of the Department of Health Care Finance, Director of the Department of Health, and the Chief Procurement Officer of the District shall take such actions and implement such measures as may be necessary or appropriate to protect the health and safety of persons in the District of Columbia from the emergency declared by this Order, such as by entering into contracts for the provision of health care services to District residents participating in the Medicaid and Alliance programs, and the City Administrator, Deputy Mayor for Health and Human Services, Director of the Department of Health Care Finance, Director of the Department of Health, and the Chief Procurement Officer of the District are hereby delegated such authority as may be vested in the Mayor to take such actions and implement such measures.

III. DURATION OF ORDER

This Order shall remain in effect until fifteen (15) days after it becomes effective, unless earlier rescinded, extended, or superseded.

IV. EFFECTIVE DATE

This Order shall become effective immediately.

MURIEL BOWSER
MAYOR

ATTEST:

KIMBERLY A. BASSETT
SECRETARY OF STATE OF THE DISTRICT OF COLUMBIA