

**Expanding Health Coverage in
the District of Columbia:**

D.C.'s shift from providing services to subsidizing individuals and
its continuing challenges in promoting health, 1999–2009

A Report Prepared for the Brookings Institution and the Rockefeller Foundation
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Executive Summary

In the late 1990s the city of Washington, D.C. faced a crisis in the health delivery system serving its large low-income population. Its public hospital and associated clinics were offering poor quality care at high cost per patient. Low-income residents had poor access to primary or specialty care and relied heavily on emergency departments. Health outcomes were abysmal.

Starting in 1999, the District initiated a series of health reforms to expand access to health care and improve residents' health. The city closed the public hospital's inpatient facility, transferred control of the hospital's emergency department and affiliated clinics to a nonprofit health care provider, and created the DC HealthCare Alliance to pay for health services for uninsured low-income District residents who were not eligible for Medicaid. The District government shifted from directly providing health care to purchasing health care services from private providers.

The closure of D.C. General Hospital was controversial and politically unpopular, but officials determined it was necessary based on the hospital's out-of-control finances, serious quality problems and low utilization rates. By setting up the DC HealthCare Alliance, the city created an insurance-like program that allowed low-income residents to access primary and specialty services from participating private providers. Enrollment in the Alliance program exceeded 50,000 in 2009. As a result of the Alliance and a generous Medicaid program, the District currently has one of the lowest uninsured rates in the country. The Alliance helped stabilize and strengthen community health centers—both the former public clinics and nonprofit community health centers—since it attached a revenue stream to patients the centers had been serving without reimbursement.

The District's successes and challenges in redesigning the health care system for low-income residents provide important lessons for other states and localities. To be sure, some of the District's circumstances were unique: The political opposition to closing the public hospital and the public clinics was neutralized by Congressional pressure for cost containment. Moreover, the reforms were supported by a federally-appointed Control Board, which managed the city's finances from the mid-1990s until 2001 as the city emerged from insolvency. But the city's experiences in shifting its role to a purchaser of health care services rather than an operator of a public provider system highlight common opportunities and pitfalls.

- Providing access to health services via insurance coverage is a viable option for governments, as an alternative to providing services through a public hospital and associated clinics. The shift to “buying” from “making” health services is a challenge, but a manageable one. Either approach can work well or poorly, depending on choices in design, financing, implementation, and ongoing management.
- However, key to the success in “buying” health care is the existence of a functioning health care delivery system—a network of providers (primary care, specialists, diagnosticians, and so on) willing and able to serve low-income patients, and able to communicate with each other and coordinate care. The Alliance had difficulty recruiting

providers, especially physicians. Access to primary and specialty care is still inadequate, and the city is still struggling to create an integrated model of care.

- Health outcomes are still poor. The District's health care system is still struggling to improve health outcomes by focusing on chronic diseases, increasing primary care usage and reducing reliance on emergency departments and other hospital-based care.
- Moreover, health system redesign does not address the social determinants of health, such as personal behavior, income, education and environmental factors. Improving health outcomes will take not only reforms in health care delivery, but improved education, housing, and job opportunities, as well as changes in diet and exercise and reductions in smoking and substance abuse. Many of these factors are outside the control of the health care system and require major coordinated efforts across multiple agencies.

The key lessons for privatization and coverage expansion alike are that changes in health care financing cannot succeed to their fullest without supportive changes in delivery of care and complementary efforts in public health and other areas that greatly affect health status.

Overview: The Story of and Lessons from D.C. Health Reform

This report describes how the District of Columbia has sought to improve its residents' access to health care and their health, through a series of reforms starting in 1999. That year a new mayor took office seeking to improve insurance coverage and the performance of an ailing public hospital. A watershed occurred in late 2000, when the city decided to close D.C. General Hospital's inpatient services, to privatize the hospital's remaining operations, and to contract with a private group for insurance-like coverage. Later, this contract with a private-sector provider became more like public program coverage. The long-standing D.C. safety-net public hospital and its affiliated clinics were perceived to have intractable managerial and fiscal problems and to have made little headway toward improving the city's troublesome public health statistics.

D.C. General was supplanted by an innovative form of local public subsidies directed to individuals rather than a specific provider. This arrangement is called the DC HealthCare Alliance. The Alliance is a group of health care providers, including community health centers and hospitals, who agree to provide a wide range of health services to low-income uninsured residents of the city. It gives these individuals a card that covers a wide range of health services, including:

- primary and preventive health services
- emergency and Level 1 trauma services
- inpatient and outpatient hospital services
- specialty physician services
- language translation services
- disease management
- diagnostic testing and evaluation
- dental care

Mental health and substance abuse services were not covered under this package of health services, with participants in the Alliance instead directed to obtain needed services directly from the city department providing mental health and substance abuse services.

The District's decade of health system redesign is a fascinating story. Its main developments and how they were shaped by circumstances are described in this report. Such circumstances were frequently unique to the District—for example, the extent to which congressional oversight and the existence of a supra-governmental control board shaped the District's state-local decision-making. Many key observations, however, can be generalized. They should be of interest to other jurisdictions facing similar challenges, from underperforming public service providers to system-wide shortcomings in care delivery. Lessons are relevant both for other

states and localities (the District is both) within the United States and for other countries that traditionally rely mainly upon public provision of health services.

The key developments in the District's reforms are the following:

- A decade ago, when the reforms assessed in this report were launched, the health care delivery system for low-income people in the District was in very bad shape. Expenditures were very high, the public hospital (D.C. General) and its clinics (managed under one roof by the Public Benefit Corporation, or PBC) were poorly coordinated and extremely badly managed, and other hospitals were not eager to serve low-income patients, particularly not the uninsured.
- The decision to close D.C. General, and create the Alliance to “buy” health care from private health care providers rather than “make” health care through a public provider was an attractive idea, but it was made under great external pressure. The city could not afford to keep the PBC going (and Congress refused to permit it), so leaders in the District had to move quickly without adequate time or resources for planning the new system.
- There was no strong local private, non-profit provider both willing and able to manage the new system. Greater Southeast Community Hospital (GSCH) was known to be weak, but was the only credible bidder, so the city had no choice. It cobbled together the Alliance as best it could in a highly charged political atmosphere. The hospital unions mounted vocal protests and put a lot of pressure on the mayor and the City Council to keep D.C. General open, as did other hospitals that feared a steep rise in uncompensated care as more uninsured patients came to them.
- Despite its complexity and the rocky finances of GSCH, the Alliance survived and managed to enroll a growing number of residents (proving that an unmet need was there). These patients got service at hospitals and community health centers. The health centers grew stronger in this period, in part because the ones that had been providing charity care upgraded their administrative capacity and began billing both Medicaid and the Alliance.
- Eventually the city was able to simplify the Alliance and integrate it with Medicaid in what appears to be a more workable solution. The locally-funded Alliance program is designed to provide coverage for low-income people who do not fall into the categories covered by the state-federal Medicaid program. Thus, the integrated Alliance-Medicaid program now offers coverage to any District resident with an income under 200 percent of the federal poverty level. The District's rate of uninsured residents dropped from 18.7 percent in 1999 to 11.6 percent in 2006-07; over the same time period the national uninsured rate rose from 15.5 percent to 17.2 percent.
- The District enrolled a large number of the uninsured (greater than 50,000 people in 2009) in the Alliance, and managed to stay within budget each year, two major accomplishments. An ongoing challenge has been to strike a balance between the goals of enrolling as many low-income people as possible and avoiding attracting and serving large numbers of people from neighboring jurisdictions (Maryland or Virginia), who are not the responsibility of the city. Many non-residents have enrolled, and the District is trying to tighten up on this now.

- Another challenge has been to accurately identify the patients who should be enrolled in Medicaid, so as to draw in a very generous rate of federal matching funds (70%). There have been some missed opportunities to move low-income adults into Medicaid to leverage this matching money, as many states have done.
- There is progress on creating a more integrated health system with less emphasis on hospitals and more on prevention and primary care, but there is a long way to go. Redesigning the delivery system to achieve this goal as well as more integrated and coordinated care has proven to be a daunting challenge not only in Washington, D.C. but across the nation as well.
- The District has accomplished a rarity, which is to move from a system of heavy financial support for a troubled public hospital with poor health outcomes and high costs to a system that covers the large majority of the uninsured by giving them a card that creates affordable access to a full range of health care providers. Among large and medium-size American cities, perhaps only San Francisco has had comparable success.

These developments suggest many lessons for other jurisdictions in the U.S. or elsewhere from the successes as well as the unfinished agenda and limitations of the District's shifting from public to private provision of services for the uninsured:

- Providing access to health services by giving insurance-like coverage to otherwise uninsured low income people is a viable health care option for governments, as an alternative to providing services through a public hospital, clinics, and employed professionals.
- Either public "buying" or "making" health services can work well or poorly, depending upon their design, financing and implementation, ongoing management, and health system changes beyond a jurisdiction's direct control. Both need to be well managed to achieve better services for patients and a healthier population.
- Shifting from providing services to providing coverage is a challenge, but a manageable one. The District was able to make this shift even during an atmosphere of crisis and under huge time pressure. D.C. had well under a year to close down inpatient hospital operations and start up a new insurance-like program of coverage. More time for planning is desirable.
- In order to buy services, a prospective buyer needs sellers—an existing stock of health care providers able and willing to serve a new set of clients under new financing mechanisms and requirements for accountability.
- Another kind of seller is also needed for a government to buy services *indirectly*, as D.C. intended to do—through a prepaid entity responsible for delivering a full continuum of health care to enrollees. An existing or newly formed managed-care entity must be able to reliably supply a coordinated network of providers, to accept some financial risk by being partially prepaid for services, and to implement new forms of accountability for providers and to the government.
- Implementation can trump design. It is not enough to create "on paper" an appealing framework of service delivery mechanisms, financing and payment incentives, and requirements for oversight information. All those elements must be actively created and managed. Both managerial capacity and management data are needed.

- Different forms of accountability are appropriate for buying rather than making services. Performance data are central to both, but they differ, and obtaining them can be difficult under any mode of operations. Insurance performance measures are available, for example, but enforcing actual measurement under a new form of coverage is a challenge.
- There is more than one right way to structure or implement a coverage strategy. D.C.'s Alliance went through several distinct configurations before settling in to the Medicaid-like program at the decade's end.
- A key element to improving both service quality and value for money is shifting from hospital-centered to community-oriented care. At least in D.C. and across the US, an appropriate goal is to reduce reliance on very expensive hospitals for routine services and to cut emergency department use and ambulatory-sensitive hospital admissions by promoting access to key primary care and preventive services. This approach can work either under a system of publicly operated providers or under publicly purchased coverage of services from private providers.
- The "medical home" strategy is a very promising model to promote community-based preventive care by having a capable primary care provider arrange for and coordinate all needed care. It proved difficult to implement in the District, however, owing to shortcomings in both financing and delivery. Progress is occurring over time.
- In addition to assigning subsidized residents of the city to a medical home, program leaders need to attract and retain an adequate number of specialist physicians in the system's provider network, along with diagnostic centers. Waiting times for treatment in medical homes, and for referral appointments with specialist physicians, need to be minimized, and the results from visits to such physicians and diagnostic tests need to be fed back to the medical home. Electronic health records can help make this flow of information seamless.
- It also takes time and continuing effort to go from the concept of a medical home to the reality. Many Alliance enrollees were not assigned to a medical home, and where they were, changing patterns of care sometimes proved difficult. Again, some progress is occurring.
- Any localized public support for services is subject to boundary issues, that is, in-migration from other areas to utilize care, without contributing to the local tax base. As a relatively small, central urban area, D.C. has faced such problems both before and after shifting to the Alliance. Larger jurisdictions seem likely to experience smaller problems.
- Implementation never ends. It just merges into ongoing program management and periodic re-consideration of the existing program design.
- The "bottom line" for reform is that it is possible to improve access to and quality of care for low-income populations either by making or buying services—so long as the public-support system is well managed and adequately resourced, both in payment for care and for administration.
- A remaining challenge, in the District of Columbia and countrywide, is to address the fundamental underlying behaviors and lifestyle factors that threaten public health and pile up health care costs. The city will need to devote more time and resources to the "social determinants of health," including dangers in the environment, poverty, a lack of health education and health literacy, and risky personal behavior such as tobacco use,

substance abuse, inadequate physical activity, and poor diet and nutrition. There is also an imbalance in resources devoted to health across the city's various geographic subdivisions, creating disparities in health access and health outcomes. Racial and ethnic disparities in access to care and health status pose key challenges. These are longer-term challenges and addressing them will be a necessary complement to reshaping the health care delivery system.

We begin this report by presenting some key background information about the District—its people, its governance, its health care and insurance, and the public's health. The main body of the report traces the evolution of the District's safety-net support for the uninsured, starting with problems of the Public Benefit Corporation that ran D.C. General Hospital and proceeding chronologically through stages of evolution to the challenges and opportunities of current policy making. The report concludes with lessons learned and recommendations. Our narrative and conclusions draw from a review of published and unpublished materials, key informant interviews, and the authors' own experience as participant observers during this period of change.ⁱ A list of people interviewed for this project is included at the end of this report.

Background on the District of Columbia

Demographics and Governance

Washington, D.C. is a diverse city with extremes in wealth and poverty, multiple public health problems, and unique governance.ⁱⁱ The District's 590 thousand residents live in a compact central city within a metropolitan area about nine times as populous that includes numerous inner and outer suburbs.ⁱⁱⁱ The area is economically integrated—over a third of D.C. residents work elsewhere, over two-thirds of District jobs are held by suburbanites, rapid transit operates regionally, and about half of D.C. hospitalizations serve non-District residents.^{iv} But governments are split—D.C. is the country's only federal district, situated between the states of Maryland and Virginia.

Two additional, more practical dividing lines affect transportation—including ambulance transit—and housing patterns: The Anacostia River flows southwest through the District, joining the Potomac in Southwest (figures 1 and 2, box). "East of the Anacostia" is roughly equivalent to Wards 7 and 8 or to Southeast and is often used as shorthand for a disadvantaged area, high in the number of uninsured and low in health status. Rock Creek Park is a U.S. national park that bisects the Northwest quadrant, running north from the Potomac into Montgomery County, MD. "West of the Park" carries the opposite connotation of a well-to-do area; its residents are almost 100 percent insured.

Geographic Dimensions of the District

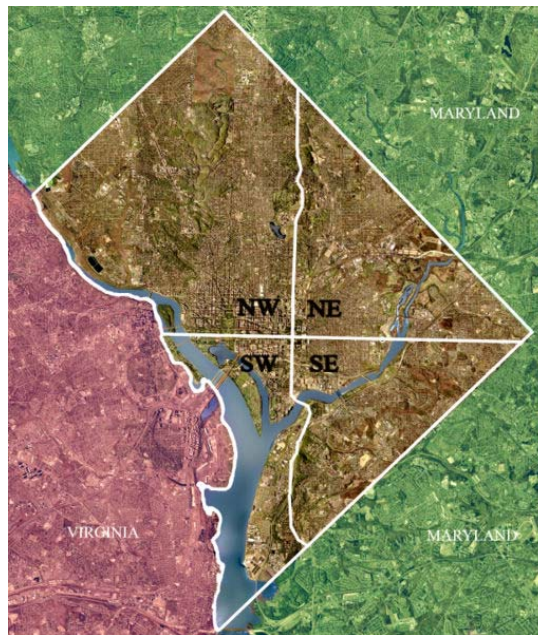
Washington, D.C. is the country's 21st largest city in population but very small in land area, only 61 square miles. Local legislators are elected by wards. Eight wards are frequently adjusted to maintain equal populations. They are numbered in an outward spiral from Ward 1 in the center. The graphic below illustrates these city subdivisions.

Figure 1. Washington, D.C. by Ward



For street addresses, the city is divided into four uneven quadrants (satellite image below). These are based on approximate compass points and centered on the U.S. Capitol Building. This is one of many reminders of how large the federal presence looms in the District. [[N.B. image needs color to be legible; can it be in color in the pdf if not in hard copies?]]

Figure 2. Washington, D.C. by Quadrant



The District combines city and state functions. It operates local health, safety, educational, and environmental services. It also assumes many state responsibilities, including the roles played by states under various federal grant programs. Most important for this report are the District's administration of health coverage under Medicaid, low-income cash subsidies under TANF,^v and nutritional assistance under Food Stamps. Lacking the full sovereignty of a state, D.C. operates under a federal Home Rule Act, and its annual budgets are subject to Congressional approval. During 1995-2001, D.C. finances and most consequential policy making were also subject to approval by a special Control Board that was mandated by Congress after the city nearly became insolvent.^{vi} Key health care decisions were reached under the aegis of this Board, as discussed below.

The District's chief executive is the mayor. Legislative powers are exercised by a city council known as the D.C. Council. Council elections are held in even-numbered years, like federal elections. Mayoral elections occur every four years, in between federal presidential elections. In 1999, then Mayor Anthony Williams was beginning his first of two terms. In 2010, Mayor Adrian Fenty is in the final year of his term. The public health agency is the Department of Health (DOH), which traditionally housed the administration of Medicaid, in its Division of Medical Assistance. At the end of 2007, Medicaid operations and the Alliance were spun off into a new Cabinet level Department of Health Care Finance.^{vii}

Some 55 percent of residents are black or African American, 34 percent white, and 8 percent Hispanic or Latino of any race.^{viii} This demographic split is of course atypical of the U.S. as a whole, but less different from other large urban centers. Integrated neighborhoods exist, but the District is generally segregated along lines of income and race; health status correlates with both. The southeastern quadrant has the most concentrated populations of low-income and black residents, especially in Wards 7 and 8 east of the Anacostia River. The northwestern quadrant has the highest share of upper-income and white persons. The northeastern quadrant is home to many higher-income black residents. Overall, D.C. residents have higher average incomes than do other Americans, but the median family income is the same as in the country at large. There are more high- and low-income people, with proportionately fewer in the middle, in the District, relative to the nation as a whole.

Health Care Financing

The District's health "system" follows the same general patterns of decentralized, independent actors seen elsewhere in the U.S. Most D.C. residents of working age and their families have private health insurance, usually obtained through their workplace group rather than bought individually. People aged 65 and above almost universally have federal Medicare coverage. Many low-income people have state-federal Medicaid coverage—mainly children, custodial parents, and those unable to work.^{ix} D.C. employers more commonly offer health insurance than elsewhere in the country, and almost the same share of D.C. residents have private coverage as elsewhere.^x However, far more have the public coverage of Medicaid, which reflects both the large low-income population of the District and D.C. Medicaid's generous income-eligibility standards.

Almost 19 percent of non-elderly District residents had Medicaid coverage as of 1994-95, versus just over 12 percent for the nation as a whole.^{xi} The Medicaid percentage rose to 22 percent of the non-elderly population in the District for 2006-07, compared with 14 percent for the U.S.^{xii} Like D.C., the entire country has seen a rise in public coverage partly offsetting a decline in private coverage during this era.^{xiii}

Nonetheless, many residents remain uninsured. In 1999, 18.7 percent of the population under age 65 lacked health coverage, compared with 15.5 percent nationally.^{xiv} Although D.C. ranked somewhat above the national norm, it was not unlike most other large central cities. By 2006-07, the share of the D.C. population without health insurance had dropped markedly, to 11.6 percent as conventionally tabulated, well below the national average of 17.2 percent—mainly as a result of the coverage expansions described in this report.^{xv}

Medicaid has long been a very expensive program in D.C., costing substantially more per person than in other states.^{xvi} (Overall per capita health spending in D.C. is also high.^{xvii}) One contributing factor for Medicaid is relatively generous benefits and eligibility standards, which increased markedly during 1999-2009. However, relatively high payment rates (for some providers) also contribute. Where Medicaid itself pays fees for services directly to health care providers (mainly for the elderly and disabled persons, who incur the majority of program spending^{xviii}), rates have long been high for hospitals, while at the same time relatively low for community health centers and physicians.^{xix} Payment rates for the city's Medicaid managed care plans rose to the top quartile of all states as of 2006.^{xx} (These plans are similar to health maintenance organizations and by 2007 had come to cover almost two-thirds of program enrollees, mainly children and parents.) Medicaid became much more affordable for the District after 1997, when the federal government began to pay for 70 percent of its allowable expenditures, up from the historical 50 percent.^{xxi} In the 1990s, Medicaid was widely perceived to suffer from severe deficiencies in administration, however. Indeed, perceptions of general public management problems created support for Control Board oversight.^{xxii}

Health Care Delivery and 'Safety Net' Providers

Americans who lack health insurance, about one-sixth of the population, must pay out of pocket for their own care.^{xxiii} They pay a higher share of costs than do insured people. Traditionally they also face higher fees than those negotiated by private insurers or allowed by Medicare or Medicaid. They also receive substantial charitable or reduced-fee care from health care providers, often "safety-net" providers. Safety net providers are those that by location or by mission disproportionately serve the otherwise underserved.^{xxiv} In the District, through the 1990s, by far the largest provider of such care was D.C. General Hospital and its associated clinics. The city's public hospital accounted for over one-third of all hospital uncompensated care in 1999.^{xxv} Uninsured people receive substantial amounts of service, but still fall short of the extent of care received by similar insured people and are much less likely to have a regular source of care other than a nearby hospital emergency room, which by law must see everyone who presents for care.^{xxvi}

A decade ago, the uninsured in the District received help primarily through charity care not only through D.C. General, as noted above, but also through safety net health centers. These

centers provide primary care services but little or no specialist physician care. In 1999 there was one FQHC network (Federally Qualified Health Center) and one FQHC “lookalike” health center in the District, as well as a variety of other community health centers with a mission to provide care regardless of ability to pay. Many of the health centers offered free care and did not have the administrative capacity to seek reimbursement even if the patient was enrolled in Medicaid or had other insurance. In fact, the culture of charity care was strong, including at D.C. General, which made it difficult to retrain providers to bill Medicaid or the Alliance.

It is not reliably known how much charitable or reduced-fee service is provided by private physicians in the District. National estimates suggest a substantial amount, but declining over time.^{xxvii} Even with some low-fee ambulatory care available, it is widely believed that uninsured people frequently postpone care until a condition becomes severe, incurring substantial amounts of expensive emergency room care^{xxviii} as well as of “ambulatory sensitive” hospital care, admissions that could likely have been avoided with regular care.^{xxix}

Overall, the District was and remains very well endowed with health care service capacity, although some downsizing has occurred over time.^{xxx} However, providers are disproportionately located in Northwest, rather than spread throughout the city. The supply of physicians, hospital beds and registered nurses per thousand population all far exceed national averages, although some of this excess serves the many nonresidents who work in D.C. or travel in to access care.^{xxxi} Such geographic concentration is not atypical of large cities.^{xxxii}

This report will trace and assess the major change that occurred over the past decade, which involved shifting from the situation in which a public hospital and various clinics provided charity care, and frequently did not bill properly for it, if they billed at all, to one in which uninsured people were enrolled in a new system of care and received a card entitling them to access to a range of private health care providers, who were able to bill for their services albeit at rates below those received from people with commercial insurance coverage.

Population Health

Public health statistics in the District are poor. As of the mid-1990s, for example, the District ranked high in the rate of low birth-weight babies (<2,500 g), at 14.2 percent, versus 7.4 percent for the U.S. as a whole; in infant mortality (deaths per 1,000 live births), at 12.1, versus 7.1; in premature death rate (years lost per 1,000) at 120.9, versus 46.7; and in AIDS cases reported per 100,000 residents.^{xxxiii} A more recent and much larger study cited the following shortcomings, among others.^{xxxiv}

- More than one of four D.C. residents (27 percent) has hypertension. As with most health indicators, the prevalence varies considerably by locality across the city—from 37.6 and 35.5 percent in Wards 7 and 8, respectively, where average incomes are lower and poverty rates much higher than the city norms, to 15.4 and 13.9 percent in better-off Wards 2 and 3.
- More than half of the residents are overweight or obese (54.6 percent). In Wards 7 and 8, this rate is 65.4 and 71.2 percent, respectively, compared to 39.1 and 38.1 percent in Wards 2 and 3.

- Premature mortality (age-adjusted, per 100,000 people 18-64 years old) from any cause is 515 for the city as a whole; the figure for Ward 8 (789) is more than five times that of Ward 3 (140). Premature mortality from heart disease is 45 per 100,000 residents for the city as a whole, ranging from 128 in Ward 8 down to 16 in Ward 3.

These and other D.C. population-health statistics are very unfavorable when compared with optimal health status, or with the stretch goals of *Healthy People 2010*.^{xxxv} As a benchmark of District performance, however, such figures are inadequate because they fail to adjust for D.C.'s urban nature, to account for minority status and the burdens of poverty, or to track developments consistently over time. Compared with other large cities, for example, the District ranks far better than it does when compared with other states or with the nation at large.^{xxxvi} Residents' health status could be greatly improved.

In sum, two key themes emerge: Care coordination needs improvement, and so does health promotion to reduce the need for care. The potential value added by such improvements appears to be great, especially for patients with chronic conditions like hypertension and diabetes, which greatly affect patients' life chances and also cause very high medical spending, for insurers and individuals alike.^{xxxvii}

First, with regard to coordination of care, the District's health "system" is little different from that in the rest of the nation, as care is provided by a multitude of independent, fee-for-service providers. There is little coordination across them, and each responds to the mix of market and regulatory signals that they face.

"Primary prevention" is very important for many or most chronic conditions, that is, reducing the risk of developing the illness or condition to begin with, a classic role for population-oriented public health services rather than the clinical medical care paid for by insurance. By many accounts, the medical system is responsible for a relatively small share of population health.^{xxxviii} More important are the "social determinants of health," including income, education, behavioral factors such as exercise and nutrition, and environmental factors.^{xxxix} The distinction between clinical and population health activities can be overstated; caregivers may play an important role in patient education through well baby care, annual physicals and in other ways. The early detection of disease through timely health screenings forms a "secondary" tier of prevention. Chronic care is a form of "tertiary" prevention," that is, preventing or slowing further deterioration for an already sick patient.

The balance of this paper proceeds chronologically by developmental era, tracking to the following timeline.

Time period	Reform Era
1995–1999	Problems as a Prelude to Reform
1999–2001	Envisioning the Shift from a Public Hospital to Public Insurance Coverage
2001–2002	The Alliance Contract—Initial Experience
2003–2004	The Alliance Contract—Subsequent Modifications
2005–2006	Reconfiguring the Alliance to Resemble Medicaid Managed Care
2007 - 2009	Recent Experience—Achieving the Vision in New Ways

Source: Authors' compilation; see Appendix Timeline

Problems as a Prelude to Reform: D.C. General and the PBC

D.C. General Hospital was a venerable institution with a very long tradition of charitable care.^{xl} It was conveniently located near a subway station, next to the Anacostia River, on federal land designated for health care use. The hospital and a set of primary care-focused public clinics were once run as city entities, but won increased operating independence over time, even as bed capacity declined from over a thousand beds in the 1950s to a few hundred in the late 1990s. In October 1997, the hospital and the community health centers were transformed into an independent, quasi-public Public Benefit Corporation (PBC),^{xli} an arrangement that lasted just over three years.

The switch in governance gave the new PBC control over its city budget allotment, which was meant to cover uninsured care. It also allowed the hospitals and clinics to keep the insurance revenues they earned from paying patients and freed them from city procurement rules. However, it did not fix the pre-existing managerial and other problems of D.C. General, including declining patient census and inadequate billing practices.^{xlii} Interviews conducted for this study and other research suggested many different problems, here grouped into five key categories:

Shortcomings in Financial Management

According to knowledgeable officials, the PBC continued DCGH's prior pattern of over-spending its budget. The D.C. Council had been authorizing the funds to underwrite these budget excesses. Allowing this problem to fester would have placed in jeopardy the goal of long-term local budget control and thus perpetuated the federally-appointed Control Board's management of the District's financial affairs. City leaders were eager to end the federal government's takeover of District finances during 1995-2001. According to one interviewee, the cumulative PBC deficits comprised \$74 million of \$400 million in total city budget shortfalls over the period from 1996 to 2000.^{xliii}

An important component of the financial and management problems at DCGH involved Medicaid billing.^{xliiv} One continuing problem was under-billing; for example, some of the PBC

clinics, it was discovered, had not billed Medicaid in three years despite seeing many Medicaid patients. Contrariwise, the hospital also appeared sometimes to overbill Medicaid. It consistently claimed that the program owed it money, but in fact, the reverse appeared to be true. The city carried what some interviewees referred to as “phantom receivables” on its books, and when Medicaid refused to pay without documentation, the hospital could not substantiate its claims. DCGH was not reconciling its receivables with actual corresponding receipts and marking them down for bad debt.

The result was that receivables kept building up—padding the institution’s apparent assets—until it finally became clear that they were not realistic. Many billing errors were made, involving such basic matters as getting the patients’ birthdays wrong, ID numbers wrong, or incorrect or missing billing codes. Some bills were sent in duplicate or even triplicate. The bottom line was that the PBC was showing a large dollar value of receivables from Medicaid, treating them as assets when in fact they were largely uncollectible.

Problematic Quality of Care

Even though the hospital had won certification to participate in Medicare and Medicaid, the Control Board discovered serious lapses in quality and basic patient safety at DCGH. For example, they found that the ER department and the ICU did not have a single physician who was board-certified as a trauma surgeon, or even board-certified in emergency medicine. General internists and general surgeons were staffing these units. Some of these were not board-certified in their own fields. When pressed about these issues, DCGH officials replied that their physicians had the status of being “board aware.” By this they meant that these physicians had been informed of the requirement for board certification, but as far as could be determined, there were no plans to move ahead to get physicians actually certified. Popular news accounts also cited instances of low quality care.^{xiv} Soon after the PBC was terminated, officials told the Health Care Reform Commission that the city had incurred very high liability costs, which the city had self-insured, even under the PBC. Payouts were expected to continue over many years.

Problems of Staffing and Care Coordination

Some units of the hospital were heavily over-staffed, in what appeared to be “feather-bedding.” A Neonatal Intensive Care Unit was fully staffed despite caring for only a few babies at any given time. There were far more nurses, for example, than were needed for the actual census of patients. Moreover, PBC obstetricians, like other physicians, were free to see patients at other facilities as well, which created opportunities to “cream skim” paying patients away from the PBC.

The PBC in practice did not do much to improve integration of care, which is a key goal of combining clinics with hospital operations.^{xvi} Physicians at the PBC outpatient clinics frequently did not have admitting privileges at DCGH, thereby undermining the basic concept of a public system in which satellite clinics feed patients into the hospital that is part of that system. Clinic physicians were members of one union while the physicians working in the hospital were members of another union. There were, in fact, several unions representing various staff in the PBC system, which hampered continuity of care considerably. Moreover, the clinics and the

hospitals maintained separate medical records, and each clinic maintained its own network of referral physicians. The PBC did close two clinics and planned to improve others, but the general perception of underperformance continued.^{xlvii}

Low Utilization of Capacity and High Incidence of Severely Ill Patients

At the time decisions were being made about the future of the hospital, about 165 beds on average were occupied out of more than 300 beds at D.C. General, leaving considerable excess bed capacity. Moreover, the hospital was not attracting its share of patients with commonly occurring medical conditions who needed only relatively short stays. Instead, a disproportionate number of its beds were filled by patients with very special medical needs, including HIV/AIDS patients, end-stage renal disease patients, and the prison population requiring medical attention. Of course, serving these high-need populations served a very important function; however, the hospital had become a provider of last resort for people in dire medical circumstances, and was frequently not billing for its services. D.C. General was not getting enough routine medical work or paying patients to help meet its expenses. The very high severity of illness and long length of stays (exceeding, for example, Medicare DRG payment allowances, which are imperfectly adjusted for severity) had adverse implications for the financial viability of the hospital. Sadly, there were also some long-term “boarders” at the hospital, whose stays were no longer medically indicated but who had nowhere else to go. The patient mix thus included many patients whose actual costs exceeded the revenue streams they brought with them, if any.

Non-Resident Care and Other Problems

An ongoing feature of care in the District has been its “magnet effect” on people from other jurisdictions coming into the city for care. Paying patients are, of course, welcomed by D.C. providers. But charity patients impose burdens in D.C. rather than in their home jurisdictions. D.C. General certainly had this problem. It was serving, without payment, people from the state of Maryland and other political jurisdictions who should have received assistance from their own governments, in the view of D.C. policy makers. As will be illustrated later in this report, this problem also persisted throughout the transformation to a new system based on coverage rather than direct service provision.

D.C. General also suffered from an inefficient, aging physical plant, in need of refurbishing, but difficult to modernize because it operated from a sprawling campus with numerous separate buildings, some of them very old. Medical records and radiological records were not combined, and administrative record keeping was also very troublesome—“a mess,” concluded one *Washington Post* article.^{xlviii} It was difficult for city policy makers to find out, for example, the characteristics of uninsured patients being seen. Support services were inadequate, including “massive problems with old computer systems,” according to another *Post* account.^{xlix}

Envisioning the Shift From a Public Hospital to Public Insurance Coverage through the Alliance

The Shift from “Making” to “Buying” Health Care for Low-Income Residents

By 1999, the momentum for change in the District’s support of the PBC was visible in several quarters. Newly elected Mayor Anthony Williams had been elected on a reform platform. The holdover Medicaid Director Paul Offner was a strong proponent of purchasing care for the uninsured rather than funding a hospital’s budget to produce services—that is, of buying rather than making health care.ⁱ He asserted that the same funding could cover more people if spent at competitive prices.ⁱⁱ Mayor Williams soon proposed major insurance expansion as part of his 2000 budget. The mayor proposed a \$70 million program, counting both D.C. funds and federal matching funds, designed to enroll up to 48,000 uninsured D.C. residents in Medicaid. This plan would have covered all adults, including those without dependent children, with family incomes up to twice the federal poverty line, which at that point was \$13,650 for a family of three. The mayor’s Medicaid expansion plan was designed to bring insurance coverage to 97 percent of the population.ⁱⁱⁱ This plan would have made D.C. General compete for newly insured patients, but it was immediately attacked by stakeholders and quickly lost support in the D.C. Council.ⁱⁱⁱⁱ The idea of insurance expansion did not disappear, however, and some city leaders were beginning to ask whether they could get better results, in terms of health outcomes and cost control, from a strategy based on *buying health care services for the uninsured* instead of continuing to prop up a badly damaged public provider system.^{iv}

It was fiscally attractive to make more of the uninsured eligible for Medicaid. Seventy cents of every Medicaid dollar came from federal matching payments; direct city subsidies to the PBC came from 100 percent local D.C. revenues. Another influence on thinking was the emerging success of the federally-mandated State Children’s Health Insurance Program (SCHIP was enacted across the US in 1997 but after some delays was actually ramping up sharply in 1999-2000). Interviewees commented on growing interest, at least among administrative policy makers, in finding ways to redeploy funds spent on the PBC as matching funds to bring in federal Medicaid/SCHIP funds to expand health insurance coverage. Political support for the hospital remained strong, however, in the D.C. Council.

The precipitating event for change occurred in August 2000 when Control Board officials met with the chairman of the D.C. Subcommittee of the US House of Representatives Appropriations Committee, which approves D.C. budgets, who was angry about PBC financing.^v In that meeting, District officials received what interviewees termed a near “ultimatum” to cease funding deficit spending at the hospital beyond its approved operating budget, at a minimum—a stern warning that Congress would no longer authorize open-ended funding for the PBC. This meeting was viewed as a turning point after which District leaders concluded that they needed to make major policy changes in support of the uninsured in the city. That fall, Congress followed through, by approving the D.C. budget with a directive that the District restructure health services delivery and downsize the PBC.^{vi} Some suggest that this strong intervention, with “directives” and “ultimatums” from Congress, would not likely have happened if the District had true representation in Congress, like that of the 50 states. The District of Columbia is

unique in America in that it lacks voting representation in Congress. On the other hand, Congress also gave the District a much higher Medicaid match than it would get under normal state rules.

This provision threatened the PBC's survival. On November 14th, D.C.'s Chief Financial Officer warned that, in the absence of a restructuring plan, the PBC would exhaust its appropriated budget and have to close by March 2001 and that, because of required advanced notice to Congress, action was needed before Congress resumed its session on December 5th.^{lvii} On December 4, 2000, the Control Board took action. It issued a "recommendation" that the D.C. Council "approve a plan to establish an alternative publicly-financed health delivery system in the District of Columbia that a) is consistent with the current budget and financial plan of the District of Columbia, b) provides for equivalent volumes and types of services as currently provided by the PBC to uninsured District residents, and c) ensures that the services meet standards of quality and accessibility."^{lviii} The Control Board clearly indicated, moreover, that it would use its authority to order such action if the Council did not act on its own.

In summary, at this juncture near the end of 2000, it became clear that the city's ongoing investment in D.C. General would be coming to an end. There was no interest on the part of the Council in replacing this investment with a major Medicaid expansion. Thus, the city needed to develop a new approach to assisting the uninsured.

A New Way to Buy Services for Public Beneficiaries

Under these pressing circumstances, Mayor Williams and his staff, with input from a reform commission, developed a new vision of how the District should support the health care of the uninsured. The 1999 proposal would have expanded Medicaid to cover all adults with incomes up to 200 percent of the federal poverty level (FPL).^{lix} However, not only had that failed in Council, but it was also infeasible in 2000 because time was lacking to obtain the requisite federal waiver for such an expansion. The new approach that took shape in the fall of 2000 can be briefly summarized as follows:^{lx}

- All uninsured residents of the city with incomes below 200 percent of the federal poverty line would be given an insurance-like card to pay for their health care. They could use this card to pay for primary care, specialty care, diagnostics, and hospital care, among other services at private facilities located in the District.
- The "hub" of the provider network for each patient would be a "medical home," a primary care physician or community health center that would serve as the patient's advocate and navigator through the health care system, organize and maintain the patients' records, and make referrals, as clinically appropriate, to specialist physicians, lab centers, and other diagnostic testing centers, and inpatient care. Hospitals would be included in the provider networks, but not dominate them.^{lxi}

- A key premise of the vision for health reform is that more timely and effective primary and preventive health services, built around a medical home, would reduce inpatient hospital expenditures and emergency room use.
- Under the reforms the city was considering, the District would take bids from “integrated provider systems” that would commit to providing a nearly comprehensive set of services within a fixed budget, while sharing risk of unanticipated overruns. The hope was to get competing bids from more than one provider system.
- Participants who did not select a medical home would be “auto-assigned” to a participating primary care provider. Enrollees who “self-referred” for specialty care, diagnostic care, or hospital outpatient care of a non-emergency nature, would be routed back to their medical home or, if provided services, the results would be fed back to the patient’s medical home, and they would be directed to use that source of care the next time.
- Under this vision there would be care coordination across an integrated set of providers, to replace the traditionally self-directed and more haphazard use of health resources.
- In order to move toward the medical home model, the District planned to use a portion of the funding that had been devoted to the PBC to support and modernize the former PBC community health centers. Community health centers across the city would compete for funds based on proposals related to capital improvement projects and the modernization of facilities, including needed repairs, staffing, modernization of information systems with the aim of creating interoperable electronic medical records, and assistance in building relationships between the health centers (including hospital-affiliated primary care clinics), managed care organizations, diagnostic facilities, specialty care centers, and hospitals.^{lxii}

Thus, the initial vision tried to address a key flaw in the typically American delivery system, one that is by no means unique to Washington, D.C.—many uninsured residents do not make good use of primary care. The vision sought (a) to expand insurance-like coverage and improve access to care from a range of private providers in lieu of paying open-ended costs at the public PBC; (b) to shift residents’ use of care from episodic services to routine and preventive services using medical homes and managed access to specialist and hospital inpatient care; and (c) to contain costs by contracting with a preferred provider network, setting an overall budget limit, and asking the lead contractor to share risk.

Many elements of a high-performing health care delivery system serving uninsured people can be found in Healthy San Francisco, a program serving uninsured residents of that city with incomes *up to 500 percent of the federal poverty line*. This program provides a non-insurance approach that relies on an integrated network of San Francisco General Hospital, a public

hospital, 11 community health centers, 13 private clinics, and the local health department, which provides inpatient and outpatient mental health. Under this program, patients who lack a primary care physician are auto-assigned to one when they present elsewhere for care (e.g. in an ER or hospital outpatient setting). The information from their visit is transferred to the medical home ahead of the patient's first visit, which is scheduled by the ER or hospital before the patient leaves. This program is tracking trends in ER use and avoidable hospital admissions.

The final reform plan in the District differed from the reform commission's vision for moving toward multiple, integrated provider systems, each of which would contract with the city under a full-risk contract, with the provider systems fully responsible for all cost-overruns.^{lxiii} Instead, the District planned to contract with only one entity, as considered next, which in turn sub-contracted with other contributing "partners." This design made the city arguably over-dependent on that single contractor.^{lxiv}

Alliance Contract: Initial Experience and Subsequent Modifications

Against the backdrop of this vision, what reality actually emerged from policy makers' intensive efforts to reorganize safety-net support during late 2000 and early 2001?

Initial Implementation: The Procurement Process and the Contract of April 2001

Implementation of the above vision began in December 2000, when the city (the Control Board and mayor's office) asked for bids "to obtain the services of one qualified health care organization to provide comprehensive, integrated and coordinated health care services for the uninsured population of the District..."^{lxv} By this point policy makers had decided to *choose just one bidder* from what it hoped would be multiple bids instead of striving to qualify multiple provider systems. The plan was to get one prepaid entity to deliver health care--like a closed-panel HMO--not to buy services through Medicaid from competing sets of providers, as had earlier been proposed.^{lxvi}

Only two bids were received in early 2001—one from the PBC itself (whose leadership was still struggling to keep it alive despite federal and local officials' decision to close it), and one from Greater Southeast Community Hospital. Apparently, Howard University Hospital had been asked to bid and planned to do so but decided not to just before the deadline. Several other local hospitals and hospital systems, such as Washington Hospital Center/Medstar, George Washington University, Providence, and Georgetown, could have bid, but chose not to do so. In fact, at the time, Greater Southeast Community Hospital was not viewed as one of the highest-quality hospitals in the city, or as being in good financial shape. Moreover, as explained below, it was owned by a for-profit entity located far from the city. This last factor raised questions in some quarters about whether the management had the best interests of the District at heart.^{lxvii}

It is noteworthy that both bids that were received, along with the one considered but not tendered, *were from hospital-led systems*. This development was ironic for a reorganization meant to replace a public hospital with a community-oriented system based on primary-care medical homes, especially since success was expected to call for reducing expensive hospital care by providing more timely ambulatory services. The bids thus did not reflect the vision of a

delivery system built around primary care with direct lines through referrals as clinically indicated to secondary and tertiary care centers. The simple reality, however, was that no ambulatory-centric bidder had emerged.

A decade ago, the District did not have well developed integrated provider systems that matched the vision. There was nothing in the District resembling the long-standing Geisinger Health System in Pennsylvania, Denver Health, or Group Health Cooperative of Puget Sound in Washington state and Idaho, capable of taking on a large influx of new low-income enrollees.^{lxxvii} Denver Health arose in a situation similar to that facing the District under the PBC, as the city's public hospital integrated with ambulatory providers. It then took on Medicaid managed care responsibilities as well. It serves a population that includes many low-income and uninsured people, and brings a modern IT system and an integrated system of physicians, clinics, and a hospital together to coordinate care for people with chronic illnesses and other serious health problems.^{lxxix} Other than its Kaiser plan, which does not serve as a Medicaid HMO, the District did not have the advantage of having this historical development of integrated systems with a long history of care coordination, physician peer review, and service integration.^{lxxx} In short, D.C. lacked the capacity on the "supply side" of the market to meet the vision emerging on at least the public portion of the "demand side." This lack of capacity can be found in some other American cities, and in various developing countries as well.

Before reaching a decision, the Control Board met with the PBC bidding team. There was uncertainty as to who would actually lead the effort if the PBC were awarded the contract, particularly in light of the forced departure of the CEO who had led the PBC throughout its financial collapse. The Control Board quickly decided to eliminate this PBC bid, leaving a single bid from a team led by Greater Southeast Community Hospital (GSCH). The chair of the Control Board later explained that "There were no viable competing proposals."^{lxxxi}

After some negotiations, a final contract with GSCH was signed on April 12, 2001.^{lxxii} The drama over D.C. General, however, did not end there. On the same day that the contract was signed, the D.C. Council voted to defy Mayor Williams, the Control Board, and Congress, passing legislation to keep D.C. General Hospital open. This would be accomplished through an appropriation authorized in this vote of \$21.5 million, designed to buy time for the hospital. The Council's measure also purported to block spending for the new contract signed that day. Mayor Williams vetoed this measure. On April 27, 2001, the D.C. Council voted to over-ride this veto.^{lxxiii} Further, a federal lawsuit was filed seeking a restraining order blocking the city from closing D.C. General and signing the new contract.^{lxxiv}

As the events described above suggest, the decisions about closure of D.C. General and development of a new health system to replace it were the subject of extreme public scrutiny and intense politics. Lined up against the closure of D.C. General were some obvious opponents, such as the unions that represented hospital employees and groups of community activists who believed they were protecting the interests of the poor by fighting the closure of a public hospital. Some claimed that they had little faith that the District could properly manage a contract with a private provider, and others worried that costs would increase under the contracted model. The ranks of the opponents also included the D.C. Hospital Association and

many of its member hospitals (several of which are the largest employers in the District of Columbia after the federal government), who feared that any new system would inadequately compensate them for the increased numbers of poor, vulnerable and uninsured patients that they would have to serve, threatening their financial viability. These groups fought hard against closure, with some opponents contending that it would “leave residents from eastern portions of the District literally dying in the streets.”^{lxxv} Ultimately, all members of the D.C. Council opposed closure of the hospital--perhaps in response to these powerful constituents or because of their own personal belief that services for the indigent should be delivered by the government—not a private entity.

The proponents of closure and development of a new system were primarily members of the US Congress charged with overseeing the finances of D.C. and the federally appointed Financial Control Board. In addition, a number of health policy experts recognized the opportunity to move toward the “Medical Home” vision described in the previous section. Many experts pointed out that lower-income people ineligible for Medicaid would be better served by enrolling in a system of care with a card that provided access to all levels of health services in varying locations, rather than relying heavily or solely on the D.C. General emergency room as the initial point of contact for many health problems that were not of an emergency nature. They advocated for a new model of care that stressed prevention and early detection of disease as well as the management of chronic illness. The city, they believed, could stretch available dollars further, and get more return in terms of improved health per dollar invested, under this new approach.

The final decision was made by the Control Board, exercising its extraordinary powers under its Congressional enabling act. On April 30, 2001, despite an incursion from protesters, the Board shifted locations and finalized the Alliance contract. On the same afternoon, a federal judge denied a restraining order in the pending lawsuit.^{lxxvi}

Thus, after much wrangling, the new contract between the District and GSCH went into effect at the beginning of May, meant to govern Alliance operations for five years. It called for the total of payments for the delivery of health care services plus the Administrative Services Fee not to exceed \$66,276,244 during the first contract year. Beyond this target of expected spending, the agreement called for “...an aggregate amount up to \$11.8 million for reasonable and necessary capital expenditures made by Contractor to renovate, modify, or replace the existing Public Benefit Corporation (PBC) Clinics, D.C. General Hospital, and GSCH.”^{lxxvii}

This contract was designed to achieve a compromise between full insurance risk for GSCH, on one hand, and the prior open-ended cost reimbursement arrangement that the District had with the PBC, on the other hand. The idea was to share the risk with the contractor through a partial reimbursement for excess costs that still left GSCH with ample incentive to manage costs. Thus, the contract was to reimburse GSCH for 50% of actual costs that exceeded the contracted target amount for the first year, up to 120% of that amount, with “best efforts to negotiate additional payments, if any...for costs beyond the 120% threshold.” There was a parallel provision to share any savings below 80% of expected costs.

There was also a maintenance of effort clause that required GSCH to “continue to provide at least its historical level of free charity care services to uninsured residents of the District of Columbia,” which for GSCH was the share of \$8.4 million in charity care “that was provided to District of Columbia residents...”^{lxxviii} The maintenance of effort provision also called for other hospitals in the city to continue providing the same level of uncompensated care for the uninsured that they had previously been providing.^{lxxix} But there is no indication that this provision was ever enforced (or could be enforced against non-parties to the contract).^{lxxx} Some hospitals did not provide data requested by the city to establish their compliance with this agreement.

Moreover, the new plan called for portions of the physical plant at D.C. General to remain open and operated by GSCH (rather than PBC) as a stand-alone emergency room and ambulatory clinics. This ER was to remain open to District EMS units and other critical patients. Patients needing admission were to be transferred from D.C. General to GSCH. GSCH and D.C. General also took responsibility for 24/7 emergency care and, to address one of the quality issues explained earlier, there was a commitment that “emergency services at D.C. General will be provided by board-certified emergency room physicians.”^{lxxxii}

Thus, in the first year, the city contracted with one entity—GSCH. This hospital system, in turn, formed a consortium of providers and a managed care organization to help provide services. This consortium called itself the DC Healthcare Alliance (“the Alliance”), a name that has persisted to this day, despite changes in program structure and ownership of the hospital. GSCH entered into sub-contracts with the following entities to help them carry out all the responsibilities under the Alliance contract with the city:

- DC Chartered Health Plan is a managed care organization. It served as the Alliance’s third-party administrator (TPA) that handled reimbursement for hospitals, community health centers, and other Alliance members, who were compensated on a fee-for-service basis. Chartered also provided access for Alliance enrollees to some 230 Chartered Health Plan private practice primary care physicians and 750 private practice specialty physicians. Thus, the Chartered network of physicians became the Alliance network.
- Unity Health Care is a private nonprofit organization that operated four community health centers, 10 medical sites in homeless shelters, a specialty HIV treatment center, and outreach vans. Unity took responsibility for managing the six formerly public PBC clinic facilities; these clinics were made operational one-by-one over a transition period. Unity was paid on a lump sum based on previous budgets to the PBC clinics, as opposed to payment related to volumes and quality.
- Children’s National Medical Center (CNMC) took responsibility for pediatric services and school-based health.
- George Washington University Health Center agreed to provide trauma care for Alliance patients, along with GSCH.

- Although not formally a part of the network, other hospitals, including Howard University Hospital, Providence Hospital, and the Washington Hospital Center were part of Chartered's other networks and could receive some payments under the new arrangement. All of these providers were paid on a fee-for-service basis. Thus, all hospitals with emergency departments agreed to provide emergency room care to Alliance patients.
- As noted earlier, the Alliance was not an *insurance program during this period*. Thus, reserve requirements and various insurance regulations did not apply to this arrangement.
- There were also a number of further specific allocations of responsibility.^{lxxxii}

The Alliance contract was finalized on April 30, 2001, and the Alliance began enrollment on June 15, 2001, after a short transition period to make the changes needed to shift patients and functions from the PBC to the Alliance.^{lxxxiii} GSCH provided assistance with the transition of inpatient services from D.C. General to GSCH, and Chartered developed materials and prepared for the enrollment of Alliance members. The hospital also credentialed qualified physicians who wanted to become part of the GSCH medical staff. The D.C. Department of Health also developed a plan for a free standing emergency room at the former D.C. General (later downgraded to an urgent care center), which was managed by GSCH as part of the contract for a flat annual fee. Other participating providers billed Chartered for services to patients, and providers who submitted "clean claims" were paid by Chartered, not always without dispute, as interviewees recalled. Some approved pre-payments were also made from Chartered to providers.

In the first year, numerous administrative challenges arose and were imperfectly dealt with.^{lxxxiv} Concerns persisted, for example about the expense of maintaining underutilized emergency services at the D.C. General location and about GSCH's slow action on promises to improve emergency care at its own location. Still, the program managed to enroll over 15,000 people, sign up and pay providers, and avoid the major over-budget cash infusions that had been routine for D.C. General.^{lxxxv} Limited performance data, when finally available, suggested some shifts from hospital to community care, as intended, discussed further below.^{lxxxvi} As the Alliance entered its second year, the City Administrator emphasized, essentially, that the glass was more than half full—the Alliance was functioning and its problems were not major.^{lxxxvii}

This view was soon overtaken by events. The big problem was the ongoing weaknesses of GSCH as an institution and hence as a suitable prime contractor. Being limited to a single, weak contractor proved to be a significant problem in implementing the vision as embodied in the formal contract.

Recurring Crises at Greater Southeast Community Hospital/United Medical Center

An ongoing problem for the Alliance was the continuing problems that GSCH had with its finances and its accreditation. These problems were not new. A short time earlier, GSCH had been a local, nonprofit hospital that had failed to attract enough paying patients and had filed for bankruptcy in May 1999; later that year, the hospital was sold to an Arizona-based for-profit company, Doctors Community Healthcare Corporation. Doctors received tax abatement from the city and promised to invest in improving GSCH, but over time the firm failed to deliver on many of its promises. GSCH experienced serious financial problems again in 2000, and was on the edge of bankruptcy in Fall 2000 when decisions were being made about the fate of D.C. General.

The story took on new importance when GSCH became the head of the Alliance, as its failures would not only greatly affect its neighborhood but also the city's finances and the viability of the new health coverage. In November 2002 came the collapse of National Century Financial Enterprises, an Ohio lender vital to financing the hospital's cash flow. The lender filed for bankruptcy on November 18, 2002 leading to a series of painful adjustments at Greater Southeast, including ambulance diversions, temporary closure of a 19-bed pediatrics unit, and a decline in the number of filled beds from 220 earlier in the year to 149. It did not help that the hospital was already starting to have problems with its accreditation and hence in attracting paying patients and physician staff, problems that persisted until the hospital was eventually sold in 2007.

Doctors' Community Healthcare Corp. filed for protection from creditors on November 22, 2002, only days after the meltdown at National Century. These developments led to strong criticism of the city government from the D.C. Council, which included "I told you so's" about closing D.C. General and "privatizing" health care for lower-income people.

In the aftermath of the city's decision not to build a new hospital on the site where DC General had operated, the city invested a sizeable proportion of its securitized tobacco settlement funds in updating and modernizing GSE (described below). The hospital was sold in 2007 to Specialty Hospitals of America, LLC, and the name of the hospital was changed to United Medical Center.

Since the time covered by this report, difficulties have persisted. The latest development is that the District forced out Specialty Hospitals of America for defaulting on its loan and grant agreements and took over United Medical Center at an auction held on July 9, 2010. No private bidders attended this auction and the city committed \$20 million to take control. This money would, in effect, reduce the \$55 million liability of Specialty Hospitals to the city by \$20 million.

The District took immediate possession of the 184-bed hospital and appointed a five-member board to oversee the new hospital.^{lxxxviii} The city aims to protect its sizeable investment in United Medical Center and keep it financially viable until a private buyer can be found in which the city has confidence.

The city's latest investment in this hospital also included a new pediatric emergency unit. This 10,800 square foot unit will receive staff and training from Children's National Medical Center. The majority of the unit's construction was funded through an \$11 million capital grant from DOH.^{lxxxix}

Natwar Gandhi, the District's Chief Financial Officer, questioned the financial viability of the city's purchase of United Medical Center, noting the large debts and liabilities that the city will incur and the likelihood that the hospital will lose about \$1 million a month.^{xc}

At this point the District's hope is that its ownership of United Medical Center will turn out to be a temporary stewardship leading to another private owner, not a return to the "make instead of buy" health care model that prevailed prior to the closure of DC General. At least two potential private purchasers have approached the city. After multiple experiences with outside owners who make grandiose promises but typically fail to deliver, however, the city could reasonably conclude that the only way to assure that the needs of the local population are met is to keep control itself. The downside is that this exposes the city directly to the ongoing operating losses at this facility that have persisted despite considerable investments in modernization and quality improvement. If the losses continued, the city would have to decide whether a full service hospital on this site is viable and consider alternative uses for the facility.

Subsequent Modifications to the Alliance Contract

GSCH's problems forced the city to take over management of the Alliance. By the end of 2002, DOH had put the Alliance's component members, then supported at a level of about \$70 million a year and serving close to 30,000 people, under the direct control of the government instead of GSCH's private business. Instead of one contract with GSCH, under which that hospital sub-contracted to the other participating providers, the city entered into what became known as the "five-party agreement," with GSCH as just one of the providers. Thus, a reform that had started out as a single contract with multiple sub-contracts turned into separate bulk payments negotiated with each partner in the loose provider network. GSCH and Chartered each received lump sums of funding for operating the Alliance program, "off the top," while all other service providers negotiated for their share of the pool of funds. Each partner received a "line-item" budget allocation based on historical city budgets to carry out its own set of responsibilities. The five-party agreement was the most consequential change, but the city made some nineteen modifications to the initial contract over its five years, according to respondents interviewed for this study.

In the ongoing five-party “re-negotiations,” funding was a constant issue, but generally totaled about \$80 to \$100 million per year. Many disputes arose throughout. Unfortunately for the District, each of the participating providers had near veto power over the entire arrangement because all were essential to service provision. Unlike a typical government program where the government insurer or purchaser (e.g. Medicare or Medicaid) can change its rate structure without getting sign-off from the many and varied providers, this arrangement was more like a set of bilateral agreements under which the District sought to convince each and every provider that their payments were sufficient and continuously negotiated over the size and adequacy of the total for all.

Despite their bargaining power, the five parties always claimed that they were still experiencing losses from serving uninsured patients. Of course, even though the savings from the discontinuation of support for D.C. General were substantial, such savings could not be expected to cover the costs of *all of the uncompensated care experienced across the city, including revenue shortfalls at several hospitals and various community health centers*. Indeed, the Alliance contract had contemplated that hospitals would continue to assume the levels of uncompensated charity care each had provided prior to the closure of D.C. General.

Moreover, there was constant fear each year on the part of the providers that the amount of funds allocated for the Alliance would run short. In addition to the payments to the providers in the five-party agreement, the city maintained a claims pool of about \$50 million, administered by Chartered, to reimburse claims from the other hospitals and health centers.

Claims were monitored monthly with projections to see if the funds put aside for the various providers would be adequate or would be in danger of running out. There was a heavy emphasis on getting people eligible for the new subsidized care enrolled as quickly as possible, as well as on sorting out those who were eligible for federal/state programs (Medicaid and SCHIP) so that federal matching dollars could be claimed. The city also tried to get providers paid for serving people enrolled under the new contract on a timely basis.

Alliance Successes and Shortfalls

This section highlights the major successes and shortfalls in the first five years of the Alliance. The main conclusion, explained below, is that the District did a good job of getting people enrolled in either the Alliance or Medicaid. The locally-funded Alliance program offered coverage for low-income people who did not fall into the categories covered by the state-federal Medicaid program. Thus, between its Medicaid and Alliance programs, the District now offered coverage to any District resident with an income under 200 percent of the federal poverty level. Enrollees received a comprehensive benefits package that was fully subsidized by the District government. Many of these enrollees received free primary, specialty and hospital care from providers they would not have previously been able to access—or that would have sent them very large bills for payment. As noted earlier, the District’s rate of uninsured residents dropped from 18.7 percent in 1999 to 11.6 percent in 2006-07.

After some initial glitches, providers got reimbursed reasonably quickly. This administrative accomplishment was particularly important in view of the closure of D.C. General, which had

served so many of the uninsured residents of the District. Although the Alliance was created on a fixed-budget basis, the city in practice managed the contract with GSCH, and subsequently the five-party agreement, in a way that assured that the Alliance program did not run out of money and no enrollees were ever turned away because a ceiling had been reached. In sum, the Alliance succeeded in implementing its centerpiece, the shift from funding the bricks-and-mortar of the PBC to funding coverage from a network of private providers. Enrollment grew steadily over this five-year period, private hospitals and community health centers were reimbursed (maybe less than they felt they should get, but more than they would have received otherwise for serving this population), and the program remained on budget. And there is no evidence that more people from the eastern part of the District were left stranded without health care as a result of the change from public delivery of care to purchasing care from private providers, as critics had predicted.

The downside was that the program fell short in implementing the reorganizations of health care delivery utilization and quality that were also parts of the initial vision. There was little emphasis on quality improvement and care coordination, ingredients seriously required for this high-needs population.

In addition, the Alliance departed in significant ways from the “medical home” model, with its emphasis on primary and preventive care and the development of referral systems and continuity of care. On the positive side, Alliance enrollees were assigned to a medical home and cards were issued that enabled enrollees to present for care at a wide range of provider sites and have a chance, in many cases for the first time, of getting care without being limited to a single provider system. It is important to note, however, that using that medical home to which the person was assigned *was not required*, and frequently people did not go to their assigned medical home for primary care. Basically, there was little effort to check up to assure that the medical home became a reality, versus something that existed mainly on paper. Nor did these medical homes—basically various community health centers, typically reach out to find people newly assigned to them and bring them in for an assessment and educate them about the best ways to use the health care system.

We now discuss these successes and limitations in more detail.

Notable Accomplishments

1. Eligibility and Enrollment

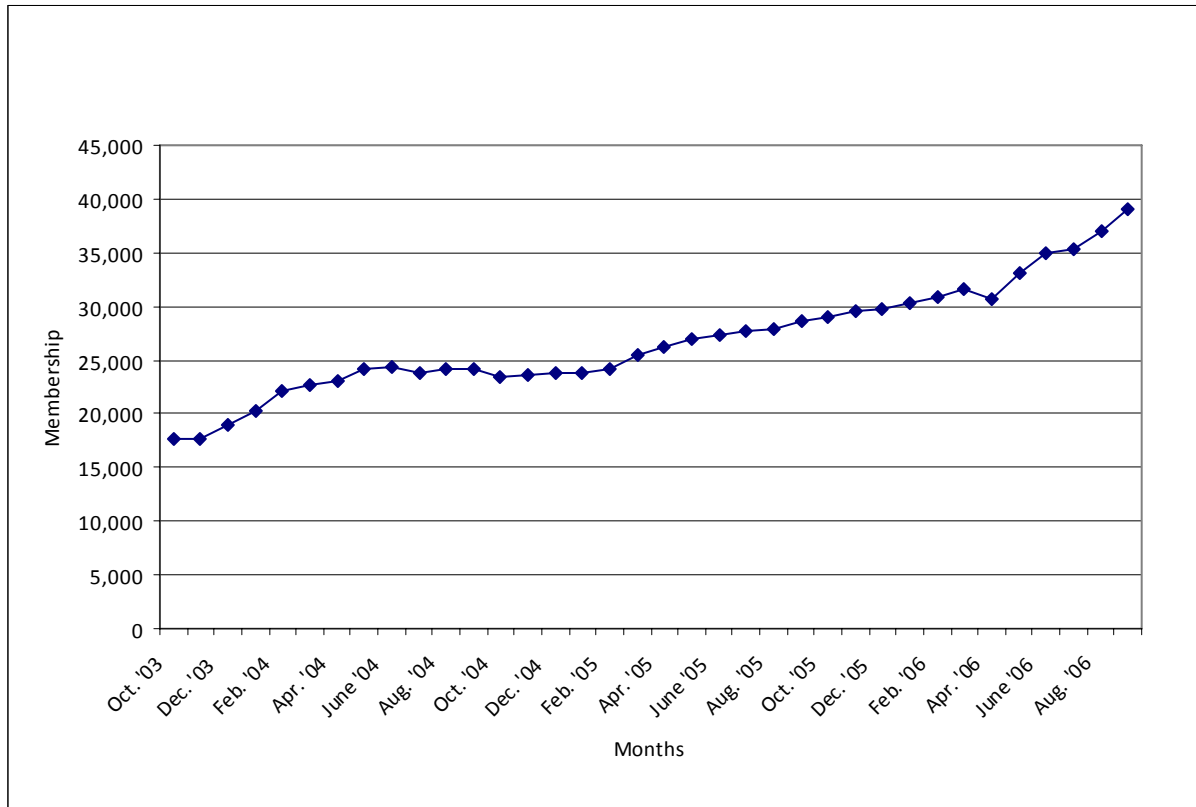
Washington, D.C., and San Francisco are the only medium- to large-size cities that have developed systematic, large-scale programs to cover a major portion of the uninsured under an insurance-like coverage model. These are noteworthy accomplishments. In fact, even among states, only Massachusetts, Minnesota, and Hawaii have succeeded in providing some form of health coverage to as large a segment of their populations as the District of Columbia.^{xci} A number of other cities have closed a public hospital because of poor results or fiscal problems, but the District was unusual in the speed with which it acted (under great pressure) and its willingness to put the same resources into broad new coverage.^{xcii} The District may also be

unique in having created a broad new coverage entirely funded with *local* dollars. Other reforms all appear to rely on Medicaid waivers or payments to help fund coverage.

Washington, D.C., was able to launch and expand the Alliance to cover a large majority of its uninsured residents. This enrollment success story over the 2001-2006 period can be seen in Figure 2 below, which shows that by Spring 2006 about 30,000 people were enrolled. The figure shows a burst of enrollment in the early part of the program, and then steady growth over the next few years. Another spurt in enrollment occurred in the middle of 2006 and will be assessed below. This growth in enrollment revealed how much need there was for a new system of care for the uninsured.

Survey data confirm the story of the administrative data and suggest that Alliance enrollment did not simply displace private coverage; a study by RAND found that adults with continuous health insurance rose from about 79 percent in 2001 to over 86 percent in 2005.^{xciii} This is an indication that Alliance participants likely think of themselves as “insured” when they respond to a survey. Enrollees had a card that provided payment not only to a broad network of community health centers, but also to office-based physicians practicing in both primary and specialty care. For the first time, many uninsured residents who were told they needed to see a neurologist, an orthopedic surgeon, an endocrinologist, or other medical specialists could arrange an appointment in a reasonable time frame instead of being turned away for lack of payment. Patients told that they needed a battery of diagnostic tests also had centers where for the first time they could be seen for this important work. And Alliance patients were able to access many hospitals and physicians in the District previously only accessible to their higher-income neighbors. Thus, one major and important accomplishment was to reduce the gaping hole in access to primary and specialty care and thus eliminate some of the disparities between the affluent and the lower-income residents of the District. This was no small accomplishment.

Figure 3. Enrollment in the DC Healthcare Alliance, 2003–2006



Source: Health Care Safety Net Administration

Since most mothers and children were categorically eligible for Medicaid and SCHIP, the Alliance enrolled large numbers of childless, non-elderly adults who are not eligible for federal health coverage programs, many of whom have complex health care needs. Enrollment also included significant numbers of foreign-born residents of the city, including many who were undocumented, according to interviews. Covering everyone, regardless of legal status, has public health benefits, and it was a difficult lift politically to include this controversial group of undocumented uninsured residents, believed to number at least several thousand people. Uninsured people got a card and were able to present for care in primary, specialty, diagnostic, and tertiary care settings and bring a payment source with them. The new system also likely reduced the amount of medical debt previously incurred by the District's lower-income population, a clear improvement over the previous one.

2. Provider Participation and Broad Patient Access to a Continuum of Care

A second achievement was that many providers of many specialties and across the city received payment for services that were previously uncompensated. Hence, patient access to services, particularly to ambulatory care, was broadened.^{xciiv} The Alliance's payments, including the negotiated add-ons to those payments over the years, may not have made hospitals "whole" from their perspective, but they covered a significant share of costs, and no doubt widened the number of providers willing to see these previously uninsured patients.

The conversion from the DCGH model to the Alliance opened up many more choices of providers to Alliance participants. This, in turn, made it possible for many people who did not live near D.C. General or one of the affiliated PBC clinics to find a provider closer to their residence or their job, which should have ameliorated transportation problems. Transportation barriers can still be a problem, of course, as some lower-income people do not have cars, and public transportation does not always connect people to a community health center or doctor's office. But the much broader network of providers should have reduced the transportation barriers.

3. Comprehensive Benefits

A third accomplishment of the Alliance was providing quite comprehensive benefits, nearly as broad as Medicaid. Notably, the Alliance made pharmaceuticals broadly available and affordable to uninsured people enrolling in the Alliance. The District was able to obtain drugs with the very large federal discount given to the Department of Defense and the Veterans Administration.^{xcv} These discounts yield prices that are significantly below even those achieved through the statutory Medicaid rebate and prices negotiated by private buyers through Pharmacy Benefit Managers.

Another key improvement in service coverage is that the Alliance program provided access to dental care, along with making more adequate payments to dentists and allied personnel than they might have received in the past. The higher payments enhanced the participation of providers in the program, thereby improving access to dental care.

The comprehensive coverage for dental care was particularly helpful for the significant population of homeless people who got care through the Alliance. Many of these people needed very major dental care, including full mouth reconstructions and treatment for serious periodontal disease. There were only a limited number of dental providers who were willing to see homeless patients and treat these very complicated situations, and the city felt that to attract and retain this limited participation, they needed to pay good rates.

4. Shifting Utilization of Care from Hospitals to Medical Homes

Some progress was made toward the medical home model. During the Alliance's first year, according to the Safety Net Administration, primary care utilization was above national norms, while emergency room utilization declined relative to DCGH experience.^{xcvi} But indicators were limited. Moreover, payments to hospitals continued to consume a large majority of the budget, while payments to community health centers and primary care physicians were too low to attract strong provider participation and were said even to be threatening the financial viability of some health centers. However, for many community health centers, Alliance payments, while less than half of their costs, as discussed below, were far preferable to the prior situation—where indigent patients brought no payment at all.

There were also some limited attempts at care management. For example, the 50 Alliance patients with the most ER visits, the so-called "frequent flyers," were identified and individualized care plans were developed for them for better managing their use of the system and their medical conditions.

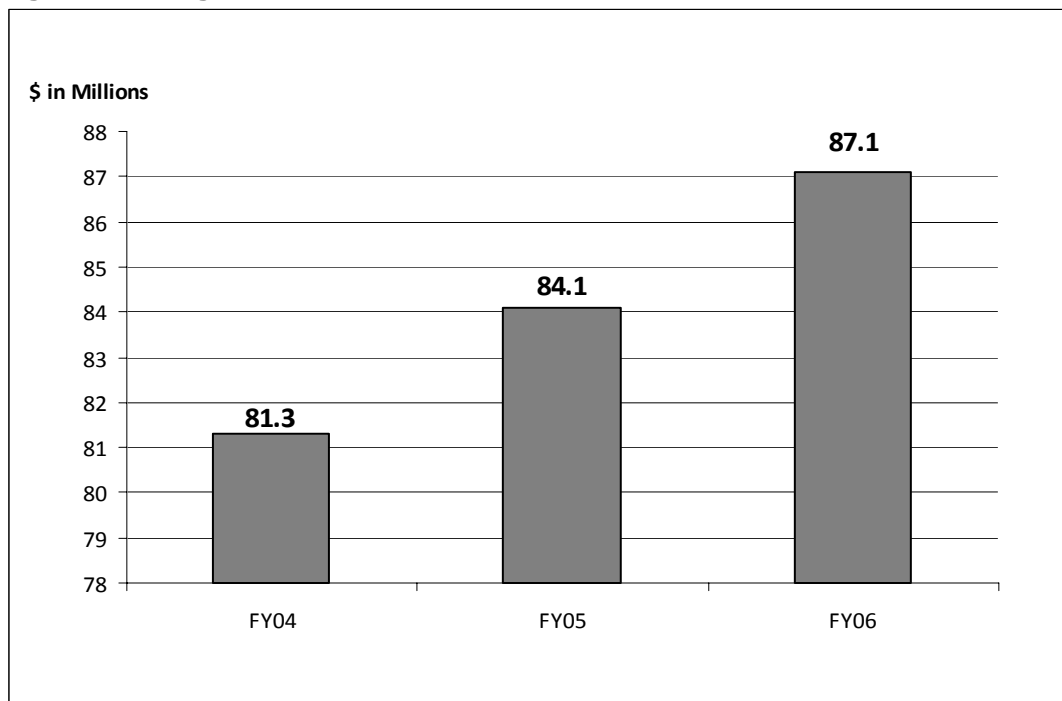
There is suggestive if not conclusive evidence that the initial surge of enrollment in the Alliance led to better health outcomes for residents. RAND research showed that in high-poverty zip codes, ambulatory care-sensitive admission rates for children fell by half over the period from 2000 to 2004, before rising somewhat between 2004 and 2005, although this result may more plausibly relate to Medicaid and SCHIP, which cover far more children. The proportion of low-income adults who were uninsured fell from over 25 percent in 2000 to under 15 percent in 2006. There was also a noticeable decline in the share of uninsured D.C. adults without a usual source of care, from 35 percent in 2001 to about 28 percent in 2006.^{xcvii}

In addition, the Alliance created a forum for discussion across multiple providers about the care of the low-income populations in the District. Monthly Alliance oversight meetings provided an opportunity for all of the players to review data on utilization patterns and also try to address and resolve some of the major challenges around access to care.

5. Relatively Stable Funding Considering Enrollment Increase

The budget for the Alliance remained roughly constant from 2001 to 2007, at \$80-90 million annually, during a time when enrollment increased by 189%.

Figure 4. Budget of the DC Healthcare Alliance, FY 2004–2006



Source: Alliance Transition Update: Briefing for the Office of the Chief Financial Officer, November 15, 2006

Stable expenditures were possible because costs during this period reflected actual utilization rates and were not tied directly to enrollment numbers as they would be in the capitated model adopted in 2006. It is likely that the earliest enrollees to the Alliance were among the highest

users of care and that, as enrollment grew, increasing number of healthier people were enrolled. The shifting utilization patterns described above likely also contributed the program's early success in cost containment.

There also appears to have been a measure of spending control that was surely not in place during the late 1990s under the PBC. The data suggest that the Alliance cost less per year than the PBC. However, comparisons are uncertain because their responsibilities differed, and the PBC spent monies from more than one funding stream. Indeed, few people seem to be sure just exactly how much money in total was being spent by the PBC, with estimates of total spending ranging as high as \$90 to \$120 million.^{xcviii} Despite these uncertainties, it seems clear that overall the Alliance was serving many more people with about the same amount of money.

Shortcomings

1. Too Little Reform Was Achieved in the Delivery of Care

In contrast to the city's vision for health reform, health care for the members of the Alliance continued to be mainly episodic and not well coordinated. Instead of an integrated delivery system driven by primary care, what unfolded was a continuation of the fragmented delivery system with a "top-down" distribution of resources directed more heavily to hospitals than to community care. Moreover, the feedback loops across sites of care envisioned in the reform models were not systematically created, and patients too often continued to make hospitals their first contact for care. Unlike Healthy San Francisco, where a public hospital is a part of an integrated delivery system but by no means dominates it, the early years of the Alliance were characterized by a loose confederation of providers, as opposed to an integrated delivery system, with hospitals continuing to play a powerful, even dominant, role.

The concept of a medical home was a critical part of the vision for creating community-centered care. But during the 2001-2006 period, too little was done to develop this model. Patients were steered to community health centers or primary physicians, to be sure, but those centers continued to be under-funded and still, in most cases, were not equipped or adequately staffed to provide all the functions of a medical home. Community health centers were particularly lacking in a systematic referral network of specialist physicians. Furthermore, the model of a medical home goes beyond community health centers, as important as they are, to also include office-based physicians. Little effort was made during this period to draw more independent primary care physicians into the Alliance network and, beyond that, specialist physicians were in particularly short supply.

Maintaining specialty care networks was one of the most difficult and frustrating parts of the Alliance development. Community health centers and similar safety net providers operated at 60 sites as the Alliance started up.^{xcix} They were willing to see Alliance patients, even at low reimbursement rates. Hospitals were generally pleased to have some reimbursement, even if not full payment, rather than delivering uncompensated care. But many specialist physicians had little interest in joining the Alliance network because of low reimbursement or perhaps other factors.

Whether in the clinic or office setting, an ongoing problem for implementing medical homes was thus that primary care providers were not adequately compensated for their services to patients or for helping to assure good coordination across levels of care. Moreover, in part because of traditionally low Medicaid fee-for-service payment levels, too few physicians practiced near lower-income areas of the city. Community health centers helped fill the gaps, but often lacked adequate facilities or key administrative or clinic capabilities; they needed capital to improve. The District had been responsible for upkeep of *its own* clinics and after the demise of the PBC made additional investments as described above.

A start toward bolstering community healthcenters' ability to serve as effective medical homes was made, however, in 2004.^c The District of Columbia Primary Care Association (DCPCA) won a three-year federal grant under the federal Community Access Program to launch a project to assist community health centers upgrade capabilities so as to serve as effective medical home models. Further, the city promised \$21 million to DCPCA for this purpose at about the same time.^{ci} The seeds planted during this grant period led to the results described below in 2008-09.

Medical homes were meant to be the hubs of care, but reform also contemplated that the surrounding network of coordinated providers would operate under a managed-care-like model of integrated financing and delivery of care, capable of accepting capitated payment for care.^{cii} Another shortcoming, already noted, was the absence of integrated delivery mechanisms that might have served to administer the new approach that became the Alliance. To be fair, there was little history of this sort of provider integration and collaboration anywhere in the District, beyond the presence of Kaiser Permanente which mainly serves privately insured and Medicare patients. As a contrast, the Henry Ford Health System in Detroit, which serves a large low-income patient population, was founded in 1915 and has decades of experience in integrated care that transcends the traditional boundaries of the health care system.^{ciii} This program builds on many years of "following the patients" after they leave the hospital, whether to rehab programs, long-term care facilities, or their homes. Ford also has a Center for Senior Independence providing an alternative to nursing home care. Moreover, in 1986, Henry Ford formed an affiliation with the Health Alliance Plan, an HMO with a long history dating back to a predecessor organization (Community Health Association), a pre-paid health plan established in 1958.

Obviously, the District could not contract with an entity that did not exist. However, it seems fair to say that there was little concerted effort to learn from the types of systems mentioned in this report—Henry Ford, Denver Health, Geisinger, or Group Health of Puget Sound. During the first five years, there could have been better planning to help build better delivery systems. The city deserves credit for switching the delivery system from public to private in an orderly and successful manner, but the population was switched to a system with many flaws and limitations. Indeed, this period from 2001 through 2006 was marked mainly by paying for an existing system (albeit one that was now serving a new, more vulnerable population) rather than planning for and working on inventing or reinventing a new delivery system with a focus on quality and coordinated care. The latter would have required surveying best practices around the country and, with appropriate adaptations, bringing such practices to the District. That is a difficult task, and it could not have been tackled in the very short timeframe available to District

decision makers as the PBC was forced to restructure. But the failure to plan for this over the next several years was a “road not taken.”

It was challenging to make the switch from a publicly provided system to an insurance-like system. Much had to be accomplished in a short time, and few of the providers acted as if they wanted a new system—they mainly seemed to just want to get paid more under the existing, uncoordinated system. There was the additional challenge, as already noted, of keeping the contracts operational within a Department of Health that had little experience serving as a contract manager on this scale. The District government had to change completely and quickly from being a provider of services to a manager of contracts—two very different roles that require very different skill sets and capacities.

2. Only Limited Efforts Were Made to Address Underlying Cost Drivers and Non-Financial Barriers to Care

The new model featured intensive efforts to enroll lower-income people in the Alliance and to reduce uncompensated care for providers. But there was insufficient attention to the underlying factors that lead to the poor health of many poor and near-poor people in the city. This includes the rising incidence of obesity, contributing to diabetes and other serious diseases; unsafe housing conditions (e.g. lead-based paint and asthma triggers); violence in the home or the community; and homelessness, among others.

While lowering the financial barriers to care is critical, it is also important to address the non-financial barriers. These include transportation problems, as well as the need for more culturally-sensitive care, including but not limited to the availability of interpreters in a variety of languages spoken in the city.

3. The Intended Accountability for Cost Control Was Not Effectively Implemented

A fundamental feature of reform was the intended fixed budget for the Alliance, which was meant to achieve cost control for the city by having a private organization assume some of the insurance risk of paying for an uncertain volume of future medical claims—as happens under private insurance or fully capitated Medicaid managed care. Given the unpredictability of actual claims experience under the new arrangement, the contract did not transfer all risk, as already noted; it provided for the District and GSCH to share 50/50 in the risk of unexpectedly high or low spending (more than 20% above or below agreed upon total support for claims spending). Even in the first two years of the contract, the city had trouble getting GSCH to perform all of its contractual responsibilities for the agreed-upon funding; neither the risk assumption nor the formal overrun-sharing arrangement was enforced as envisioned, according to interviewees.^{civ}

According to our inquiries and review, the numerous contract amendments often involved increased levels of payment from the city to the partners in the Alliance. The city was unable to enforce a fixed budget for a fixed period of time, saying to recipients “live within this budget and don’t come to us if your costs exceed it.” This failing may have been due to lack of experience of District officials in this kind of contracting process, and more importantly, the negotiating savvy and political power wielded by some of the contractors.

In practice, the system of direct payments to providers under the five-party agreement was hampered by politics. Many of the contractors had strong ties to the D.C. Council and could create pressure on the Administration to raise payments. The weakness in the city's bargaining position was part of the rationale for moving to a more conventional managed care arrangement, explained below. That changeover was designed in part to remove the city and city politics from the payment negotiations.

4. Federal Money Was “Left on the Table”

Another fundamental problem involved missed opportunities to obtain federal matching money. This problem had three aspects. First, the initial effort to screen people as they entered the program to see which applicants were eligible for Medicaid was weak.^{cv} Like Medicaid, the Alliance enrolls low-income people, up to 200 percent of the federal poverty line. These incomes can often qualify people for Medicaid coverage, if they fall within one of the covered Medicaid categories, i.e., children, custodial parents, and aged, blind or disabled persons. Thus, program officials needed to make sure that people were not eligible for Medicaid before accepting them into the Alliance, and to help those that were eligible enroll in Medicaid rather than the Alliance.

For the five-year period from spring 2001 to spring 2006, there were separate enrollment processes for Medicaid and the Alliance. The Alliance process was created to be separate, according to interviewees, in large part in response to providers' desire to enroll people at the point of service in hospitals and health centers, so that these providers could be better assured of payment. Chartered handled the enrollment. There were many errors at the start, with people who were actually eligible for enrollment in Medicaid placed into the Alliance, which left federal matching dollars unclaimed.^{cvi} This shortcoming led to numerous administrative “workarounds” to try to get people re-enrolled into the correct program. That being said, even the fragmented Alliance enrollment process did identify some uninsured people who were eligible for Medicaid, and the enrollment of such people in Medicaid did pull in federal matching funds. But the disjointed nature of enrollment in the first five years is one reason that along with the major program changes of placing Alliance enrollees into managed care in 2006, the District also switched responsibility for eligibility from Chartered to the city's Income Maintenance Administration (IMA), which already had Medicaid enrollment responsibility. Another reason was to streamline the eligibility process for applicants by creating a “single point of entry” not just for Medicaid and the Alliance, but also for Food Stamps and other programs.

A second and more fundamental issue is less about the Alliance than about the timing and circumstances of reform. If the reform had been structured as a Medicaid waiver from the beginning, as proposed in 1999, rather than being a crash effort to respond to a Congressional ultimatum, it might have qualified for the 70 percent federal matching funds associated with Medicaid. A waiver would have allowed much more time for implementation but would have entailed meeting the requirements of the US Department of Health and Human Services waiver process to cover this population. While winning a waiver is not easy, at least a dozen states had by then done so. Given the circumstances in 2000-01, District was unable to make a serious waiver effort.^{cvi}

5. Accountability for Quality Was Weak in Practice

The April 12, 2001, contract between the District and the GSCH-led five-party alliance laid out specific requirements related to quality improvement, as already noted. For example, the contract called for GSCH to:

- operate a “utilization management” system to ensure “adequate control over high-cost and high-risk services” and coordinate care for high-cost enrollees;
- create annual quality improvement plans with at least one study of unmet needs of the uninsured or the Alliance;
- implement a “case management program” and submit it for “comprehensive” review; and
- create annual work plans with a timetable, including “performance improvement initiatives,” “statistically valid performance monitoring,” and include documentation of “sustained improvement or the need for further action.”^{cviii}

The problem was the lack of execution of these responsibilities. Our interviews suggested that the District did not hold the provider consortium accountable for reporting on these quality management- and utilization management-related requirements. As one respondent reported, “there were very detailed accountability standards in the contract, for quality as well as cost—but GSCH failed to meet all of them.” Staff in District health agencies wrote reports or memos detailing the lack of adherence to standards, but they were told to put such memos “on the shelf.” When emergency room access at GSCH was benchmarked to national norms showing deficiencies, staff members were told by their superiors at the Department of Health “to pick new benchmarks.”

Nor did the city officials appear to push the Alliance providers very hard for other data and information—on utilization patterns, adequacy of the provider networks to meet the needs of the population, or patient safety. The Department of Health and DCPCA made some progress on improving the match between facilities and needs through mapping exercises that showed the location of all providers juxtaposed with a measurement of community needs to identify under-served areas. DCPCA used this information to help identify where new community health centers were needed. This exercise also suggested some areas where existing facilities, including former PBC clinics, were under-utilized. However, plans to readjust supply according to these needs have taken a very long time to become a reality.

6. Public Administrative Capacity Fell Short of Needs

A central and ongoing problem through this period was inadequate senior staff leadership and staff capacity. On October 7, 2002, D.C. Inspector General Charles C. Maddox reported that the Department of Health had been very slow to fill positions in the new Health Care Safety Net Administration that it had created to oversee the Alliance. Thus, “the District has little assurance that the Alliance is in compliance with the contract terms or that overall goals, such as the estimated expected patient workloads, are being met.”^{cix} The Health Services Reform Commission empanelled in June 2001 to oversee Alliance implementation also faced problems of staffing and leadership.^{cx}

It proved difficult for D.C.'s public health agency, the Department of Health, to assume the new role of managing an insurance program. Before the PBC, DOH had managed the city clinics, but a coverage program required a very different set of skills. The contract with Chartered in effect outsourced the processing of claims to Chartered, which acted as a third-party administrator (TPA). If incoming claims were "clean" and properly formatted or documented, they got paid. City officials applied little scrutiny. In addition, as noted above, the city "outsourced" enrollment to Chartered during this five-year period, but Chartered did not have access to the records needed to verify Medicaid eligibility and enrollment. Many of the staff at the Health Care Safety Net Administration carried out the functions of passive bill payers, rather than active and engaged contract managers.

The leadership and staff of DOH and the Health Care Safety Administration were not consistently driving upgrades in IT capacity, data base management, or quality improvement. Quality improvement activities routinely found in other cities around the nation were not found in the District. Indeed, the lack of data reporting on measures ranging from prenatal care in the first trimester, hospital infection rates, ambulatory-sensitive (i.e., avoidable) hospital admissions, patient satisfaction, and the extent of proper care management for patients with various chronic illnesses was one of the driving forces behind the move to enrolling Alliance members in managed care plans that could be held accountable for reporting this type of information, and ultimately, improving quality of care.

Consideration of the National Capital Medical Center (NCMC)

Another important milestone in the transformation of the District's health care policy for the uninsured occurred in April to August 2006, when the city withdrew from earlier negotiations to help construct a new private hospital at the D.C. General site. Negotiations and commitments dating back to 2003 had supported construction of NCMC as a new, "state-of-the-art" hospital to be owned and operated by Howard University, but with about one-half of the capital construction funds (somewhat more than \$200 million) provided by the city. Mayor Williams decided in April 2006 to revisit prior understandings and consider alternatives to NCMC, appointing a new Task Force to provide advice.^{cxix} Fears had arisen that NCMC would become a new DCGH, needing substantial operating subsidies beyond the capital infusion, and that Howard would simply add the new hospital to its old system, instead of planning to close or downsize the existing Howard University hospital.

The politics surrounding the proposed new hospital reflected the difficult challenges involved in making the transition from the prior model of hospital-centric support to the new model of supporting lower-income people directly with coverage. The push for the construction of the NCMC was a political reaction to the closure of D.C. General. Early in the life of the Alliance, DC Council members, still angry at the mayor and the control board about DCGH, pressed the mayor to negotiate with Howard University to build a new hospital on the same site.^{cxii} Rather than focusing on a need for new beds (which was a difficult case to make in a city with ample overall hospital beds), supporters of the

NCMC argued that apart from GSCH most hospital capacity was in the northwest quadrant of the District, while most disease burden was east of the Anacostia River. Howard University Hospital and Washington Hospital Center were not far away, but not actually in Wards 7 and 8. However, this argument was weakened by the fact that the D.C. General site was also on the west side of the Anacostia River—a major physical and psychological barrier—in Ward 6, not in Ward 7 or 8.

Other hospitals in the District had fought very hard to avoid ending inpatient service at D.C. General and its contribution to indigent care. However, five years later, they were adamantly against subsidizing a new *private* hospital on the site that would serve mainly paying patients. Many of them were bothered that Howard alone—without any competitive bid—was slated to receive such a huge subsidy for the capital costs of construction. The other hospitals also feared that the city would ultimately move the Alliance operating budget to the new NCMC, thus potentially depriving them of Alliance support—even though supporters promised that no operating support would ever be sought, only normal payments for serving Medicaid and Alliance enrollees.

The mayor appointed a Health Care Task Force through an order issued on April 19, 2006. The Task Force was headed by Greg Pane, then Director of the Department Health, and tasked to consider alternatives to NCMC and also provide wide-ranging advice about District health needs and how best to meet them.^{cxiii} Soon thereafter, the city's chief financial officer issued a quite negative assessment of the proposed hospital's prospects for earning net revenues.^{cxiv} Howard University chose not to sit on the panel, but gave a detailed presentation on NCMC; many invited experts also made presentations on a variety of aspects of health and health care.

The mandate of the Task Force was to develop alternative proposals for how to spend tobacco settlement funds, whether on the NCMC or on other identified health priorities. The District had “securitized” what would have otherwise been an annual flow of funds to the city from the nationwide settlement with tobacco companies, which enabled the city to obtain some \$212 million in a lump sum. These funds had been legislatively allocated to be spent on healthcare. One proposal considered was from Howard to build the new hospital, but the Task Force was charged with considering a range of alternative proposals and to obtain advice from various experts who addressed the Task Force.

Numerous options were considered, but only two received support in the final tally of Task Force members. The first was the NCMC plan from Howard, modified to include more community-oriented elements.^{cxv} This option won votes from a minority of members. A two-thirds majority of members supported a different allocation of funds—to a new a “HealthPlex”^{cxvi} at the D.C. General location to provide both emergency and ambulatory services, for renovations of Greater Southeast Community Hospital, and for additional community-oriented uses. Two versions of community-focused spending were presented, and the majority did not indicate a preference between them. One version consisted entirely of investments in new ambulatory health centers; the other reduced health-center support in order to provide significant support for general health system

improvements, including prevention in addition to clinical care.^{cxvii} The Task Force voted 10-5, with two members absent, in favor of the more community-based option over the NCMC option, and issued its final report on August 1, 2006.^{cxviii}

The mayor and key Council members promptly announced support for the Task Force's recommendation not to proceed with the NCMC proposal, even in modified form.^{cxix} In December 2006 the City Council, echoing one option in the Task Force report, enacted legislation allocating a sizable portion of the tobacco settlement funds to prevention and systems improvement.^{cxx}

- \$20 million for cancer prevention
- \$10 million for anti-smoking initiatives
- \$10 million for chronic disease treatment
- \$6 million for establishing a regional health information exchange
- \$2 million to buy new ambulances

The Council required a needs-assessment study of the District's health system to be done before these funds were spent.^{cxxi} That study was completed in 2007. As of Fall 2009, the funds had not all been spent, and some yet could be reallocated.

Legislation enacted the following year further authorized the use of \$79 million to revitalize Greater Southeast Community Hospital in conjunction with its sale to a non-profit hospital chain. The funding was part of a public/private partnership agreement between the District and the Specialty Hospitals of America, a New Hampshire-based non-profit that already owned two long-term acute care hospitals in D.C.^{cxixii} This result was consistent with the Task Force recommendation.

The city's process of considering, and then reconsidering the state-of-the-art hospital, while painful, represented a major turning point for its support for indigent health care. Faced with the possibility of spending all of the tobacco settlement on a "bricks and mortar" approach, with no funds invested in either improving a hospital already located in an under-served area or investing in public health improvements and primary care capacity, the city backed away. This choice marked a decision by the leadership at both the executive and legislative levels to focus the city's capital support less on hospitals and more on a community-based system, just as the Alliance shifted operating funds from a largely hospital-oriented PBC to a more community-based coverage program.

Reconfiguring the Alliance to Resemble Medicaid Managed Care

Options for Redesign and Choices Made

In 2005 District policy makers announced that they would not continue the five-party agreement beyond the Alliance's five-year term. Managing that contract had required time-consuming contract modifications, was not administratively sustainable, and offered no structure to drive

quality improvements and care management. The policy goal was to move Alliance participants into a managed system with more accountability for cost and quality—which was what the Alliance had promised but could not implement. According to interviewees, three options were considered:

- Contract with a health plan (possibly Chartered, but open to other competitors) to serve as a third-party administrator (TPA). Under this model, the health plan would be responsible for creating a provider network, negotiating rates with providers, and processing claims. But the District would not transfer risk and would ultimately pay providers, through the TPA, on a fee-for-service basis. This model was closest to the existing Alliance arrangements, with the major difference that the District would have a contract with only one entity rather than five. In addition, it would have eliminated any lump-sum payments to specific providers, with all providers in the network being paid according to volume of care delivered.
- Transition the Alliance program to fee-for-service payment, akin to Medicaid's coverage for aged, blind and disabled populations. Under this approach, the District would define a benefits package and a fee schedule and would accept all qualified providers as part of the network. The District would then establish a budget and directly reimburse providers for care to Alliance patients, as it does under Medicaid fee-for-service, without transferring any risk to any managed care organization.
- Develop a model similar to that of Medicaid managed care (which served the SCHIP parents and children population) under which Alliance members would enroll in the same health plans that participated in Medicaid for children and custodial parents, although with somewhat different covered services under the new Alliance. As under Medicaid managed care, health plans would be paid on a full-risk capitated basis with no risk sharing above or below a target corridor as in the original Alliance contracts. This arrangement would give Alliance enrollees the choice of two plans, down from three, as a third MCO was dropping out of Medicaid at the same time.

In sum, the choices were (a) keeping the program similar to the original Alliance, but with a prime contractor MCO to manage the program as a non-risk bearing TPA; (b) mimicking Medicaid fee-for-service, perhaps even with merged administration; or (c) mimicking Medicaid capitation, making the Alliance into a Medicaid managed care lookalike. In addition, policy makers made clear that under any new model, *funds would follow patients*. All “lump sum” contracts with specific providers, such as the ones that had remained with Unity and Greater Southeast Community Hospital, would be phased out. Finally, the District also stated (with much support from most of the participants) that any new model would transfer all enrollment responsibility to the District's Income Maintenance Administration, thus merging the Medicaid and Alliance enrollment processes, and begin auto-enrollment of all Food-Stamp eligibles into the Alliance. After some deliberation and debate, policy makers and stakeholders found a surprising amount of consensus around the third option among existing Alliance participants.

The main rationale for a managed care organization (MCO) model was that the MCOs would be clearly accountable for cost and quality, with a goal of ultimately implementing “pay-for-performance.” Further, this arrangement ended the District’s direct negotiations with hospitals, who (as the largest employers outside the Federal Government and as tangible monuments to health services) are viewed as among the most politically powerful interests in the District. In addition, this arrangement was relatively simple administratively. It was possible to amend the existing Medicaid managed care contracts to add the new Alliance population. This simplicity mattered because there may not have been enough time to conduct an entirely new competitive bidding process, with new standards, before the expiration of the prior Alliance. One downside to the “Medicaid MCO” model was that it was unclear how to set capitation rates for a population that was very different and received a different package of benefits. Further, costs could change, especially if changes in enrollment practices under IMA increased enrollment or changed its composition.^{cxxiii}

An early implementation activity was the development of a new set of quality performance metrics that the new Alliance MCOs would be measured against.^{cxxiv} The new contract represented the first time that quality measures were formally instituted, though it is unclear about how much follow-through has since occurred; the District has found MCO norms hard to enforce under Medicaid. The metrics had to change from those appropriate to Medicaid, even though they would apply to Medicaid MCOs, because Medicaid managed care covers a younger and generally healthier population of parents and children. In any event, the development of performance metrics was one step in the direction of actually implementing more accountability for quality, and it happened quickly.

To help determine the amount of money that the District should pay participating managed care organizations under the new arrangement, the District had already contracted for two studies. One was a detailed actuarial analysis, prepared by the Lewin Group, to help the city set payment rates for the managed care organizations. The other report, also prepared by Lewin, compared provider payment rates in the fee-for-service part of D.C. Medicaid and in the Alliance with those in Medicare and with Medicaid payment rates in selected other states. Although the District would not be paying providers directly under this managed care model, the purpose was to determine what the health plans’ costs would be so that an appropriate capitation rate could be negotiated. The second report was also designed to broadly benchmark the District’s health coverage programs against Medicare and other state Medicaid programs. The resulting reports were published on February 9, 2006, three months prior to the expiration of the five-party contract, and reached the following main conclusions:

- Alliance inpatient hospital payment rates were well below all of the benchmarks. Payments for surgical care were particularly low; medical, obstetrics, and trauma rates were closer to benchmarks. Alliance surgical rates were 49% of the Medicare level, while D.C. Medicaid was equivalent to Medicare (99%). Overall, inpatient payments under the Alliance were 68% of Medicare while D.C. Medicaid was 104%.
- Part of the reason for the low average Alliance payments was that the Alliance hospital fee schedule included just one case-rate for all medical cases and one

somewhat higher case rate for all surgical cases. Thus, it was not operating under a Diagnosis Related Group (DRG)-like system with multiple case rates associated with the type of service provided. A DRG-based or similar system adjusting for case mix and severity of illness was recommended.

- Alliance fees for primary care physicians were only about half what Medicare paid these physicians in the District. (D.C. Medicaid primary care fees were similarly low, representing only 53% of Medicare). Alliance fees for specialist physicians were the lowest of all the benchmark programs (46% of Medicare). In contrast, Medicaid in North Carolina and Delaware paid 95% of Medicare rates to both primary care and specialist physicians.
- Alliance payments to FQHCs (not counting former PBC clinics) were \$65 per visit while D.C. Medicaid paid these FQHCs \$135 per visit. (The average per visit cost was found to be \$161.)
- In contrast, Alliance dental payments were consistently above the benchmark states. The average payment for a dental visit, at \$98, was nearly three times the average dental payment for the next highest payer (\$35).^{cxv}

The challenge in transferring enrollees into Medicaid MCOs as the Alliance program was restructured as a capitated managed care program was to develop a capitation rate that was adequate but not excessive. Achieving this balance required estimating utilization rates appropriate to the set of covered services and setting capitation rates to permit provider payment rates that would be adequate to attract enough physicians to meet patients' needs. In establishing the initial rates under managed care, the city also tried to set rates at levels that would permit the plans to pay community health centers adequately. The countervailing challenge was to stay within budget and allow room for increased enrollment, which was expected as the program transitioned to auto-enrollment for Food-Stamp beneficiaries.

Effectuating the Shift to Medicaid-Style Operations

After significant negotiations, the Alliance was able to agree on capitation rates with two health plans, Chartered and HealthRight, and amend the existing Medicaid contracts with these plans to include the Alliance population. When the Alliance transitioned to managed care on June 1, 2006, enrollees were assigned to one of these two health plans. The third Medicaid managed care plan, Amerigroup, never came to an agreement with the District on rates, so it opted not to participate in the Alliance.

A Second Enrollment Surge

Alliance enrollment increased dramatically after the transfer of Alliance participants into managed care organizations in mid-2006. This spurt in enrollment was facilitated by the conversion to auto-enrollment based on participation in the Food Stamp program. This shift occurred in tandem with the change in payment to capitation. There was a huge increase in enrollment in a matter of months, over the summer and early fall of 2006. In fact, as shown in

the table below, enrollment grew by over 12,000 people (35 percent) from June 2006 to June 2007.

With the enrollment surge and the capitation payments, Alliance spending quickly rose to about \$20 million over budget on an annual basis. Some observers believed that the city had set rates too high, using estimates from prior Alliance utilization, because the new auto-enrolled members were likely lower users of health services. (High users were already enrolled because providers had the incentive to get them enrolled.)

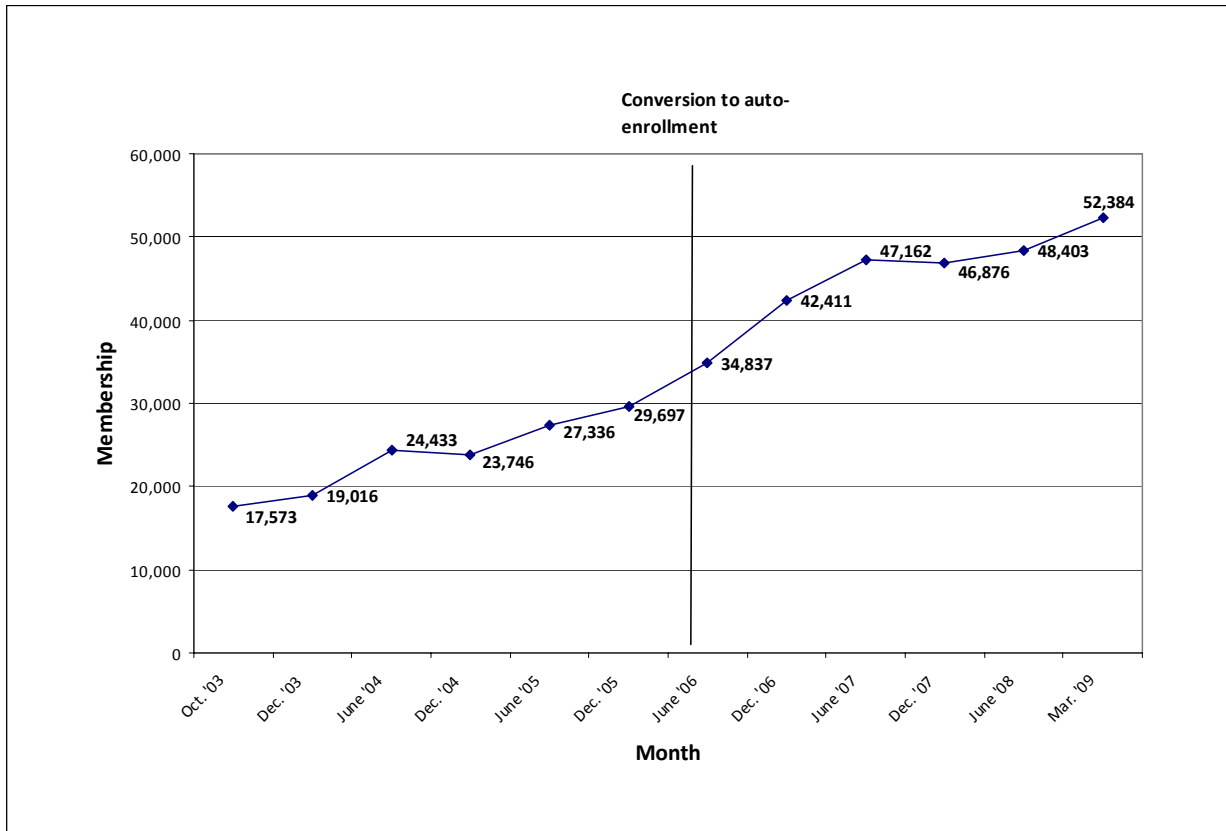
The District developed a unified system for enrollment into publicly financed health coverage programs, streamlining the work of several city agencies; established a clearinghouse of information on health insurance products; improved outreach and enrollment for both the Alliance and Medicaid; and developed a “buy-in” option for uninsured people with incomes between 200% and 400% of poverty to enable them to enroll in either Medicaid or the Alliance, paying on a sliding scale basis related to their incomes.^{cxxvi}

Under the auto-enrollment system, adults and children participating in the Food Stamp program were presumed to be eligible for one of the two health programs, since these programs are available to people with incomes below 200 percent of the FPL while Food Stamps eligibility requires incomes less than 130 percent of the FPL.^{cxxvii} Auto-enrollment allowed IMA, which was responsible for Food Stamp, Medicaid, and Alliance enrollment and, as of June 2006, Alliance eligibility determinations, to identify and enroll Food Stamp recipients into the appropriate health care program, without the person having to submit a separate application. It also required after-the-fact verification of the “presumptive eligibility.” Providers had pushed hard for presumptive eligibility, which enabled them to place patients showing up for care immediately in either Medicaid or the Alliance (hence the term “presumptive”), with later verification of their actual income and resources.

Auto-enrollment was the dominant factor responsible for increases in enrollment, but an additional factor, which the District is currently addressing, is that the District did not tightly manage proof of residency, accepting little more than a personal affirmation, as documented by a 17-month audit.^{cxxviii} From the beginning of the Alliance program, substantial numbers of people enrolled in the Alliance have been found to live in Maryland and to a more limited extent in other jurisdictions. The District’s lax residency verification procedures may have had a “magnet effect,” drawing in residents of adjacent counties and others who rightfully should not be participating in a program financed with the tax dollars of District of Columbia residents.

The table below shows trends in Alliance enrollment after the conversion to managed care:

Figure 5. Enrollment in the DC Healthcare Alliance Before and After Auto-Enrollment, 2003-2009



Source: D.C. Health Care Safety Net Administration (Oct. 2003-June 2006); D.C. Department of Health Care Finance (Dec. 2006-Mar. 2009)

The mayor's proposed FY 2010 budget for the Alliance was \$141.3 million. A D.C. City Council technical accounting adjustment to rectify an inappropriate transfer of \$5 million from the Alliance budget to the Medicaid budget during the Baseline Budget process led to a starting point for Council budget deliberations of \$136.3 million. The Council reduced this amount by \$34.0 million to reflect the following initiatives: \$2.0 million for limiting Alliance enrollment to residents not eligible for other health insurance; \$13.6 million for enforcing a residency requirement, a major shift in policy; \$1.1 million to use Disproportionate Share Hospital (DSH) funds to transition individuals to Medicaid; \$13.7 million to redirect funds from DSH to help with the cost of moving some uninsured people into Medicaid; \$2.8 million to "realign" MCO payment rates; and \$0.8 million to transition unborn children of undocumented immigrants to Medicaid. The District is currently reassessing its processes of eligibility determination, and the budget cut reflects the expectation of the D.C. Council that proof of eligibility will be tightened.

Recent Experience: Achieving the Vision in New Ways

Over the past two years, the District has begun to institute changes that could allow it to achieve more of the Alliance's original vision. According to interviewees, the changes encompass both the approach to the provision of services to the Medicaid and Alliance populations and the personnel charged with implementation. There is new emphasis on setting realistic goals, measuring progress toward the goals, and holding implementing agencies and contractors accountable for the degree of progress made. Changes in personnel at the top and throughout the new Department of Health Care Finance (DHCF), which was carved out of the DOH to run Medicaid and the Alliance, as well as improvements in training of the existing staff, suggest greater promise in the call for system accountability.

An early focus on two of the District's greatest health problems—perinatal health and chronic disease—will allow the new system to be tested and fine-tuned as necessary before addressing the remaining health problems. To enhance its role as purchaser rather than provider of care, as a first step, the District received substantial technical assistance from George Washington University to rewrite and rebid the previously spotty and ill-defined managed care organization contracts for both Medicaid-SCHIP and the Alliance population. Whereas prior requirements were loosely defined, the new contracts were written with much more specificity. They incorporated stricter accountability in structural areas such as network adequacy, enrollment procedures, accountability through requirements for regular reporting on specific performance measures, and in quality of care through the development of individualized care plans for new enrollees and the institution of formal grievance procedures.

The creation of the DHCF—a new cabinet-level agency separate from the Department of Health—finally brought Medicaid and the Alliance together administratively. Up to this point, the Health Care Safety Net Administration (Alliance) and Medical Assistance Administration (Medicaid) had each reported separately to the Director of the Department of Health. (In fact, during some periods the HCSNA/Alliance had effectively reported directly to the mayor's office because of the events and political considerations that led up to the program.) In addition to the advantages of management integration, the new arrangement elevated the Medicaid director to cabinet level, and the new director and deputy director brought knowledge and skills from both the private and foundation sectors. Other key staff were brought in from outside or promoted from within the department. Departmental initiatives sought to upgrade the skills of all staff and to provide them with the tools to better meet their responsibilities, particularly through improving the information system.

Increased Focus on Quality and Outcomes

Over the past year, DHCF and DOH have worked to implement systematic approaches to improving quality of care and health outcomes under both Medicaid and the Alliance. Officials developed criteria for selecting program initiatives so that the problem addressed was both epidemiologically important and amenable to improvement, progress toward improvement was feasible to measure, an evidence base existed to support the proposed initiative, and the initiative did not duplicate existing programs, either private or public. Using these criteria, the city chose to begin by attacking problems in perinatal care and chronic disease

management.^{cxxix} The District created Collaboratives to focus on each initiative over multiple years. The perinatal Collaborative has brought together DHCF, DOH, the three Medicaid-Alliance health plans (which under the newly bid contract include Chartered, Health Right, and Unison), Health Services for Children with Special Needs, and George Washington University. Special emphasis is being placed in the perinatal care Collaborative on reducing the incidence of low birth weight babies, screening expectant mothers for HIV, and reducing infant mortality. The initial focus of the chronic disease Collaborative is on reducing emergency room visits and hospitalizations for enrollees with diabetes, asthma, hypertension, and congestive heart failure. Both initiatives are to examine medical, psychological, and social factors as drivers of adverse outcomes.

Within the ongoing Medicaid and Alliance programs, DHCF has worked to incorporate quality improvement into the MCO contracts by establishing the Health Care Accountability Administration (HCAA). Under leadership with considerable experience in care management, the HCAA is driving the work of the Collaboratives while at the same time building momentum toward improvement within the existing delivery system. The emphasis is on measuring health outcomes and trying to reduce adverse outcomes over time across the whole Medicaid-Alliance population.

Medicaid and Alliance officials made some key decisions at the outset of these initiatives. First, they decided to measure progress for the three participating plans as a whole rather than to compare and contrast their performance. The intent was to establish a baseline for 2008 and then gauge progress of the whole managed care effort, to drive improvement on a population rather than health plan basis. All plans are required to participate, but they are not competitively scored on these initiatives. Second, officials established a multi-year framework of incentives to encourage lasting rather than transitory progress. The Collaboratives are set up as 2009-2011 programs, with expectations that Medicaid will build on their progress after 2011.

The Collaboratives meet on a monthly basis, with some smaller working group meetings in between. Both Collaboratives have sought community participation to solicit input from providers and patients and to expand their influence beyond the formal membership. The Collaboratives are planning to develop "Report Cards" that indicate how the MCOs as a whole are doing on the chosen quality measures for each initiative. Each plan will also document its individual progress. Over time, DHCF plans to develop financial incentives in addition to these softer incentives to spur improvement in chronic illness and perinatal care.

These promising quality improvement initiatives have been supported by changes elsewhere in DHCF. For example, the new leadership for the Medicaid Management Information Systems program has instituted promising changes in data management and analysis. The Service Delivery office has seen substantial improvements. New strategies have been developed to serve developmentally disabled individuals in the two public programs. Contract oversight has been substantially tightened to enforce the new accountability standards for the participating plans. New initiatives related to Home and Community Based Services for elderly and disabled populations have been developed in a renewed effort to help people stay in the community and avoid or delay nursing home admissions. These new initiatives may well prove to be harbingers

of a more serious, continuing effort to address chronic illness and to increase the focus on improving health outcomes. But they remain in a very early and formative stage, and the challenge will be to maintain this momentum and translate the new strategies into concrete results.

The changes in leadership and programs are supported by new and serious efforts to train staff, as already noted. These efforts include regular weekly training sessions on a wide range of competencies relating to program management and operations, including data management, IT, mental health and substance abuse, program operations, and care management for a range of special needs populations.

Progress toward the Medical Home Model

The overhaul of DHCF programs has allowed considerable progress over the past one to two years toward realizing the original Alliance vision of a medical home for all enrollees. Mayor Williams' Health Care System Development Commission had recommended funding to help community health centers pass a quality certification process meant to improve care and care management. It also envisioned office-based physicians serving as medical homes as well as community health centers. The Alliance contract did not address these issues.

Subsequently, the Medical Homes D.C. initiative, managed by the D.C. Primary Care Association (DCPCA), made steady progress with nearly \$70 million in funds granted by the city for capital expansion projects, and additional support provided through private, federal, and city funding for training and technical assistance to health centers. DCPCA selected and granted funds for 13 capital projects on a competitive basis, five of which are in Wards 7 and 8 where needs are greatest. Completed projects notably include improvements in the availability of dental services, an area of perennial need, as well as expansions in primary care capacity and improvements in site-specific emergency preparedness. Capital projects were accompanied by intensive work with medical providers, administrators, and leadership teams to ingrain the principles of continuous quality improvement within health center operations, and to prepare surrounding communities for effective utilization of newly upgraded, neighborhood-based medical homes. The city supported DCPCA through management funding for facilitation of capital project development, information technology systems upgrades for health centers, quality improvement in chronic disease interventions for providers, and the development of a standardized Community Health Worker (CHW) curriculum for health promoters and outreach workers based in and around these newly-developed medical homes. In addition, there are other projects involving improving community health centers in the pipeline.

Other projects include the formation of a small capital revolving fund, training for health center boards, and the creation of a Diabetes Self-Management Manual. Finally, and critically important to the Medical Homes model, the city funded DCPCA's implementation of electronic medical records at six health centers as a first step toward the implementation of a Regional Health Information Organization (RHIO), to move toward an interoperable electronic medical record and health information exchange system. Progress toward the RHIO model is now substantial, according to our interviewees, with live data exchanged between participating health centers and hospitals and more than 400,000 patient records currently held within the system. This investment by the city was leveraged to submit a successful application to the new federal Office of the National Coordinator for Health Information Technology in 2010, designating DCPCA as a Regional Extension Center for electronic medical records; and ensuring 1,000 additional primary care providers will implement, be trained on, and achieve meaningful use of technology within the medical homes system in the next two years.

Figure 4. Medical Homes D.C. Capital Projects Status as of May 2010

Health Center	Project Description	Status
Family and Medical Counseling Services	Move and renovate new floor in current building; expansion of primary care capacity.	Complete
Unity/Walker Jones	Renovation and move to new, larger space	Complete
La Clinica del Pueblo	Renovation to improve patient flow, add financial intake, and add two new exam rooms	Complete
Community of Hope	Addition of dental suite	Complete
Perry Family Health Center	Addition of two new exam rooms	Complete
SOME Health Center	Upgrade of dental suite	Complete
Mary's Center for Maternal and Child Care	28,000 s.f. commercial condominium on ground floor of mixed income retail and housing	In progress – construction stage
Bread for the City	2-story addition (11,000 s.f.) on adjacent lot	In progress – construction stage
Unity/Anacostia	Move and expand services, include specialty care	In progress – design and permitting stage
Unity/Parkside	Move and expand services	In progress – design and permitting stage
Community of Hope	Open 2nd site to expand services	In progress- design to begin shortly
Unity/Brentwood	Merge 2 sites and increase capacity	In progress - negotiation

Source: D.C. Primary Care Association.

DHCF has launched a series of other policy initiatives designed to improve the Alliance, some of which are broader changes that affect both Medicaid and the Alliance. To address the longstanding problem of physician participation in public programs, DHCF has raised the payment rates for both primary care physicians and specialists and has pushed providers to

increase availability of after-hours care in more provider groups and health centers. In addition, the District is seeking federal stimulus (ARRA) funding to finance further needed investments in community health centers. It is also considering imposing a threshold requirement for the “medical loss ratio” for participating plans to insure that at least 85% of premium dollars are spent on health services in an effort to limit plans’ administrative expenses and profits.^{CXXX} Finally, DHCF is placing greater emphasis on addressing the social determinants of health, using the Collaboratives to address behavior and lifestyle choices such as smoking, obesity, and triggers in the home environment that exacerbate chronic disease.

Summary and Lessons Learned

The city managed the transformation from the PBC to the Alliance in a way that expanded the percentage of the population with health coverage and improved access to a wide range of health services. Indeed, some 25 to 30 percent of the population is now covered by Medicaid or the Alliance, representing a very significant local commitment of resources. Moreover, the city accomplished this coverage expansion under very difficult circumstances, both from the viewpoint of a short time frame, with Congress issuing an ultimatum, and from the perspective of the difficult politics surrounding closing a local institution with nearly two centuries of service to its constituency. While there was much bitterness about the closure of D.C. General Hospital that lingered for at least a few years, at the present time, most people seem to have accepted the transition from a publicly run delivery system to a system based on purchasing care from a broader-based private sector delivery system. And the transition was accomplished while keeping the Alliance within its present budget, no mean feat given the large expansions in enrollment, and a stark contrast to the continuous budget excesses of the PBC.

Of course, many challenges remain. The city espoused a medical home model for Alliance patients, but did not attract as many primary providers as many might like and found it challenging to change the traditional pattern of looking to hospitals as the true champions of health services. The city through a DCPCA grant has made a reasonable start toward building up community health centers to serve as more capable medical homes tapping federal grant funding as well, although much remains to be done. Similarly, the Alliance has had difficulty enlisting significant numbers of specialist physicians in its network. Residency verification of Alliance applicants presents another challenge. The surge in enrollment to at least 58,000 is commendable, making the District one of only a few cities to develop a viable system to enroll a clear majority of the uninsured in a system of care, but the District should not extend this system to those that reside outside the city.

Finally, only recently has the city begun to tackle the underlying threats to public health and the fundamental cost drivers for health services spending. Until the social determinants of health, particularly involving behavior and lifestyle, are addressed, sustained progress in improving health outcomes and lowering spending cannot be made. Efforts to measure health indicators and assist people with chronic illness are just getting underway, and it remains to be seen if they will lead to breakthroughs in quality or cost.

The District is not alone in making slow progress in “bending the curve” of health spending. There is still an emphasis on high-cost acute care with little spending on preventive measures that can address and reduce the risk factors that lead to so much illness and disability. This is a national problem and a national challenge. We cannot expect the District to go from having a high-cost, low-performing health system for the uninsured to an “ideal” model that meets all the elements of the vision laid out earlier. We can only expect that the city will continue to incrementally develop and improve its system, learning from others around the nation where it can, while also sharing its successes for those who have not even tackled these challenges. The story of the past decade suggests that the District is well on the path to continuing progress through iterative reforms that have laid the groundwork for future improvement efforts—from the closure of a public hospital, to a prime contract with one provider, to a multi-party contract with many providers, to a rudimentary managed care program, to an improvement of the managed care model and establishment of multiple new programs aimed at quality improvements.

* * *

The Start of Another Decade, after National Health Reform

The enactment of national health reform in March 2010 presents the District with numerous opportunities and challenges over the next few years.^{cxxxix} Four key opportunities are that, first, the new law allows DC to enroll many Alliance members into Medicaid, those who qualify as citizens and by having incomes below 133 percent of the federal poverty line.^{cxxxix} DC made this shift through a Medicaid “state plan amendment” in July 2010. By becoming an “early adopter” of the Medicaid expansion feature of national health reform, the District obtained the ongoing federal matching funds that it could not receive in 2000. Second, starting in 2014, the reform makes available new federal-only subsidies for higher-income Alliance members and others to buy private coverage through a new insurance exchange to be run by the District. Thus, city funding for Alliance enrollees could shrink further, even as beneficiaries receive expanded choices among coverage options with broader networks of providers. Third, starting in 2011, the act provides for \$11 billion in funding for community health centers and school-based health centers nationwide, of which the city could apply for a share. Fourth, numerous other federal grant programs will be established, including many within a new Prevention and Public Health Fund for prevention, wellness, and public health activities. There are also new initiatives to address work force shortages in nursing, primary care, and other fields. These and other provisions of national health reform all present opportunities for the District.

As for challenges, the District already grants eligibility for Medicaid or the Alliance to all adults with incomes up to 200 percent of the FPL, so that the city will not have the same new costs from having to expand eligibility standards that most states will face. However, there will be some new costs from requirements to further improve outreach and enrollment into Medicaid, to bring in those already eligible for but not participating in Medicaid. The act calls for moving toward automatic enrollment procedures, with which Washington has some experience already, described above. An ongoing challenge is to improve the value provided by insurance and the

medical services that it funds. Both quality and cost need improvement going forward, to keep both private and public coverage sustainable.

A final note is that combined reforms create a very large opportunity. The new insurance exchange will serve uninsured residents and employees of small and medium-sized businesses (initially those with up to 100 employees) starting in 2014. The District will then have the opportunity to improve insurance purchasing choices for about half of the city's residents, combining the exchange, Medicaid, the Alliance, and city employees. Good city oversight and better health plan competition for enrollees can help drive changes in the delivery system through holding providers and health plans accountable for quality improvements and cost management, particularly for people with complex medical needs.

Key Lessons Learned

A number of important lessons can be learned from the decade-long evolution of the District of Columbia's efforts to help the uninsured find affordable, high-quality, and timely health care.

We organize these lessons within four key issue areas—health service provision versus purchasing through insurance, delivery system redesign, chronic disease management and prevention initiatives, and public health operations management.

Reform Health Care Financing from “Make” to “Buy”

- If government decides to put most of its resources into supporting a direct service delivery model of support, as opposed to a coverage model, accountability for cost and quality should be built into the effort. There was nothing inherently wrong with the idea of a Public Benefit Corporation built around a hospital and its satellite clinics located in under-served areas with a large number of Medicaid and uninsured residents. What led to the closure of D.C. General Hospital and the end of the PBC was not a philosophical preference to “buy” care from the private sector rather than “make” it through public delivery. Rather, the decisive factors were the open-ended cost reimbursement system where chronic budgetary over-runs were permitted and the lack of accountability for quality of care. The resulting crisis forced precipitous change. Simply put, the PBC was poorly managed. There was little or no continuity of care, nor feedback loops between the clinics and the hospital. Credentialing, even at its most basic level of safety, was missing. The PBC, in fact, won much popular support as a source of good jobs as well as free care. Yet, the shift from direct service provision to coverage seems unlikely to have made District health workers unemployable, given how rapidly the health sector has grown for decades, adding jobs even during the historically bad economic downturn that began in December 2007.^{cxxxiii}

Reform Health Services Delivery

- With the decision to move from a direct service provision to a coverage model, government can offer its uninsured population more choice in service providers while at the same time potentially achieving efficiencies and cost savings.
- The District's vision was thwarted because there was little in place on the supply side of the health care system to meet the government's new "demand." Success requires a clear assessment of current capacity in the health services delivery system and the possible mechanisms to integrate services and bear financial risk, as well as a clear plan from the outset to drive change in that system through financial incentives and technical assistance. Merely changing payment methods and financial incentives is unlikely to engender the necessary changes in the delivery system. To change health outcomes and lower spending, intervention is needed on both the demand and the supply side. A big remaining question, both in the District and nationwide, is how can policy foster the creation of better models of delivering care.
- Inpatient institutions should not dominate the delivery of care. While hospital care is undeniably a critical component of any good delivery system, and the city's hospitals provide life-saving interventions as well as critically important teaching and research, the District had trouble squaring its vision of providing enrollees with medical homes with the reality of the power of the hospitals. The perceived need to compensate the city's private hospitals for their increased uncompensated care burden became dominant in the ongoing five-party arrangement at the cost of attention to the underlying drivers of poor health and the need to revitalize and modernize the primary care delivery system.
- Building a continuum of care is an essential element of reform. There must be pathways and affordable access at each level of care and across levels, starting with primary care and leading to specialty and diagnostic visits, affordable medications, and inpatient care, as needed. The Alliance improved access to these different levels. But the city is still short of organized delivery systems that combine or integrate the various components of the system, and so manage patients' conditions, improve outcomes, and help contain costs. It is not enough to improve access to primary and preventive care, as critical as that is. People must also have a pathway to affordable access to specialty care and diagnostics.
- Mental health and substance abuse services have been left out or "carved out" of the District's programs for lower-income people. While they are available directly through city agencies, there is limited access and poor coordination between these services and other acute care services. Optimal care recognizes that mental health and substance abuse frequently go hand-in-hand with deteriorating physical conditions, requiring coordination across services.

Create Initiatives in Public Health and Prevention

- The District's experience shows the importance of addressing and devoting resources to the underlying cost drivers in the system, including the social determinants of health—poverty, lifestyle, and the environment. Reorganizing the health delivery system cannot by itself solve the problem of the high incidence of disease and injury in the city. A serious attempt to improve health outcomes must address such factors as obesity, smoking, substance abuse, child abuse and neglect, and violence.
- Achieving improved health outcomes and better cost management requires learning how to manage the health care of people with chronic diseases. The Alliance population is dominated by middle-aged and older adults who are not yet eligible for Medicare, many with unmanaged or poorly managed long-term medical conditions. The District has only recently begun a serious effort toward chronic care management. Medicaid costs in the District are well above the national average, and there is much more work needed to bring these costs down.
- Local health reform must also address the problem, long-standing in the District and widely prevalent elsewhere, of overcrowded emergency rooms and gaps and problems in ambulance service. Improvements in emergency services were made under Mayor Williams but problems persist and the city should build on its gains.
- Some early steps were taken to capture the benefits of information technology. For example, some community health centers have developed electronic health records. Building on its early success in establishing an electronic backbone, the city must make it possible for providers across the continuum of care and from different institutions to view patient data through interoperable systems. A sharable information base will help improve the fragmentation of the delivery system and ultimately enable quality and cost improvements. Meeting these goals will require considerable financial investment and some technical assistance. Federal funding now available for health IT via the economic stimulus package will be helpful, and moving toward a RHIO will facilitate the transformation.

Improve Management Capabilities

- Implementation can trump design. The Alliance did not develop as originally designed in part because of the lack of an integrated delivery system but also in part due to weaknesses in management. Strong leadership and tailored skill sets are required to bring a good design to fruition. Good implementation frequently entails a willingness to take political heat.
- There is a corresponding need to build capacity in different skill sets when transforming a health care system. Staff transformation takes time and requires a clear implementation plan. Skill sets include contract development and management;

negotiation; data storage, retrieval, analysis, and use; IT capacity; and program evaluation, among others.

- Effective leadership is important. The District's ten-year effort was not built around a single "champion," who if lost from the effort, would lead to a collapse of reform. Rather, there were a series of champions, including Mayor Williams and his Department of Health directors, and new leaders in the Department of Health Care Finance in the Fenty administration.
- The city did an excellent job enrolling large numbers of uninsured people into a new coverage-based system of care created in just a few months. However, lax enforcement of residency requirements may have led to "excessive enrollment." Enrollment processes and policies are difficult to design and effectively implement. In the District, which has so much leakage in from other jurisdictions, the need for efficient yet fair residency verification further complicates the process. Stringency needs to be balanced with not tightening requirements so much that people who should be in the program are kept out.
- The city's later experience with auto-enrollment of lower-income uninsured people into the Alliance is instructive. Passive approaches are insufficient and reliance on the standard tools of outreach, such as enrollment at provider sites, while helpful, misses many people. Auto-enrollment uses hard information of probable eligibility to find more of the uninsured and get them into a health care program. However, education is also key as enrollees were not always aware that they had been enrolled in coverage.
- Better data is needed. The Alliance is still struggling to get basic data on its enrollees. Successful programs require steady tracking of basic information regarding patterns of use of services. And ultimately, program managers need to know if health outcomes are improving. Some measures are now available citywide, and even by Ward, but not specifically for Alliance enrollees.
- Implementation is never finished. The Alliance is still a work in progress.

Conclusion

The District has made considerable progress in transforming its support for the uninsured from "make" to "buy." Ten years ago the city was spending heavily on a poorly performing hospital with mounting cost over-runs and questionable quality of care. Simply put, the city was paying a lot of money and not getting a good return on it.

The experience in Washington, D.C., shows that it is possible to move quickly, even during an atmosphere of crisis, to set up a new system based on purchasing insurance-like coverage for

lower-income residents rather than financing a single provider system. The city geared up fast and, over time, has covered the majority of the uninsured, a major accomplishment for which it has gotten little national recognition. The Alliance opened the doors for low-income patients to free albeit imperfect access to all types of providers, as well as affordable pharmaceuticals and diagnostic tests. And it gave residents coverage for care at a range of high-quality hospitals, previously used mainly by higher-income populations. Tens of thousands of residents of the city have benefited from this help. Moreover, the city accomplished this without setting up a big new bureaucracy.

In addition, the District accomplished a good measure of cost control. While cost data are fragmentary, available budget information indicates that spending has been holding steady in recent years, even with rising enrollment. Thus, the experience in Washington, D.C., shows that governments can provide comprehensive coverage for the uninsured at a reasonable and sustainable cost, and do so without a big bureaucracy.

Yet, despite these major accomplishments, much remains to be done. The delivery system is still too fragmented and lacking in coordination. The city is only now beginning to collect, synthesize, and disseminate data on cost and quality of care. Basic indicators of success or failure are still lacking. Current health leaders in the city appear committed to tackling this challenge.

Emerging initiatives on perinatal care and better management of chronic illness are promising. But the District has considerable catching up to do with many states in areas such as reducing hospital infections, better management of a range of chronic diseases, redirecting people from emergency rooms to primary care settings, reducing inappropriate referrals to specialists, and moving toward electronic medical records. The District needs to work closely with both participating managed care organizations and the hospital and physician communities to adopt best clinical practices and move toward a higher-performing health system. But this, of course, is the challenge that faces the whole nation.

Appendix 1. Timeline for the District of Columbia’s Health Reform, 1999–2009

years	Key Developments, by Era		
	<i>Health Care Financing</i>	<i>Health Care Delivery</i>	<i>Political & Other</i>
1995-1999: Problems as a Prelude to Reform			
1995			Apr. Congress creates Control Board to oversee finances of the District
1997	Oct. Public Benefit Corp. (PBC) enables city hospital and clinics to collect insurance reimbursements outside the city’s budget	PBC is created to run DC General Hospital and associated clinics	
1997-1999	Fiscal problems persist at PBC	Complaints about access to care, quality, support systems, are also heard.	
1999-2001: Envisioning the Shift from a Public Hospital to Public Insurance Coverage			
1999	The Mayor’s FY 2000 budget unsuccessfully proposes Medicaid expansion to 200% of FPL (reduce uninsurance to 3%), financed with fund-shift from PBC support	Proposal would have made DC General Hospital (PBC) compete for patients to earn its funding	Jan. New Mayor Anthony Williams takes office
2000	Fall. Control Board, Administration, and advisory commission develop plan to replace direct financing of care at public facilities (PBC) with private contracting Dec. Control Board issues Request for Proposals for a contractor to run new system	Proposal called for private delivery of services, every enrollee have a primary-care medical home to oversee care	Aug. Key Congressman gives DC and Control Board an ultimatum to end traditional financing of PBC Nov. DC’s congressional appropriations act follows through
2001	Jan.-Feb. Two bids are received for new financing arrangement; only the one from an “Alliance” of providers led by Greater Southeast Community Hospital was deemed credible. Apr. DC Council rejects Alliance, but Control Board approves a five-year contract	Feb.-May Alliance finalizes its network of participating hospitals, clinics, and physicians Apr. Control Board takes over PBC management	Apr. Control Board promulgates enabling legislation for Alliance May. Court refuses to block Alliance May. City establishes Safety Net Administration within Health Department to oversee Alliance
2001-02 The Alliance Contract: Initial Experience			
2001	Jun. Enrollment begins into Alliance Jul. Billing begins for Alliance	May. pediatric services shift to Children’s National Medical Center, OB & deliveries to Gr SE	Jun. Mayor establishes Health Services Reform Commission as independent

		Jun. Inpatient operations shift to Gr. SE; DC General becomes outpatient and emergency site only	oversight body
		Jun. Alliance enrollment begins	Sep. Control Board suspends its activities after DC achieves its 4th consecutive balanced budget
		Jul. Alliance assumes full safety-net responsibility	
2002	May. Alliance enrollment reaches 25,000	Nov. Parent company of Greater Southeast Hospital files for bankruptcy protection	
	Nov. DC Dept of Health creates plan to take over administration of Alliance from Gr SE in case of latter's non-performance		
	Dec. Alliance enrollment reaches 30,000		

2003-04 The Alliance Contract: Subsequent Modifications

2003	Nov. District announces new agreement with key Alliance hospitals and clinics, which becomes known as the "five party" agreement, frequently renegotiated	Aug. DC Dept of Health finds safety & quality deficiencies at Gr. SE, agrees to 60-day correction process	
		Aug. Joint Commission on Accreditation of Healthcare Organizations denies GSE accreditation	
		Nov. Dept of Health issues Gr. SE a restricted license allowing continued operations	
2004		Jan. After Council enabling act of prior Nov., Mayor signs agreement with Howard Univ. to support construction of a new National Capital Medical Center (NCMC) at the site of DC General	
		DC Primary Care Ass'n gets three-year federal grant to plan for improvements in community health centers	

2005-06: Reconfiguring the Alliance to Resemble Medicaid Managed Care

2005	Jan.-Mar. District considers three options for new approach to Alliance at end of initial five-year contract		
	Mar.-Jun. District selects option to place Alliance members in MCOs, embarks on a year of		

	planning for shift		
2006	May. All Alliance members switched over to enrollment in MCOs	Jan.-Aug Mayor agrees to, then after convening and hearing from special task force, backs away from paying for half of Howard University's NCMC Dec. City Council reallocates the capital funding	
2007 to date: Recent Experience--Achieving the Vision in New Ways			
2007		Oct. Specialty Hospitals of America agrees to buy Gr. SE Community Hospital Nov. District agrees to loans and grants in support of hospital improvement	
2008	May. New MCO contracts agreed with three health plans participating in Alliance	Dec. Four projects renovating community health centers completed	Oct. Dept of Health Care Finance (DHCF) begins operation separate from Dept of Health--a new cabinet level entity that includes Medicaid and Alliance operations; enabling legislation passed in 2007
2009		1st quarter. Two community health center projects break ground for new building, renovations Apr. DHCF partners with private firms and Dept of Health on multi-year quality improvement initiative	Jun. Meeting sponsored by DCHF with community leaders, physicians held at Howard University Hospital to review new quality initiative

Source: Authors' compilation

Appendix 2. List of Interviewees

Dave Chandra, DC Department of Health Care Finance

Julie Hudman, Director, DC Department of Health Care Finance

John Koskinen, Director and Interim Chief Executive Officer, Freddie Mac; former Deputy Mayor and City Administrator, Washington, DC

Gina Lagomarsino, Managing Director, Health Systems Development, Results for Development; former assistant to the City Administrator, Washington, DC

Patricia MacTaggart, George Washington University

John McCarthy, Deputy Director, DC Department of Health Care Finance

Doneg McDonough, Health Care for America Now; formerly with the Financial Responsibility and Management Assistance Authority

Ann Page, DC Department of Health Care Finance

Emil Parker, Hospital and Health Care Consultant; former health policy advisor to the Deputy Mayor, Washington, DC

Daniel Rezneck, Office of the Attorney General of the District of Columbia

Theresa Sachs, Health Management Associates

Francis Smith, DC Chartered Health Plan, former Executive Director of the Financial Responsibility and Management Assistance Authority

Shauna Spencer, Pittsburgh Regional Health Initiative; former Director, DC Health Care Safety Administration

Jane Thompson, DC Primary Care Association

Anthony Williams, former Mayor, Washington, DC

ⁱ Interviewees are listed in Appendix A. Jack Meyer was a consultant to Mayor Williams' Health Care System Development Commission in 2000. Randall R. Bovbjerg served on the Mayor's Health Reform Commission during 2000-2003. Bovbjerg and Barbara A. Ormond led the policy inquiries of the city's State Planning Grant during 2003-2005, and they staffed the Mayor's Health Care Task Force in 2006. Gina M. Lagomarsino was Senior Policy Adviser For Healthcare in the City Administrator's Office during 2004-2006. All four authors have written previously about DC health issues, and all live and work in the District of Columbia.

ⁱⁱ See generally Barbara A. Ormond, Linda J. Blumberg, John Holahan, David G. Stevenson, Susan Wallin, and Joshua M. Wiener, *Health Care for Low-Income People in the District of Columbia*, Washington, DC: The Urban Institute, December 01, 1999, <http://www.urban.org/url.cfm?ID=309044>.

ⁱⁱⁱ The Census Bureau estimated 5,358,130 residents for the 22-county Washington-Arlington-Alexandria, DC-VA-MD-WV Metropolitan Statistical Areas as of July 1, 2008; see "Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2000 to July 1, 2008," <http://www.census.gov/popest/metro/CBSA-est2008-annual.html>. DC alone totaled 591,833 <http://www.census.gov/popest/states/NST-ann-est.html>.

^{iv} DC Hospital Association, Financial Indicators report. Fiscal Year 2005. Winter 2006, p. 5. <http://www.dcha.org/Publications/05Financial.pdf>.

^v Temporary Assistance for Needy Families, created by the Personal Responsibility and Work Opportunity Act of 1996. It replaced AFDC, Aid for Families with Dependent Children. Both are popularly called Welfare. The Act also largely de-linked receipt of cash welfare from eligibility for Medicaid, and gave states including DC much more flexibility to expand their Medicaid programs.

^{vi} Michael Janofsky, "Congress Creates Board To Oversee Washington, D.C.," *N.Y. Times*, April 8, 1995, <http://www.nytimes.com/1995/04/08/us/congress-creates-board-to-oversee-washington-dc.html>. The full name was Financial Responsibility and Management Assistance Authority. The Authority, a five-member body more popularly known as the "Control Board," was established by Congressional legislation—Public Law 104-8, the District of Columbia Financial Responsibility and Management Assistance Act of 1995. The Authority was responsible for overseeing the finances of Washington, DC until it suspended all activities on September 30, 2001, when the District achieved the legislatively-required fourth consecutive annual balanced budget.

^{vii} "Medicaid Expected to Improve in D.C.," *Washington Times*, Friday, January 25, 2008, <http://washingtontimes.com/news/2008/jan/25/medicaid-expected-to-improve-in-dc/print/>. Certain Medicaid functions are located elsewhere; for example, enrollment operations including eligibility determinations occur within the Department of Human Services' Income Maintenance Administration.

^{viii} U.S. Census Bureau, District of Columbia 2005-2007 American Community Survey 3-Year Estimates, accessible from <http://factfinder.census.gov/home/saff/main.html>. Somewhat dated demographic and health data by ward are available from DC Department of Health, Center for Policy, Planning and Epidemiology, Ward Specific Profiles for Wards 1 - 8 (web page with 8 documents) <http://www.doh.dc.gov/doh/cwp/view,a,1374,q,603445.asp>.

^{ix} In DC, the state-federal "SCHIP" coverage expansion for children is integrated with Medicaid; it covers children with family incomes somewhat above Medicaid levels. Its official name is DC Healthy Families, but it is commonly spoken of as part of Medicaid.

^x Jennifer King and the State Planning Grant team, Insurance and Uninsurance in the District of Columbia, Starting with the Numbers, DC Department of Health and The Urban Institute research report, September 2005. Available at <http://www.urban.org/publications/311234.html>.

^{xi} Ormond et al. (1999). For many states, two-year averages are conventionally used to increase the statistical accuracy of estimates made from the surveys on relatively small annual samples.

^{xii} DC Medicaid Fact Sheet, 2006-07, Kaiser state health facts online, undated but current webpage, <http://www.statehealthfacts.org/mfs.jsp?rgn=10&rgn=1>.

^{xiii} John Holahan and Allison Cook, "The U.S. Economy And Changes In Health Insurance Coverage, 2000–2006," *Health Affairs* 27(2):w135-w144 (published online 20 February 2008).

^{xiv} Ormond et al., 1999.

^{xv} Data for the years 2006-07 are the most recent available. They come from the federal CPS (Current Population Survey), which underestimates insurance in DC because it does not obtain accurate information about enrollment in the Alliance, the District's new form of coverage (below). See Allison Cook and Barbara A. Ormond, "Who Has Insurance and Who Does Not in the District of Columbia?" Washington, DC: The Urban Institute, Policy Brief DC-SPG no.3, December 14, 2007, <http://www.urban.org/url.cfm?ID=411589>.

^{xvi} Ormond et al. (1999) and DC Medicaid Fact Sheet, 2006-07. Medicaid spending per capita reached \$8484 in the District in FY 2006, 85 percent greater than the national average (ibid). Of course, simple comparisons of the District to other states lack adjustment for the nature of the populations and prevailing prices in the area. Yet, it is noteworthy that Medicaid spending in the District is three times as high as in California (where Medi-Cal provider payment rates for providers are among the country's lowest), and is 75 percent higher than Medicaid spending per capita in Pennsylvania or Virginia. <http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4>.

^{xvii} DC residents' per capita personal health care spending was \$8,295 in 2004, according to federal actuaries. For Massachusetts, the second highest state, the comparable figure was \$6,683; the national average was \$5,283; and for the lowest state, Utah, spending was \$3,972 per resident, less than half the DC amount. The average annual rate of growth for the District during 1991-2004 was below the national average, however, 4.4 percent versus 5.5 percent. Office of the Actuary, CMS, Health Expenditures by State of Residence: Summary Tables, 1991-2004," September, 2007, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-us.pdf>. These figures are not adjusted for differences across states.

^{xviii} Some 19 percent of enrollees are disabled, another 9 percent elderly, but together these categories of eligibility account for 63 percent of spending. DC Medicaid Fact Sheet, 2006-07.

^{xix} Rates were average as of 1998 but 13 percent below average in 2008. Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation," *Health Affairs* 23: W4-374–W4-384 (published online 23 June 2004); Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs* 28(3):w510-w519 (published online 28 April 2009).

^{xx} John Holahan, Suresh Rangarajan, and Matthew Schirmer, "Medicaid Managed Care Payment Rates in 1998," *Health Affairs* 18(3):217-27 (1999); John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," *Health Affairs* 22(1):204-18 (2003).

^{xxi} District of Columbia Revitalization, Title XI, Balanced Budget Act of 1997, Public Law 105-33.

^{xxii} Paul Offner, then Medicaid Director, detailed many shortcomings in his op-ed essay "In the Belly of the Beast," *Washington Post*, June 29, 1997. The *Post* in this era ran a number of front-page investigative stories on problems in many agencies, some of which were under federal court orders to correct litigated deficiencies. E.g., Michael Powell, "From the Top, a City That Doesn't Work: Bureaucratic Inefficiency, Political Machinery Keep D.C. From Functioning," *Washington Post*, July 20, 1997, page A01. Offner left office at the end of 1999, citing major managerial improvements, Paul Offner, "D.C.'s Most Improved Agency," *Washington Post*, December 5, 1999; p. B08, <http://www.washingtonpost.com/wp-srv/WPcap/1999-12/05/024r-120599-idx.html>.

^{xxiii} On care for the uninsured nationally, see Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs*:W3-66-81 (published online 12 February 2003). For a detailed explication of state and local systems that pay for or provide care in New York, see Randall R. Bovbjerg, Stan Dorn, Jack Hadley, John Holahan, and Dawn M. Miller, *Caring for the Uninsured in New York: What Does it Cost, Who Pays and What Would Full Coverage Add to Health Care Spending?* Washington, DC: The Urban Institute, report to the New York Community Trust, October 2006, <http://www.urban.org/publications/311372.html>.

^{xxiv} Marion Ein Lewin and Stuart Altman, eds., for the Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* Washington, DC: National Academies Press, 2000.

^{xxv} DC Hospital Association, 1999 Fiscal Indicators.

^{xxvi} For an accessible overview of legal requirements, see Jennifer Coles Schecter, "COBRA Laws and EMTALA," Medscape Medicine Specialties, Emergency Medicine, Special Aspects of Emergency Medicine, updated: May 26, 2009, <http://emedicine.medscape.com/article/790053-overview>.

^{xxvii} Hadley J., "Sicker and Poorer: The Consequences of Being Uninsured," (available at www.kff.org/content/2002/20020510) and Medical Care Research and Review (Supplement to Vol. 60, No. 2, June 2003); Hadley J. and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *Health Affairs* web exclusive, February 12, 2003; Hadley J. and T. Waidmann, "Health Insurance and Health at Age 65:

Implications for Medicare and Medicaid," The Urban Institute, April 2003. The Robert Wood Johnson Foundation supported the following work through a grant to The Center for Studying Health System Change: Cunningham P. and J. Hadley, "Expanding Care vs. Expanding Coverage: Alternative or Complementary Approaches for Improved Access for Low-income Persons?" Center for Studying Health System Change, May 2003.

^{xxviii} <http://www.cga.ct.gov/ph/HealthFirst/Docs/Health%20First%20CT%20Authority%20-%20Report%20to%20Legislature.pdf>

^{xxix} Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Lurie N, Billings J, Stewart A., "Preventable Hospitalizations and Access to Health Care," *JAMA*. 1995 Jul 26;274(4):305-11. The issue of appropriate access to care remains for insured patients as well, even under national health insurance, Roos LL, Walld R, Uhanova J, Bond R. Physician Visits, Hospitalizations, and Socioeconomic Status: Ambulatory Care Sensitive Conditions in a Canadian Setting," *Health Serv Res*. 2005 Aug;40(4):1167-85.

^{xxx} Amy Goldstein, "Hospitals Cornered," *Washington Post*, June 15, 1997; p. W06.

^{xxxi} Barbara A. Ormond and Randall R. Bovbjerg, *The Changing Hospital Sector in Washington, DC: Implications for the Poor* Washington, DC: Urban Institute, October 1998, <http://www.urban.org/publications/900659.html>.

^{xxxii} See the excellent comparative "Appendix 5: Benchmark Cities" in Nicole Lurie, Carole Roan Gresenz, Janice C. Blanchard, Teague Ruder, Anita Chandra, Bonnie Ghosh-Dastidar, Amber Price, Bruce Siegel, Marsha Regenstein, Donna Sickler, Bonnie Norton, Karen Jones, *Assessing Health and Health Care in the District of Columbia*, Arlington, VA: The Rand Corp., interim report, no. WR-534, for the Executive Office of the Mayor, January 2008, accessible from http://www.rand.org/pubs/working_papers/WR534/.

^{xxxiii} Ormond et al. 1999.

^{xxxiv} Lurie et al., *Assessing Health* (January 2009). The final report sets out policy options: Nicole Lurie, Carole Roan Gresenz, Janice C. Blanchard, Anita Chandra, Barbara O. Wynn, Kristy Gonzalez Morganti, Teague Ruder, Amber Price, Donna Sickler, Bonnie Norton, Karen Jones, Marsha Regenstein, and Bruce Siegel, *Assessing health and Health Care in the District of Columbia*, Arlington, VA: The Rand Corp., phase 2 report, no. WR-534, for the Executive Office of the Mayor. June 2008, accessible from http://www.rand.org/pubs/working_papers/WR579/.

^{xxxv} "Healthy People," webpage managed by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services <http://www.healthypeople.gov/>. For DC's "Healthy People 2010 Plan," see http://doh.dc.gov/doh/cwp/view,a,1370,q,574815,dohNav_GID,1787,dohNav,{33139}.asp.

^{xxxvi} See DC Department of Health, "Major Causes of Death for the District of Columbia, U.S., and Selected Cities, 2002-2004," March 6, 2007, accessible from <http://www.doh.dc.gov/doh/cwp/view,a,1374,q,602052.asp>; *Big Cities Health Inventory: The Health of Urban America, 2007*, National Association of County and City Health Officials, Benbow, N., editor. Washington, D.C. 2007, no longer web posted by NACCHO but accessible at http://www.who.or.jp/2008/urbanh/US_Big_Cities_Health_Inventory_2007.pdf.

^{xxxvii} Various estimates may be cited. For example, Medicare enrollees with three or more chronic conditions account for 92.9 percent of spending and virtually all Medicare spending growth since 1987. Kenneth E. Thorpe and David H. Howard, "The Rise in Spending Among Medicare Beneficiaries: the Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs* 25(5):w378-88 (published online 22 August 2006). Hoffman C, Rice D, Sung HY. Persons with chronic conditions. Their prevalence and costs. *JAMA*. 1996;276(18):1473-1479.]]

^{xxxviii} McGinnis, Health Affairs; The New York Academy of Medicine/Trust for America's Health. September 2009. "A Compendium of Proven Community-Based Prevention Programs.

^{xxxix} Richard Wilkinson and Michael Marmot, Eds., *Social Determinants of Health: The Solid Facts* Geneva: World Health Organization, International Centre for Health and Society, 2d ed. 2003, <http://www.euro.who.int/DOCUMENT/E81384.PDF>.

^{xl} U.S. National Library of Medicine, "District of Columbia General Hospital," in Historic Medical Sites in the Washington, DC Area, Celebrating the Bicentennial of the Nation's Capital, last updated: 8 September 2006, <http://www.nlm.nih.gov/hmd/medtour/dcgeneral.html>.

^{xli} Ormond and Bovbjerg 1998, Ormond et al. 1999.

^{xlii} See, for example, US General Accounting Office (now Government Accountability Office), *District of Columbia: Information on Health Care Costs*, GAO/AIMD-96-42, April 22, 1996, <http://www.gao.gov/archive/1996/ai96042.pdf>.

^{xliii} GAO reviewed DC General finances in two different time periods. Before the shift to PBC operations, in "fiscal years 1991 to 1994, the District provided a total of \$309 million in subsidies, \$75 million of which was characterized as loans, to cover large operating deficits," US General Accounting Office (now Government Accountability Office), *District of Columbia: Information on Health Care Costs*, GAO/AIMD-96-42, April 22, 1996, at p. 38, <http://www.gao.gov/archive/1996/ai96042.pdf>. The PBC during fiscal years 1997 through 2000 was budgeted to receive \$195 million in city subsidy to cover uninsured care. It overspent that allowance by some \$33 million and also received some \$99 million in "un-repaid cash advances." US GAO, "Anti-Deficiency Act Violation Involving the District of Columbia Health and Hospitals Public Benefit Corporation," letter report to the Chairman, Subcommittee on the District of Columbia, Committee on Appropriations, US House of Representatives GAO no. B-285725, September 29, 2000, at pp. 4-5, <http://archive.gao.gov/legald426p9/164189.pdf>.

^{xliv} US GAO, "Information on Health Care Costs," 1996.

^{xlv} Stephanie Mencimer, "First, Do No Harm," *Washington City Paper*, Aug. 18 - 24, 2000 (Vol. 20, #33), <http://www.washingtoncitypaper.com/display.php?id=20184>. Press has not always been negative, Victor Cohn, "D.C. General Hospital; Blueprint for Change; Underfunded, Understaffed and Under Fire, the City's Public Hospital Battles the Odds to Give Decent Care," *Washington Post*, September 20, 1988.

^{xlvi} Denver General Hospital, now called Denver Health in recognition of its comprehensive, integrated services, provides a counterexample, described for example by its CEO, Patricia A. Gabow, "Making A Public Hospital Work," *Health Affairs*, 20(4):182-7 (2001); see also its web site <http://www.denverhealth.org/portal/>.

^{xlvii} "D.C. General Malaise," *Washington City Paper*, Dec. 3-9, 1999, vol. 3 no. 48.

^{xlviii} Avram Goldstein, "Deficits Cast a Pall Over D.C. General," *Washington Post*, February 1, 2000, p. B01.

^{xlix} David A. Vise, "Computers May Be a Risk at D.C. General," *Washington Post*, March 24, 1999. p. B1, <http://www.washingtonpost.com/wp-srv/local/daily/march99/dcgeneral24.htm>.

^l Paul Offner, "We Can Afford To Insure All D.C. Residents," *Washington Post*, January 23, 2000, p. B01, <http://www.washingtonpost.com/wp-srv/WPcap/2000-01/23/083r-012300-idx.html>; Paul Offner, "Politics and the public hospital in our capital," *Health Affairs* 20(4):176-81 (2001).

^{li} Detailed figures appear in Paul Offner, "Purchasing Health Care for the Uninsured," Washington, DC: Institute for Health Care Research and Policy, Georgetown University, manuscript prepared for Council on the Economic Impact of Health System Change, Expanding Health Insurance / Strengthening The Safety Net: Policy Options and Trade-Offs, April 5, 2000, council.brandeis.edu/pubs/Offnersafety.pdf.

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- ^{lii} Avram Goldstein. "D.C. Health Plan Would Cover Most Uninsured; Program Overhauls Medicaid." *Washington Post*. March 14, 1999.
- ^{liii} "Mayor's Fiscal Year 2000 Budget, Testimony of Mayor Anthony A. Williams," before the Subcommittee on the District of Columbia, Appropriations Committee, U.S. House of Representatives, April 15, 1999, <http://dcwatch.com/mayor/990415.htm>; Avram Goldstein, "D.C. Health Plan Would Cover Most Uninsured; Program Overhauls Medicaid," *Washington Post*, March 14, 1999.
- ^{liiv} The Health Care System Development Commission report in December 2000 called for new contract-based payment per patient to DC General, other improvements, including medical homes, and better monitoring capacity at Department of Health. <http://www.dcwatch.com/archives/council13/13-911.htm>; Avram Goldstein, "D.C. Panel Outlines Health Proposals; Payment Plan Absent From Long List of Fixes," *Washington Post*, February 27, 2000.
- ^{lv} The Chairman's displeasure had already been made clear in Report 106-786 to accompany H.R. 4942, the District of Columbia Appropriations Bill, 2001 (submitted by Mr. Istook of Oklahoma, from the Committee on Appropriations), 106th Congress, 2d Session, House of Representatives, July 25, 2000, <http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr786&dbname=106&>.
- ^{lvi} District of Columbia Appropriations Act of 2001, Public Law 106-553, accessible from <http://thomas.loc.gov/cgi-bin/bdquery/z?d106:HR04942:@@D&summ2=m&>.
- ^{lvii} Chief Financial Officer Natwar M. Gandhi, Memorandum: "Urgent Need for Action in Regard to PBC," November 14, 2000, <http://www.dcwatch.com/govern/cfo001114.htm>.
- ^{lviii} <http://www.dcwatch.com/control/cb001204.htm>
- ^{lix} It is important to note that the lack of support of a Medicaid expansion approach meant that the District missed an opportunity to gain a large amount of federal matching funds for a coverage strategy, a point that will be developed further later in this report.
- ^{lx} Slightly different versions of the administration's vision appear in different sources. See Office of Policy and Evaluation, Executive Office of the Mayor, and the District Department of Health; Building on Success to Create a Model Health Safety Net for District Residents, May 2001. http://www.dc.gov/mayor/health_care/model1.shtm.
- ^{lxi} Primary physician specialty societies emphasize the role of physicians. According a more recent definition, a medical home should assure that each patient has an ongoing relationship with a personal physician trained to provide first contact, with continuous and comprehensive care. The personal physician would lead a team at the practice level that would collectively take responsibility for the ongoing care of patients. The personal physician would provide for all of the patient's health care needs or arrange for other qualified medical professionals to do so. The physicians on the team would coordinate and integrate subspecialty care, hospital care, home health, and long-term care, assisted by registries and health information technology. Also important to the medical home model is enhanced access to care through open scheduling, expanded hours, and new, modern options for communications between patients, their personal physicians, and office staff. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. "Joint Principles of the Patient-Centered Medical Home," March 2007, <http://www.medicalhomeinfo.org/joint%20Statement.pdf>.
- ^{lxii} Government of the District of Columbia. Health Care System Development Commission. *Strategies for Change: Final Report*. December 2000. P.1.
- ^{lxiii} *Ibid*.
- ^{lxiv} Randall R. Bovbjerg and Barbara A. Ormond, "DC General Is History. Let's Focus on Its Replacement," *Washington Post*, p. B08 <http://www.urban.org/url.cfm?ID=900441>.
- ^{lxv} Request for Proposal No. DCFRA#-00-R-039, December 2000. This ultimately led to the Agreement Between The District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation I. <http://dcwatch.com/control/cb010412.htm> It is not an RFP.
- ^{lxvi} Paul Offner, Mayoral plan of 1999.

^{lxvii} E.g., Councilmember David Catania, The Case Against Contracting with Doctors Community Healthcare Corporation (“DCHC”), February 20, 2001 (DCHC was parent of GSCH, seen as unreliable contractor) <http://www.dcwatch.com/issues/pbc010220.htm>.

^{lxviii} Geisinger was founded in 1915 and Group Health of Puget Sound in 1945. See “Why Geisinger,” <http://www.geisinger.org/about/index.html>; “About Group Health,” http://www.ghc.org/about_gh/index.jhtml.

^{lxix} See <http://www.denverhealth.org/portal/AboutDH/tabid/2108/Default.aspx>; Patricia A. Gabow, “Denver Health: Initiatives For Survival—How One Public Health Care System Is Not Only Surviving, But Thriving,” *Health Affairs* 16(4):24-6 (1997).

^{lxx} Group Health Association of Washington DC had been a pioneering prepaid group practice when founded in 1937, but by the mid 1990s had become moribund and had sold out to Humana, K. Scott, “Case study—Group Health Association: Can Humana Resuscitate the Moribund HMO?” *Health Syst Lead* 2(4):12-8 (1995). Humana in 1997 sold out to Kaiser Permanente, which in 2000 was not positioned to take on a major role in serving the uninsured.

^{lxxi} <http://www.dcwatch.com/control/cb010427a.htm>.

^{lxxii} Agreement Between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation I, April 12, 2001, <http://dcwatch.com/control/cb010412.htm>.

^{lxxiii} Avram Goldstein. “Council Defies Mayor on Hospital; Funds Allocated to DC General.” *Washington Post*, April 13, 2001; Avram Goldstein. “D.C. Council Unanimously Rejects Plan for Hospital; City’s Control Board, Congress Are Likely To Overturn.” *Washington Post*. April 28, 2001.

^{lxxiv} United States District Court for the District of Columbia. Kevin Chavous v. District of Columbia Financial Responsibility and Management Assistance Authority. Case No. 1:01CV00921 (RWR) DAR).

^{lxxv} *Washington Post*, April 11, 2001, Goldstein, A.

^{lxxvi} Chavous v. [Control Board], 201 FRD 1 (US District Court for DC, August 6, 2001), accessible at <http://www.dcwatch.com/issues/pbc010806.htm>.

^{lxxvii} Agreement, pp. 9, 29.

^{lxxviii} Agreement pp. 9, 28.

^{lxxix} Agreement sect. 1.41, p. 9.

^{lxxx} Key informants with a city perspective suggested that a constant thread of the city’s negotiations with hospitals was providers’ desire to be “made whole,” evidently meaning to be paid close to full average costs incurred.

^{lxxxii} Agreement. p. 9.

^{lxxxii} All ambulatory surgeries and invasive procedures were to be provided by GSCH and CNMC, with any inpatient service that cannot be provided by GSCH to be provided by GWU on a “back-up” basis. Correctional system care was to be provided by GSCH along with the former PBC Clinic sites (now under the (now under the management of GSCH). Ancillary services along with X-ray and lab services were to be available to Alliance enrollees at all four ambulatory care clinics; various sites such as Howard University Hospital’s physician clinic and Chartered’s full service Ward 7 family health center also provided routine X-ray, lab, and diagnostic tests; more intensive diagnostics were to be provided, depending on the service, at DC General, GSCH, or Children’s National Medical Center.

^{lxxxiii} Ivan Walks, Chief Health Officer, Testimony to the Committee on Health and Human Services, June 22, 2001, <http://www.dcwatch.com/issues/pbc010622a.htm>; DC Healthcare Alliance, Presentation to DC Health Services Reform Commission, July 12, 2001.

^{lxxxiv} See also discussion below, notably of the Office of the Inspector General’s report.

^{lxxxv} Chris Silva, “Mayor’s office: Too Much Ado about Healthcare Alliance,” *Washington Business Journal*, May 17, 2002 <http://washington.bizjournals.com/washington/stories/2002/05/20/newscolumn4.html>

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- ^{lxxxvi} Health Care Safety Net Administration (DC Dep't of Health), 2002 Annual Report: First Year Achievement Highlights, February 2003.
- ^{lxxxvii} Chris Silva, "Mayor's office: Too much Ado about Healthcare Alliance," Washington Business Journal, May 17, 2002
- ^{lxxxviii} Lena H Sun. "Sole Bidder at Foreclosure Sale, D.C. Pays \$20 million for Southeast hospital." Washington Post. July 10, 2010.
- ^{lxxxix} Executive Office of the Mayor. "Fenty Commemorates New Pediatric Emergency Unit at United Medical Center with Ribbon Cutting." Press Release. July 14, 2010.
- ^{xc} Jonetta Rose Barras. "Another Health Care Battle in the District." Washington Examiner. July 5, 2010.
- ^{xcⁱ} State expansions are described in State Coverage Initiatives (a program of the Robert Wood Johnson Foundation, "State Specific Strategies," <http://www.statecoverage.org/node/50/cs>.
- ^{xcⁱⁱ} Five other cities are reviewed in Randall R. Bovbjerg, Jill A. Marsteller, and Frank C. Ullman, Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion (Washington, DC: Urban Institute/Assessing the New Federalism, Occasional paper no. 39, September 2000), <http://www.urban.org/UploadedPDF/309647_occa39.pdf; as part of implementing the Alliance, city policy makers reviewed this experience and that of a few other cities as well.
- ^{xcⁱⁱⁱ} Nicole Lurie et al. "Our History in Numbers: What Does the Data Tell Us? DCPCA Annual Meeting.
- ^{xc^{iv}} One early news account noted, "Alliance clinics are registering more than 11,000 patient visits a month, and doctors at charity clinics say that enrollment is smooth and that they are able to get their patients specialty care and prescription drugs more easily." Avram Goldstein, "D.C. Health-Care Program Defies Predictions: Fewer of the Poor Are Using Services; \$15 Million Unspent," Washington Post, December 4, 2001, p. B03. Perceptions of how well the Alliance worked of course differ by observer and also by time period.
- ^{xc^v} Prices are set under the Federal Supply Schedule, see National Acquisition Center - Federal Supply Schedule Service - Pharmaceuticals <http://www1.va.gov/oamm/oa/nac/fsss/pharmfss.cfm>. They can be some 40-50% below the Average Wholesale Price.
- ^{xc^{vi}} Health Care Safety Net Administration, 2002 Annual Report: First Year Achievement Highlights (Feb 2003), http://dchealth.dc.gov/doh/lib/doh/about/pdf/achievement_highlights.pdf.
- ^{xc^{vii}} Lurie. Supra. Oct. 8, 2002.
- ^{xc^{viii}} One estimate from a member of the House Government Reform Committee was \$90 million a year, Avram Goldstein. "Council Defies Mayor on Hospital." Washington Post. April 13, 2001. The GAO's estimate for FY 2000, the PBC's last full year, was some \$122 million—\$44 million from a general fund appropriation, then \$58 million as an "advance" plus a final \$10 million as "incurred obligations that exceeded the total amount appropriated." See US GAO, "Anti-Deficiency Act," (2000), above.
- ^{xc^{ix}} These sites were operated by "independent nonprofit clinics, hospital affiliated clinics, and school-based clinics." DCPCA, *Primary Care Safety Net: Health Care Services for the Medically Vulnerable in the District of Columbia: A 2002 Update*, October 2002, p.21.
- ^c DC Primary Care Association, "Medical Homes DC" webpage (Aug 2007), <http://dcpca.org/index.php/Programs-and-Accomplishments-8-2007.html>.
- ^{ci} Jim McElhatton, "D.C. Officials Back Health Care Clinics," the Washington Times, January 29, 2004.
- ^{cⁱⁱ} Office of Policy and Evaluation, Executive Office of the Mayor, and the District Department of Health, *Building on Success to Create a Model Health Safety Net for District Residents*, May 2001, http://www.dc.gov/mayor/health_care/model1.shtm.
- ^{cⁱⁱⁱ} "About Henry Ford," <http://www.henryfordhealth.org/body.cfm?id=37460>.
- ^{c^{iv}} Some contemporaneous accounts note that the Alliance sometimes received additional monies beyond its annual budget, though not on an open-ended basis as at the PBC, e.g., Avram Goldstein, "Indigent Health System Overspending: D.C. Council Asked to Draw From Reserves to Avoid Limiting Service," Washington Post, June 3, 2003; p. B04 (Alliance \$10 million under budget in fiscal 2002, expected to be

\$15-34 million over in 2003). Reconstructing Alliance spending year by year was beyond the scope of this report

^{cv} During the first year of Alliance operations, an audit found many eligibility errors. Office of the Inspector General, *Audit of the Health Care Safety Net Contract*, OIG No. 02-1-2HC, October 4, 2002, http://oig.dc.gov/news/view2.asp?url=2002_Oct_4%2Fahcnc_100402.pdf&mode=release&archived=0&month=20029.

^{cvi} This problem was a focus of the OIG report already noted. The Alliance was unable to provide documentation for the majority of its eligibility determinations for its 20,000 plus enrollees. The audit found that over 6% of Alliance enrollees were also enrolled in Medicaid, although only 15% of them received Alliance payments, totalling only about \$300,000. Over 10% of enrollees had invalid social security numbers; and, among the valid ones, the OIG found over 400 individuals with the prior year's income above the Alliance ceiling.

^{cvi} Once the city had funded the Alliance itself, getting federal financial participation was no longer possible under federal waiver rules, our interviewees explained.

^{cvi} Agreement. Exhibit A. pp. 14-15.

^{cix} Avram Goldstein. "Firm Faulted on Health Plan for D.C. Poor; Audit Finds Contractor Provided Free Services to Thousands of Ineligible People." *Washington Post*. October 8, 2002.

^{cx} Sewell Chan and Avram Goldstein, "Council Finds It Hard to Speak Kindly of Mayor," *Washington Post*, December 6, 2001; p.DZ02.

^{cx} Eric M. Weiss, "Panel Named to Study Hospital Alternatives: Some Advocates of New Facility Question the Task Force's Intent," *Washington Post*, April 20, 2006, p. B06.

^{cxii} Craig Timberg, "Williams Willing To Help Finance New SE Hospital: Howard Would Operate Facility Near the Campus of D.C. General," *Washington Post*, November 1, 2003, p. B01, <http://www.washingtonpost.com/ac2/wp-dyn?pagename=article&contentId=A49546-2003Nov1>.

^{cxiii} The Task Force's mission was to "review types of health care facilities appropriate for Reservation 13 and examine alternative approaches to best meet community needs; identify the District's most pressing health issues; consider ways to promote financial stability of the District's hospitals; improve emergency medical services; and examine ways to allocate disproportionate share dollars and DRG payment weights to improve equity and appropriateness of use of these funds." *Health Care Alternatives for Reservation 13 and Eastern Washington. Report of the Mayor's Health Care Task Force*. August 1, 2006. Pp. ii-iii, http://dchealth.dc.gov/doh/lib/doh/information/reports/final_rept_hlth_care_tforce.pdf.

^{cxiv} Office of the Chief Financial Officer, "National Capital Medical [Center]" Memorandum to Mayor Anthony Williams, May 5, 2006, <http://app.cfo.dc.gov/CFORUI/news/release.asp?id=145>.

^{cxv} These elements included information technology links with community providers and government, EMS training and disaster preparedness, and a community advisory board.

^{cxvi} A HealthPlex includes such services as emergency care, primary and specialty physician offices, ambulatory surgery, diagnostic imaging, laboratory, and health education. Formal partnerships with hospitals would provide access to care for patients requiring more intensive treatment.

^{cxvii} The optional community oriented uses, said the report, "might include, but are not limited to: study of emergency department utilization, trauma transport, and EMS issues (\$1-2m); smoking cessation programs (up to \$14m); prevention grants (\$10-\$30); diabetes and asthma management grants (\$TBD); healthcare system quality and efficiency initiatives (\$TBD); new non-EMS transit system (\$3-\$5m); electronic health records (\$20-40m)." It later noted that "components have intentionally been described in general terms, sometimes as a range of investment, so as to leave flexibility for subsequent decision makers." Report at pp. 20, 25. Press accounts focused only on the "bricks and mortar" recommendations for renovations and construction. E.g., "a majority of the divided group's [called] for new ambulatory care centers in Wards 6, 7 and 8 and renovations to Greater Southeast Community Hospital," Vandana Sinha, "D.C. Mayor Kills New Hospital, OKs Renovating Greater Southeast," *Washington Business Journal*, August 2, 2006, <http://washington.bizjournals.com/washington/stories/2006/07/31/daily47.html>.

^{cxvii} Health Care Alternatives for Reservation 13. *Supra*.

^{cxviii} See Report, above, p. iv.

^{cxix} VandanaSinha, August 2, 2006, above.

^{cxx} This allocative decision may have been eased by the intervening development that the securitization raised some \$33 million more than the \$212 million the Task Force was directed to consider. VandanaSinha, "D.C. Gets More Money to Spend on Health Care," *Washington Business Journal* - August 17, 2006, <http://washington.bizjournals.com/washington/stories/2006/08/14/daily50.html>.

^{cxix} VandanaSinha, "\$245 Million Health Care Plan Passes D.C. Council," *Washington Business Journal*, December 5, 2006, <http://washington.bizjournals.com/washington/stories/2006/12/04/daily22.html>

^{cxix} Nikita Stewart and Susan Levine, "Hospital Deal Gets Financing From D.C.: Despite Warning, \$79 Million Backed," *Washington Post*, October 24, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/10/23/AR2007102300793.html> (the warning came from the chief financial officer, "that the buyer is financially unstable").

^{cxix} Some observers feared a budget shortfall even before the formal shift to IMA. Neil Adler, "Funding crunch" could cripple health alliance," *Washington Business Journal*, May 26, 2006, <http://washington.bizjournals.com/washington/stories/2006/05/29/story3.html>.

^{cxix} This was done via a committee at the time of the transition to the MCO model, led by Emil Parker, head of the HCSNA and chaired by Nicole Lurie, MD, the lead investigator on the city's needs assessment already noted.

^{cxix} The Lewin Group. "Healthcare Alliance Payment Rate Comparative Benchmarking Report." February 9, 2006. Pp. 1-2.

^{cxix} *Ibid.* p. ii.

^{cxix} Each program has its own rules regarding what is "countable income" and this and other factors may lead to slight discrepancies in methods of eligibility determination. But with Food Stamp eligibility so much lower than the health programs, it is a safe assumption that people eligible for food assistance are almost always eligible for the health care programs in the District.

^{cxix} Susan Levine, "D.C. Health Alliance Faulted on Eligibility Control," *Washington Post*, February 28, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/02/27/AR2008022704108.html>.

^{cxix} "Improving Birth and Chronic Illness Outcomes." Medicaid and DC Alliance Health Care Quality Improvement Collaboratives. Fact Sheet. April 22, 2009.

^{cxix} The new national health reform law calls for medical loss ratios to be no less than 80% in small-group and non-group markets and no less than 85% in the large-group market. Not all experts agree that loss ratios always make for sensible regulation. See James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," *Health Affairs*, 16(4):176-187 (1997).

^{cxix} The Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119-1025, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029-1083, March 30, 2010, both accessible from <http://www.gpo.gov>.

^{cxix} Darryl Fears, "D.C. jumps at health-care savings in expanded Medicaid," *Washington Post*, May 14, 2010 14, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/05/13/AR2010051304995.html> and Jessica Marcy, "D.C. In Front Of The Health Reform Curve, Officials Say," *Kaiser Health News*, Aug 24, 2010, <http://www.kaiserhealthnews.org/Stories/2010/August/24/dc-health-shorttake.aspx>.

^{cxix} U.S. Bureau of Labor Statistics, The Employment Situation, September 2009, <http://www.bls.gov/news.release/empsit.nr0.htm>. BLS, November 2009Health Carehttp://www.bls.gov/spotlight/2009/health_care/ (559,000 health jobs added nationwide during 2008 and 2009).

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