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Keynote Address

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Councilman David Catania:* Often we get together and we sometimes celebrate our defeats in the parade of horrible, but there are a lot of good news stories about what is going on here in the District of Columbia. Specifically, with respect to our health care safety net we are moving the health care ball forward. Health care has been a focus of mine since I joined the Council in 1997. Early in my tenure on the Council, I was struck by the incredible disconnect between the amount of money that the District would spend on health care and our deliverables. There are enormous life expectancy disparities in Washington, DC based on class and color. I was given the opportunity to chair the newly organized Committee on Health. For those of you who are not aware, the Council is a unique legislature. We are the state, county, and city government. The committee chairmen have quite a lot of influence in deciding the direction of policy within the respective committee. Within weeks of assuming the new committee chairmanship, a steady stream of bad news flowed into my office.

Those of you who have been in DC for a while are aware some of the things we have not done exactly well with respect to HIV/AIDS. At the time, I took over the chairmanship in January 2005, I had vendors who had not been paid for in as long as nine months. You can imagine that under-resourced non-profits were essentially funding the government's operation while trying to meet their own overhead. Going nine months without being paid obviously puts quite a damper on operations. At the same time, our Board of Medicine ranked dead last in the country. The Board of Medicine polices your doctors. If you are at all concerned about having high quality care, you want a rigorous Board of Medicine to police doctors and root the bad ones out.

Regardless of what the catastrophe de jour was at the time, there was one thing that was undeniable: no one was in charge of health care here. To hear the government's side of the story, you would believe that there was not enough money to provide the kind of high quality access to care that we are all entitled to. The truth is, at that time and today, the District has one of the highest per capita expenditures on health care in the nation. To this day, notwithstanding the progress that we are making, we still have a long way to go. The undeniable truth is, though, if you are white in the District of Columbia you have the longest life expectancy in this country. If you are African-American, you have the shortest. That is the simple truth. It is not as if we do not have the capacity or the services or the wherewithal to produce a long life expectancy. There are very real issues of race and class and income that are dividing these outcomes.

To me it was bad to see pubic officials simply wringing their hands and complaining without actually doing anything about it. I took it upon myself to begin chairing the committee in a different way. I started by reviewing every expenditure starting in January 2005. About 28 percent of the city's budget is spent on health care. That is an enormous amount of money. We have the largest percentage of the treasury of any of the nine standing committees. The fact of the matter is no one had actually looked at how we were spending the money. I will be honest with you. Over time people simply have ladled on one expenditure after another. They never actually go back and make sure we are getting what we are paying for. I took a fairly rigorous and proactive approach. We began looking at every expenditure of our two million plus dollars, right down to the phone bills. I want to share with you a couple of things that we found.

We hear the refrain of "waste, fraud and abuse" all the time. How many of you believe that it exists? How many of you think it is a tired excuse? It really does exist and it exists in a galling, maddening way. Let me give you a couple of examples. Two million dollars is a lot of money to go one line item at a time with a staff of five, but we actually took the old approach of "trust but verify." We found that the Department of Health leased over twenty pieces of property across the city. These leases originated in the late 1990's. Most of them lacked certain terms and conditions that you might find

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Councilman Catania received his bachelor's degree from Georgetown University's School of Foreign Service and his law degree from Georgetown University Law Center and is very often in the news as a true public servant.

interesting, like the number of square feet to be leased, or price per square foot. It would not surprise you that the people who were able to obtain these leases were individuals politically connected to our then mayor. To this day we are still extracting ourselves from some of these leases.

At the time I started this in 2005, we were paying as much as sixty-six per cent of the appraised value of the property in rent per year. For class-A office space downtown we pay eight to nine per cent of appraised value. These politically-connected individuals, with their friend's help, were able to simply steal money. I do not know how else to put it. We leased properties that were poorly equipped to serve the functions we needed. Some even lacked handicap accessibility. We "bought" these properties several times over. Our health outcomes did not happen by accident. We have been poorly served by five generation of leaders who allowed their friends to enrich themselves while at the same time crying a river about health outcomes. It took some doing to extract these bottom-feeders from their leases. There is no other way to describe them really. They are stealing money that is not intended for their pockets, but rather is intended to provide health care—high-quality, successful health care—for our residents. It took a lot to extract these bottom feeders, but I am pleased to say we have been fairly successful.

Another area that caught my attention through our focus on every expenditure was a telecommunications audit. Every local, county and federal government should conduct a telecommunications audit because they will find some eye opening things. I found that the Department of Health was paying for about 4,000 land lines to serve the Department. This did not in itself seem shocking, except we only had 1,300 employees. That did not include, mind you, city-owned cell phones. I am a believer in physics and even giving every employee one phone for each ear, we obviously still had more phones than we needed. We were able to dramatically beat that back as well.

One other example: Medicaid transportation. There are a whole host of people who make their money off of poor people. You have to be careful because they are usually the most clever advocates for poor people. If you are Medicaid eligible you are entitled to emergency and non-emergency transportation. The government will pick you up at your house and take you to medical appointments and back as many times as you need it. Washington, DC has the most highly developed public transportation structure of any state in the country, but our per person cost would rival that of Alaska, where patients are transported to doctor's appointments by plane.

We had a number of individuals who would bill the District seven figures and we could only find 3,000 dollars or less in actual services rendered. No one ever asked, "where is the money?" No one ever said, "where are the bills?" The amount these vendors were paid was self-determined. It was the most ridiculous honor system. It would not surprise any of you to understand that these Medicaid contracts were given to friends of public officials. This is important because of what you will hear later on about what we have done with dental benefits. We were able to save enough money by organizing a rational Medicaid transportation plan to provide dental benefits for 60,000 people. Let us just be nice and say there was *enough* waste in transporting people in non-emergency Medicaid plans. Today we still pay for Medicaid beneficiaries to get to the doctor. We simply took out the waste and we were able to provide a comprehensive dental plan for 60,000 people.

In the four years since I became chairman of the health committee, we have cut the number of uninsured in our city from about thirteen and a half per cent to roughly eight or eight and a half percent. Our uninsurance rate has recently jettisoned back up from seven percent because the economy has gone south and not everyone is availing themselves of COBRA. Still, this rate places the District in the top tier nationally with the lowest rates of uninsured. In terms of real numbers, it means about 35,000 more people that are insured today, even in this economy, than were five years ago. That equates to about half a ward.

With respect to children in this area, I am very proud. We rank with Massachusetts as having the lowest percentage of uninsured children in the country. That is the result of a very sensible policy to increase Medicaid coverage to 300 percent of the poverty level and then to have an alliance program that covers every child, regardless of immigration status, up to 300 per cent. That is something I am very proud of.

With regards to dental benefits, five years ago we ranked dead last (with Virginia and Maryland) in adult dental benefits. Misery loves company and our friends to the north and south, Virginia and Maryland, were ranked last with us so nobody made anybody look too bad. There was a perversion there, though. For example, we would pay for emergency tooth extraction—as many as you have teeth in your mouth—at local emergency room. Each extraction costs eight to twelve thousand dollars. It adds up. We thought it was a more appropriate public policy to deny care until emergency services were required. This practice caused pain and suffering and cost the tax payer. Rather, now we invest in expansive primary care dental benefits. Now we rank first in the nation in dental care reimbursement.

I receive routine calls from Medicaid and alliance managed care organizations complaining that we are too generous and are busting their budgets. Two of our managed care organizations actually lost money last year because the dental benefits have been so widely used. They asked if we could make an arrangement for them to get more money. I explained the notion of capitalism and risk-based contracting. They do not get to keep profits if they make them and also get reimbursed if they lose. They are supposed to be organized in such a fashion that they win if they do it right and fail if they do not.

Since April 2007, we have had over 30,000 unique dental visits by adults. We have invested well in excess of 60 million dollars. It really is a powerful thing to see people who really have been marginalized: the adult Medicaid population. These are poor people, most of whom work for a living. As poor adults age their teeth deteriorate,—as all of ours would if we did not take care of them,— it takes its toll on dignity and their ability to find employment. It is hard to show up for a job interview when you have no teeth. I actually had a woman testify at my appropriations hearing last year with her new teeth. It was an extraordinary moment and I felt that the city had actually delivered what it should to its residents. She explained how her teeth helped her manage her diabetes. It is not just opportunistic infections, viruses and the diminished life expectancy that come with poor oral hygiene, there are also issues associated with morbid health conditions.

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What did we do with the rest of the money? As we extracted government waste we reinvested back into health care. Although colleagues of mine have been criticized for practices with respect to earmarks, I will tell you the other side. Earmarks can work if there is proper oversight and proper public participation. I will give you a few examples. One example is a set of earmarks I have given to Children's National Medical Center. In 2005, 37 percent of our schools had full-time nurses. Full time nurses are important, not just for ice and aspirin, but for a whole host of reasons. School nurses test body mass index and help to manage special education kids.

Part of the reason we have to send kids out of our system is because we cannot manage their special needs and health-related issues at the school. It actually saves us money to have nurses present at schools. Ninety-six percent of Washington, DC schools have full time nurses. Policy makers are coming from as far as Dubai to learn about DC's integrated electronic medical record central system. We have doubled the number of professionals in our school heath program. We were the only jurisdiction last year to receive the highest child immunization award of distinction from the Centers for Disease Control and Prevention. DC is the only jurisdiction to ever have made substantial progress in preschool immunization, going from 72 percent to 93 percent of immunized preschoolers. These are all investments in our future.

Additionally, the District has a number of receiverships, including special education and services for the developmentally disabled. We created these receiverships because of the way in which we organize Medicaid reimbursements. When a plan's reimbursement rate is low, not many professionals will accept that plan. In 2009, the District's reimbursement rates for Medicaid fee-for-service were one half that of Medicare. There was a long history of underfunding Medicaid reimbursements which had the effect of forcing physicians out of service. When the fee-for-service Medicaid population—the most vulnerable seniors, the most developmentally disabled, the most mentally ill—cannot get access to care and die in care homes, it becomes front page news in the Washington Post. There is a lot of outrage. The solution is as elementary as raising reimbursement rates to attract physicians to treat the aging and disabled. It does not require a Manhattan Project. Last year, I was able to facilitate near-doubling the tax on cigarettes. We now reimburse 100 percent on Medicaid and Medicare. We are one of the few jurisdictions that offer 100 percent reimbursement. We hope to attract more Medicaid fee-for-service providers.

Later today, I am heading to United Medical Center. The urban safety net hospitals are dying because of the loss of third-party paid insurance, which cross-subsidized Medicaid and Medicare. Medicare and Medicaid do not come close to reimbursing costs, so we must rely upon a fair mix of third-party insurance payment.

When you have a hospital like United Medical Center, where about 10 percent of the people are third-party paid and everyone else is government paid, when a hospital loses 22 to 35 cents on every dollar of service it cannot make that up with volume alone. United Medical Center was owned by a company called Doctors Community Health Care Corporation. A gentleman by the name of Paul Tuff was the CEO. I have said many times that he was one of the few people I ever met who could get out of a trash can without taking the lid off. While the city shoveled millions of dollars at him and he put the hospital not through one but two bankruptcies, he formed a small company called the Redman Tuff. He took six and a half million

dollars out of Redman Tuff for his private airplane. The year before he put the hospital into bankruptcy, he took three million dollars as salary.

The company served as an employment center for the Tuff family: brothers, aunts, uncles, kids, stepchildren. It was a larcenist cabal that is now bankrupt. He bought United Medical Center, then called Greater Southeast, in 1998, a year before he bought Michael Reese Hospital in Chicago. Michael Reese, like Greater Southeast, was a 450-bed hospital that served as safety net for a largely African-American community. I am going over to United Medical Center today to see the progress that we are making on our new 11 million dollar pediatric emergency room that will be run by Children's National Medical Center. I will see the 30 million dollars in capital investment including the first ever MRI and a fully restored radiology department including cardiac catheterization equipment. Today, Michael Reese Hospital has a crew on site in Chicago, but it is a demolition crew. This shows the struggles that we have in urban health care, whether there is the will within a community to make the gap up left by under-reimbursement of a publicly funded system in the absence of third-party payment.

For those of you who live in different jurisdictions, it is important to advocate for safety net hospitals because it is in your own interest. It is more expensive to not have them than to have them. If you allow safety net hospitals in the urban core to close, uninsured patients will seek care at local hospitals. It puts a pressure on the entire system.

If we had allowed the former Greater Southeast to close, we would have added 50,000 emergency room visits to hospitals already tight on capacity, putting a further strain on the existing infrastructure. You simply cannot escape the care. Individuals who need care will find a hospital near you and they will often tax your hospital's infrastructure beyond its physical capacity.

In Washington, DC, we have had quite a struggle with the HIV/AIDS epidemic. I want to provide a greater context for this discussion. You all have undoubtedly heard the stories about three percent of the District's population having HIV/AIDS. How many of you heard the references to third world countries? There is a different perspective. To be sure, the District has not always done its best, but I can provide context. For those who live in this region who are HIV positive there is a general policy. I do not mean to offend any Virginians, but if you are poor or in need of medical care, the accepted policy is to move to Washington, DC. There is no safety net in Virginia. Therefore, if you are HIV positive in neighboring Northern Virginia you move to the District, where every resident between zero and 200 percent of poverty is given access to a 100 percent publicly financed primary, specialty, and acute care insurance model. This practice adds to Washington, DC's HIV/AIDS numbers.

If you are from Maryland, you are slightly more evolved but not much. Coverage rates are higher than in Virginia, but not for single, childless, or immigrant individuals. If you are a Marylander with HIV who is struggling financially, you move to the District. If you are in need of primary or specialty care, none of the suburban hospitals have acute care capacity in HIV treatment. The same goes for Spanish-speaking capabilities. If you are LGBT or African-American, the suburban hospitals simply do not have the capacity to finance or the infrastructure to treat you. We wind up being the focal point for a region of four million people. Numerous people come here and it makes our HIV/AIDS numbers look bigger. Our numbers are also bigger because we are vigorous with respect to our treatment of HIV/AIDS. There is no waiting list to receive treatment. We have HIV/AIDS drugs assistance programs and there is no co-pay or deductible. By virtue of keeping people alive longer, the number of people with HIV in DC grows.

We will be releasing an epidemiology report that shows we have cut our new HIV infections in half, which is good news. Our HIV/AIDS drug adherence is up by 50 percent, which is good news. We still have a long way to go. The District government falling apart did contribute to this epidemic.

When I became chairman, we had no Epidemiology Department, no data to research. If you do not know how an epidemic is being transmitted, if you do not know the populations being affected and infected, you do not know how to organize your limited prevention dollars. You do not know how to build primary care and a care capacity for the populations affected. We used one budgetary earmark to contract with George Washington University School of Public Health. We worked with them to build our data research department within the HIV administration. It is evident that we have the finest urban data in the country now.

Communities today look very different than communities did ten or fifteen years ago. We are going into communities and providing a boot camp on everything from how to organize a board, how to apply for grants and how to properly administer grants, to how to make sure you file your 990's. We intend to prevent a disorganized or underperforming infrastructure as we go forward.

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Finally, I would like to talk about long-term care. Our long-term care infrastructure speaks about who we are as a community. At present, we have nineteen nursing homes in the city. A third of those are excellent with four or five star ratings. We have another third that are not so good. Our efforts are to improve the quality of care and expand care options.

Assuming you reach a certain age, you will need long-term care. At that point, you will probably rather stay in your own home than to go to a nursing home. Thus, we have made a huge investment in home, community-based care. We provide a Medicaid waiver that gives enrollees the same quality of health care in the home as they would receive in a nursing home.

I realize that people may eventually find their way into nursing homes. We recently passed a measure that organizes our skilled nursing facilities in a way to provide the highest quality care. The District is one of the first jurisdictions to require a physician in every nursing home. Other federal rules require a relationship with, not a presence of, a physician. The policy developed based on the needs of rural nursing homes where there were not a lot of doctors to have on staff. We have a lot of doctors in the city, however. We now have the first-ever requirement of 0.2 hours of physician time per patient per week.

The city has also advanced with respect to discharge planning. Often, at nursing homes, once you check in, there is no incentive to send you home because you generate revenue. To combat this, the District builds in a discharge planning regiment to help people make the decisions that are best for them. We are also licensing personnel administrators and geriatric specialty training for those who work in nursing homes.

Those are just a few things that we are doing here in the District. It is a great time to be involved with health care in Washington, DC. We have really made some progress. We have a lot further to go, but we are a rich jurisdiction and we have a lot of talent here.

Participant: I am wondering what became of Paul Tuff. Is there any litigation in progress?

Councilman Catania: You can hide behind corporate shields in this country and get away with crimes. That is what Paul Tuff did. There were no criminal consequences for his actions and frankly, very few financial consequences for his actions. He developed a model that worked for him. He would take reimbursements from insurance companies, third-parties and the government. He would pocket the money. He made his money off the backs of the doctors and providers. He simply would not pay those who provided goods and services. He would let the accounts payable stack up. At some point, you know the adage: If you owe the bank fifty dollars, you have a problem. If you owe the bank fifty million, the bank has a problem. The system is now bankrupt.

There were actions that a federal prosecuting authority could have looked at. The only thing D.C. could do was to use our efforts to extract him. I could go into detail about the actions that the committee took along with Chairman Vincent Gray to ensure that Paul Tuff would sell his D.C. hospital. The city used its tobacco settlement money to buy the hospital for seventy-nine million dollars. Thirty million dollars were allocated for new equipment, twenty million dollars for two years of operating capital, and twenty-nine million dollars to buy the facility. I was adamant that Paul Tuff walk away without a penny. Even though we paid twenty-nine million dollars for the hospital, the money went to vendors who had not been paid. We paid for goods and services needed to keep the hospital open. In the end, he did not get a cent. I acknowledge that he had already been paid many times over through his own fraud, but it really was not in my capacity as Chairman of the Legislative Committee to prosecute him.

Going forward, I am very excited about this facility because we have added 120 employees at the hospital. We have added two floors of skilled nursing facilities. We have added an entire floor of long term acute care. We have doubled our residential mental health capacity. We have added equipment, such as an MRI. I am a patient of the hospital, by the way, for a shoulder injury. I ask others to have confidence in the institution and I get treated there too. I am very excited about everything from new hyperbaric wound chambers for diabetes patients to the Children's National Medical Center partnership in a new pediatric emergency room. Many of the District's kids live in wards seven and eight and deserve access to the highest quality emergency pediatric services.

Participant: In the news you had some sort of a fight with pharmaceutical companies about payments to doctors. Has there been any progress?

Councilman Catania: Two years ago I was named the pharmaceutical industry's number one enemy—second to the Attorney General in New Jersey. We have taken a number of actions that have angered the industry; everything from a preferred drug list, supplemental rebates, and pharmacy benefit management legislation. Most recently, we put the kibosh on therapeutic interchanges without patient consent. Pharmaceutical companies conspire with pharmacies to switch your drugs without telling you or your doctor. This practice is now illegal in the District. We also oversee the licensure of pharmaceutical representatives.

We are the only jurisdiction in the country that has a code of ethics and the ability to extract pharmaceuticals representatives for violating them. Representatives who engage in off-label prescribing or who provide false or misleading information are denied a license. There is now an association of pharmaceutical representatives who are now trying to adopt their own code of ethics.

Participant: Is there anything that can be done as far as regulation of nursing homes?

Councilman Catania: We have a couple of homes where I am not thrilled with the current management. We have always had the means to seize the license of a nursing home but we have not had a way until now to pull the operator's license. We have never really seized the license of a nursing home administrator to the performance of her or his nursing home until now. We have also expanded the way in which we can actually seize control of a nursing home away from either the management or the owner. What it comes down to is providing the Department of Health with greater tools to increase performance. You can really tell the quality of the nursing home by the number of EMS calls to the nursing home. When you have the same nursing home making multiple 911 calls a day it will tell you that patients are not seeing a physician routinely. No one on the premises tending to patient needs. We estimate that we are spending about twenty-one million dollars a year in preventable hospitalization that originated out of this poor health care infrastructure.

It is not all about money, but I spend a lot of time focused on money because I have to cut about 400 million dollars out of our budget next year. We must be mindful about how money is being spent and make the greatest use of it.

A smarter system has physicians at the nursing home, treating patients where they live. We have also expanded the types of services that we now require nursing homes be able to provide, to include dialysis. We have long transported people back and forth to dialysis. This causes transport trauma and added expense. At larger size nursing homes, you ought to be able to provide certain services on site. The same is true for mental health, substance abuse, or rehabilitative services. We have given the Department of Health the flexibility to make these determinations. Increasingly, we are going to put pressure on the nursing homes to provide the services once they reach a critical mass. Right now, nursing homes call the ambulance to essentially force costs off onto emergency rooms and hospitals. We are trying to reconfigure this.

I have one home in particular that I have got my eye on. It is called Grant Park. I believe in letting them know that we are coming. It is the largest and only nursing home in ward seven and they are poor performers. If I have my way, the current owners will not be in business very much longer.