GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

FY 2011 Oversight Hearing and FY 2012 Budget Hearing

Testimony of
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Department of Health Care Finance
Before the
Council of the District of Columbia
Committee on Health

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John A. Wilson Building,
1350 Pennsylvania Avenue, NW

Introduction

Good morning Chairman Catania and members of the Committee on Health. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and it is my pleasure today to provide testimony on the activities and progress that the Department has made over the past year. To ensure that we respond comprehensively to any questions raised during this hearing, I am joined by key DHCF staff members from across the department.

Mr. Chairman, allow me to also thank you for your decision to reschedule this hearing as a gracious accommodation to me during the time immediately following the death of my mother. Both my staff and I were especially appreciative of that kind consideration.

The first portion of my testimony provides a brief overview of the issues faced by the agency during FY2011 and the steps we have either taken or plan to implement to address these challenges. In the process of evaluating the policies, cost pressures, and implementation issues surrounding both the Medicaid and Alliance programs in FY2011, we have established a framework shaped by the agency's four major priorities that will allow DHCF to systematically address these challenges both now and in the future.

While there is considerable work to be done, I'm pleased to inform the Committee that we have made significant progress on a number of fronts and

continue to build on the momentum from FY2011 as we work through the current fiscal year and prepare for FY2013.

Role of DHCF

As you are aware, DHCF was established as a cabinet-level agency on October 1, 2008 to operate the District's Medicaid and Alliance programs. To carry out this role, DHCF manages an annual budget of just over $2.2 billion with the broad goal of improving health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia.

The agency's annual budget is funded through a combination of local dollars, dedicated tax revenue, special purpose and federal funds that enable it to provide health care coverage to the District's low-income adult residents and children.

Major Priorities and Challenges

As I outlined at last year's hearing, much of the work at DHCF is guided by the four major priorities we have established in support of the agency's broadly defined mission. These priorities -- improve patient outcomes, strengthen DHCF's program integrity operations, resolve Medicaid billing issues with our partner agencies, and successfully implement health reform -- provide the roadmap for the work that we plan to pursue throughout the tenure of this Administration.

When I joined DHCF in February 2011, the agency faced significant problems that had implications across each of these priority areas. Among the challenges were the following:

- DHCF was laboring under a 40 percent staff vacancy rate which greatly undermined agency productivity while adversely affecting staff morale ;

- Apart from the outstanding work of the agency's excellent fiscal and budget staff, DHCF had limited capabilities to perform the type of data analytics needed to more fully mine the program utilization and claims data we collect on both Medicaid and Alliance beneficiaries to inform our efforts at policy development;

- The agency's more than $600 million managed care program -- responsible for ensuring a more cost efficient delivery of services for beneficiaries in Medicaid and Alliance -- was financially stressed, in a state of flux, and the program had no clear plan forward;

- There was almost a complete absence of any real monitoring for long-term care services and no plans were underway to study and arrest the unsustainable growth in these programs which comprise nearly 30 percent of the Medicaid budget;

- A new rate methodology to pay for the services provided in the ICF/DD facilities that house some of the Districts most medically fragile populations had only limited support in the provider community, and disputes about the Steve Sellows tax and living wage stalled any additional movement on this issue;

- The Medicaid Management Information System (MMIS) was missing key payment edit protocols and the system itself was not certified and facing a fast approaching deadline which carried major budget implications;

- Few, if any of our key public partners were on line and ready to submit claims to the Administrative Service Organization (ASO) that the District contracted with to improve Medicaid billing in 2010; and, most glaring;

- Due, in part, to the transition of Administrations, the very important work in virtually every area of federal health care reform had not begun and was significantly behind schedule.

Clearly, the range of challenges faced by the agency in FY2011 touched on each of our articulated priorities and if the associated problems were not addressed, the long-term effectiveness of both the Medicaid and Alliance programs would suffer along with the future plans for health care reform.

Consider that nearly 70 percent of the beneficiaries in Medicaid and all of the Alliance members rely on the agency's health plans to manage and coordinate their care. Further, efforts to enhance the integrity of the program are inextricably linked to the agency's success in fixing the significant problems in our system of long-term care. Unaddressed, these problems place some of the long-term care services in jeopardy potentially creating serious consequences for those persons who most need and rely upon this benefit. Finally, health care reform, with its promise of universal access, efficiently run insurance exchanges, innovative care coordination models, and new mechanisms to enhance program integrity and promote quality care would not go forward in any meaningful way.

These are just three examples. For a more complete summary of these issues we faced at DHCF, a brief status report on the progress made in FY2011, and the next steps the agency will implement with respect to each area, I refer you to the tables on the pages 6 through 9.

Agency Challenge	Status In FY2011	Progress Made In 2011	Next Steps
Staff vacancies. Enhance program integrity by hiring competent staff to address vacancies across agencies	• Agency vacancy rate was over 40 percent and positions were frozen • Some key divisions – long-term care, quality, and health care reform were completely vacant • Executive management team did not exist	• City Administrator lifted hiring freeze for the agency • Agency vacancy rate down to 10 percent through combination of internal promotions and aggressive external recruitment • Executive management team fully staffed with persons of significant health policy experience • Key divisions are either nearly or completely staffed	• Continue recruitment to eliminate the remaining vacancies
Data analytics. Enhance program integrity by developing the agency's data analytics capabilities	• Limited ability to mine the agency's Medicaid and Alliance claims data. Insufficient number of staff with skills to conduct the required analysis of the claims data.	• Hired several new policy analysts with significant data analysis skills • Developed the agency's first comprehensive report on Medicaid and Alliance utilization patterns, spending trends, costs pressures, and provider performance	• Continue data mining activities and refine reporting for FY2013
Reform managed care program. Improve patient outcomes through strong Managed Care Program	• Managed care plans fiscally unstable • Program lacking 3rd health plan • No transparency on rate development • Timing of rate development process was not in line with the Mayor's budget development • Contracts heavily emphasize HEDIS process measures rather than patient outcomes	• Established actuarially sound rates for both the Medicaid and Alliance programs • Developed a rate setting process that is completely transparent and in line with the timeframes for the Mayor's budget submission • Completed RFP to bring in a 3rd MCO for the last year of the current five year contract • Developed draft criteria to establish the next MCO contracts around quantifiable measures of network adequacy, enhanced case management, staffing standards, aggressive outreach, improved hospital outcomes, and pay for performance standards	• Competitively select a 3rd MCO for the last year of the managed care contract by September 2012 • Rebid the entire MCO program with the goal of establishing three health plans to manage the Medicaid and Alliance programs for the next four years. • Following the selection of the MCOs, begin discussions around the new contract criteria that will be put in place to ensure greater accountability from the plans. Contract must be finalized and signed by May 2013

Agency Challenge	Status In FY2011	Progress Made In 2011	Next Steps
Reform the personal care program. Enhance program integrity by modifying the rules around the delivery of personal care and developing an enhanced system of monitoring	• Unchecked growth in personal care program costs • Weak ability to reliably determine actual beneficiary need and authorize appropriate amount, duration and scope of services • Program edits not in place to limit hours of services in a calendar year	• Required physicians to be more prescriptive in identifying the need for personal care. • Developed an assessment tool to allow DHCF to more accurately match service hours to patient care needs • Established program edits in the MMIS system to enforce hourly service limits • Enforced policy requiring prior authorization for service beyond established limits • Developed plan for better targeting and increased monitoring of personal care services using an ASO • Secured funded in Mayor's FY2013 budget to fund the ASO contract	• Enforce new regulations containing multiple new program integrity safeguards that will go into effect July 2, 2012 • Finalize RFP to secure services of ASO to monitor long-term care contract beginning in FY2012 • Upon passage of Mayor's budget, seek approval of RFP through OCP and secure a vendor to implement the program through FY2013 • Redesign eligibility criteria for program as a part of a comprehensive restructuring of the District's entire long-term care program
Redesign the ICF/DD rate methodology. Improve patient outcomes by developing a rate model that promotes quality care at the lowest possible cost to the District Medicaid program	• Existing rate model is more than 20 years old • Proposed replacement model is flawed, does not pay a living wage, and its approval is tied up in a dispute over the provider tax • Rate model is facility based and does not adjust payments based on changing acuity of clients • Rate model overpays capital costs and does not adequately ensure the highest level of support for patient care	• Designed a rate model that is based on individual's client needs and supports six patient acuity levels • Model has six cost center components and does not overpay on capital • Model contains stringent patient care requirements and is designed to reduce funding for administrative expenses if providers under spend on patient care • Model has received approval from all of stakeholders and the opposition to the provider tax has been dropped • Model supports the District's living wage requirements	• Develop the State Plan Amendment and rules to support the new rate methodology with an October 2012 implementation date

Agency Challenge	Status In FY2011	Progress Made In 2011	Next Steps
Strengthen the agency's MMIS. Enhance program integrity by securing federal certification for the MMIS and systematically identify gaps in program edits that expose the Medicaid program to unbudgeted and disallowed costs	• The MMIS was not federally certified with the deadline approaching. Consequence was a potential loss of the 75/25 federal match to cover the cost of operating the system • System was not properly configured to catch improper claims before payments were made • Problems with improper payments surfaced in several areas for the Medicaid program	• The agency received MMIS federal certification just prior to the established deadline in October 2011 • Internal Steering Committee established to systematically assess existing gaps in edit protocols and develop solutions • Edits added to safeguard a number of benefits – dental, personal care, DD Waiver services	• Increase pace and volume of work for Steering Committee to identify additional gaps in the DHCF's edits protocols.
Enhance Medicaid billing. Construct a billing system to increase Medicaid billing by public agencies for the purposes of reducing program cost to the District	• ASO was under contract but little work had been done to actually establish the billing systems in several key public partner agencies • Four agencies – CFSA, DCPS, OSSE, and Charter Schools-- with the most potential for receiving significant public funds were either not claiming at all or being reimbursed for a limited range of services	• DCPS has established its own billing system and it has been successfully linked to the ASO claims adjudication system. Claims submission went live during the 1st week in April • For CFSA, claiming continues for clinic services. DHCF staff is working with closely with CFSA to implement the required State Plan Amendment, pending CMS approval, to allow the agency to bill for targeted case management. Scheduled approval is prior to end of FY2012	• Work with DCPS to increase the claims volume now that the billing system is operational • Upon approval of the State Plan Amendment for Targeted Case Management, DHCF and CFSA will work with CMS to seek approval of a plan to allow for the reimbursement of rehabilitation services • Track progress on the State Plan Amendment to allow OSSE to bill for services provided in non-public schools • Bring FEMS into the ASO billing process and revisit the rates paid for ambulance services. It is possible that the rates can be increased drawing more revenue for the District

Agency Challenge	Status In FY2011	Progress Made In 2011	Next Steps
Implement Health Care Reform. Take the necessary steps to implement the many requirements of health care reform, most notably the District's insurance exchange	• Health reform Administration within DHCF was unstaffed for much of the FY2011 • No work in place to secure grants to fund the development efforts for the exchange • Missed deadlines for submission of grants to fund the Health Information Exchange (HIE) and the Electronics Health Records (EHR) projects • RFP for Recovery Audit Contract (RAC) not developed	• Received $999,398 Health Benefits Exchange (HBX) Planning Grant • Received $8.2 Million Level I HBX Establishment Grant • Successfully submitted Advanced Planning Document (APD) with DHS and received $49 million in APD funding -- 90 percent federal match -- for creation of a new, streamlined, coordinated health and human services eligibility system • RFP developed and vendor selected to develop the HIE project. • RFP developed and vendor selected to develop the EHR project	• Work with DHS to successfully recruit and fill approximately 20 additional positions for the insurance exchange and automated eligibility enrollment and case management systems • RFP released for RAC Select vendor by June 2012 • Roll out completed HIE project in May 2012 • Roll out EHR project in October 2012 • Complete design of framework for the insurance exchange in July of 2012 • Receive Level II Establishment Grant in October 2012 to build out the insurance exchange • In Jan 2013, submit the insurance exchange for system certification • In October 2013 launch insurance exchange enrollment portal

Mr. Chairman, as this status report illustrates, DHCF has inherited the weighty policy issues and implementation challenges that accompany the allocation of more than $2.2 billion for health care services. These matters encompass the full breadth of health policy issues, including access to care for the District's most vulnerable populations, provider payment reform, significant

program integrity issues, and of course, the very daunting requirements of health care reform.

For reasons not of our own making, the agency experienced a slow start in FY2011 with many of these issues. However, we have developed detailed plans to guide the implementation of the activities discussed in the preceding tables, recruited the competent staff necessary to ensure that progress does not stall, and are now well positioned to move these projects forward as we pass the mid-point of this fiscal year.

The Challenge of Negotiating District Hiring and Procurement Systems

Our residual concerns for the projects we must manage are the truncated time frames associated with the major deliverables for health care reform. These deadlines are clearly at odds with the District's normal and protracted processes for hiring staff and implementing procurement requests. This administrative conflict takes on special meaning when one considers that the technology work for both the eligibility projects and insurance exchange is valued at $70 million and must be implemented in three short phases. By design, this project touches the full portfolio of federally funded human services programs in the District while demanding the completion of complex systems development work necessary to stand up the insurance exchange.

Given the fast approaching timelines enforced by the Centers for Medicare and Medicaid Services (CMS), there is simply no room for delay in either the hiring or contracting processes. The Mayor's Health Reform Implementation Committee respectfully petitioned the City Administrator to take several actions that will expedite hiring and procurement and he has graciously accommodated us. In addition, we are working closely with the directors of the Office of Procurement and Contracting and the Department of Human Resources. Both directors have pledged their support to prioritize this project

While these actions have been enormously helpful, we are mindful that government procurement rules must be followed and they can be cumbersome to implement; thus our concern remains. We resolve to be especially vigilant of this process and will undoubtedly need your and the Committee's full support if we are to be successful in this endeavor.

Testimony Concerning Mayor Gray's FY 2013 Budget for DHCF

Mr. Chairman, if there are no questions at this time regarding the agency oversight issues just discussed, I would like to offer my testimony on Mayor Gray's Fiscal Year 2013 (FY2013) budget for DHCF. Although faced with a shortfall, Mayor Gray crafted a budget that ensures that District residents will continue to receive high levels of health care service. I am pleased to have been a

part of the Mayor's budget development process and I offer this testimony in full support of his decisions for DHCF.

My remarks on the proposed budget for DHCF highlight the specific strategies that are reflected in the formation of the agency's budget along with the underlying assumptions supporting its development. This will be followed by a discussion of the emerging cost pressures we are witnessing in Medicaid that must be addressed in coming fiscal years. Finally, I will close this testimony by briefly touching on the added complications faced should the United States Supreme Court overturn portions or all of the Affordable Care Act.

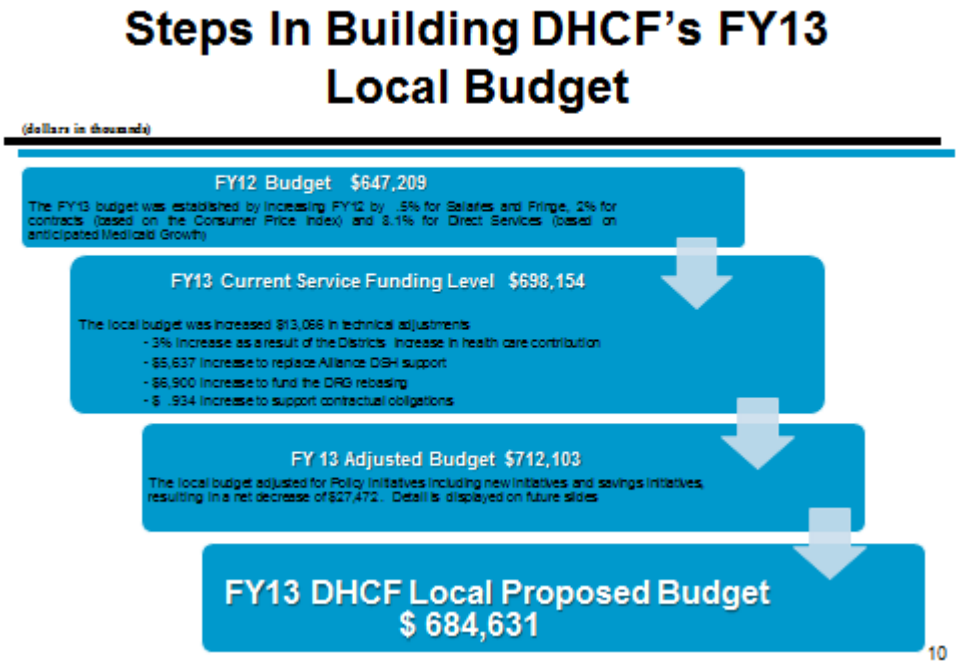
Building the DHCF Budget for FY2013

Mr. Chairman, as you are aware, when developing the budget for FY2013 the Mayor was confronted with a shortfall that totaled $172 million. Because the combined Medicaid and Alliance programs constitute such a substantial part of the local funds budget, significant reductions are difficult to achieve without extracting savings from these programs. By necessity, any decision to appreciably reduce health care spending must look for savings through enrollment reductions, benefit cuts, or decreases in provider payment rates.

Despite this problem, I am pleased to report that the budget submitted by the Mayor largely preserves the significant influx of federal dollars we receive as a result of our 70 percent federal match for Medicaid as only minor reductions in

spending are proposed from this more than $2 billion program. In addition, it is important to note that no changes were made in the Mayor's budget that restricted access to care for Medicaid recipients or reduced the program benefits they rely upon to address their health care needs.

The graphic below illustrates the budget development process for DHCF. As is always the case, the current year's budget provided the base for FY2013. This budget was inflated for several factors and then increased to reflect a Current Services Funding Level (CFSL) for FY2013 of $698.1 million. The largest portion of this amount is the 8.1% increase in the cost of provider payments. When the technical adjustments for the higher than expected DRG hospital costs and the



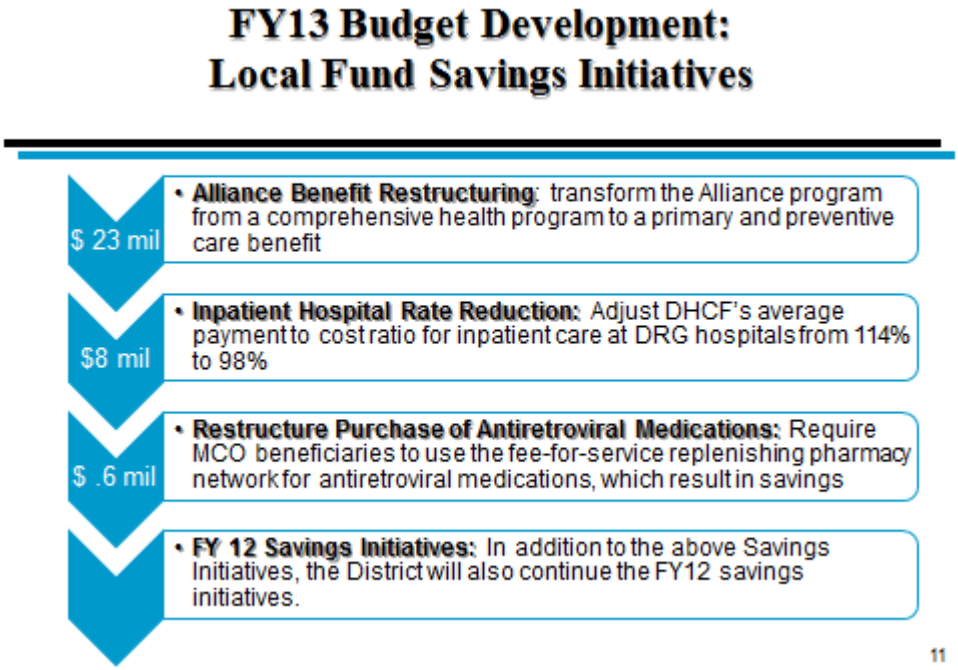
additional funds necessary to close a $5.6 million gap in Alliance budget are accounted for, the FY2013 local budget for the agency comes to more than $712 million

From this amount the Mayor funded several new initiatives, worth $4.1 million local, and imposed countervailing policy adjustments of $31.6 million, which has the net effect of reducing the local budget by $27.4 million. This amount represents DHCF's contribution to the $172 million budget shortfall that required agency reductions.

DHCF Reduction Strategies

Three policy changes form the basis for the $31.6 million local fund budget reductions and these initiatives are outlined in the graphic on the next page. As it shows, the largest of the savings initiatives is the restructuring of the benefit for the Alliance program to cover only primary and preventive health care. An additional $8 million in savings is proposed by reducing DRG hospital payments. Finally, $600,000 in savings is projected through the purchase of antiretroviral medications for MCO patients through the replenishing pharmacy network administered by DOH.

***Alliance Restructuring*.** The restructuring of the Alliance benefit essentially means that cost of any service that is billed by the hospital to the Alliance program will no longer be reimbursed. It is important to note that if the physician has



privileges at the hospital and the hospital is the site of service, the physician can bill the Alliance for the professional fee but the technical fee associated with the hospital will not be covered.

The primary concern that has been raised about this proposal is that hospitals will be forced to provide higher levels of uncompensated care. We believe, however, that the anticipated adverse impact of this policy is mitigated in several ways. Most notably, the District will continue to pay for this care using the funds hospitals now receive through the Disproportionate Share Hospital program – most commonly referred to as DSH.

Mr. Chairman, as you know, under federal rules, when calculating the amount of uncompensated care a hospital provides for the purpose of determining

the total DSH payments it will receive, the facility is allowed to report the cost of serving Alliance members but it does not have to offset this amount with the local revenue it receives from the District as payment for the Alliance hospital benefits.

Thus, the current policy legally inflates the amount of uncompensated care in the District, which in turn increases the DSH payments that the District makes to designated "DSH hospitals" to offset these inflated costs. Based on current federal regulations, most hospitals in the District will continue to receive DSH funding if they provide preventive, primary, emergency, or inpatient care to Alliance members. However, with the proposal in the Mayor's budget, the double payments cease as hospitals will no longer receive the additional revenue from the Alliance.

It is also worth noting that the pool of DSH funding available to hospitals increased in FY2012. Funds that had been set aside for two purposes -- to directly offset the cost of the Alliance program to the District and as a special allocation to Children's Hospital -- were moved back into the DSH pool for distribution to hospitals.

The hospitals that could be adversely affected by this policy are those not eligible for DSH payments. Among the non-DSH hospitals, there are two -- George Washington University Hospital (GWUH) and Washington Hospital Center (WHC) -- that provide a disproportionate amount of the hospital-based care to Alliance beneficiaries (see Table on next page).

Hospital	Outpatient Visits	Inpatient Visits	Emergency Visits
WHC and GWUH	32%	56%	52%
DSH Hospitals	68%	44%	48%
Total	100%	100%	100%

We will employ two strategies geared to reducing the impact of this change on these two hospitals. Most notably, since we have removed the Alliance hospital benefit from the managed care plans, the cost of any visit by an Alliance member to a hospital (DSH or non-DSH) for an emergency as defined by DHCF's state plan, can be billed to Medicaid. We will make sure that hospitals understand how to bill Medicaid for the cost of emergency care to Alliance members in these cases. Estimates are that roughly $8million of the care provided to Alliance members by hospitals will qualify for emergency Medicaid payments. We estimate that approximately 52% of these payments would be made to the two aforementioned non-DSH hospitals if the patient distributions and utilization do not change after the policy is implemented.

Our second change will be to ask the managed care plans to provide all Alliance members with a list of DSH hospitals and encourage them to visit these facilities for any care that cannot be provided by the clinics in the District.

Hospital Payment Reduction. The other significant proposed budget action is an $8 million reduction in DRG payments to District hospitals. Currently, most hospitals are paid for each inpatient stay based on the AP-DRG (All Patient

Diagnosis Related Group) assigned to the Medicaid claim. With this system, each stay is assigned a DRG code summarizing the type of stay based on the diagnosis, severity of illness, and age factors. Each of these codes has an associated weight which is used to create what is referred to as the DRG Base Payment

Nationwide, most States typically reimburse hospitals using DRGs at 89 percent of the cost of serving a Medicaid patient. In the District, however, Medicaid payment policies for hospitals depart significantly from this practice. The DRG payment rates were last adjusted in FY2010 and payments were set at a level estimated to be roughly 98 percent of the cost of serving Medicaid patients. Although it was believed that this change would be cost neutral, this adjustment has apparently cost about $8 million more in local funds than anticipated. The Mayor's proposed policy corrects that overpayment.

The Budget Implications Associated with the District's Medicaid Program

The savings strategies outlined in the Mayor's budget amount to approximately a four percent cut in DHCF's local funds budget. As we approach health care reform and the likely higher cost it could create for the District in the short-term, it is imperative that closer attention be given to the growing cost pressures in the current Medicaid budget.

Relative to other States, the District has a far-reaching Medicaid program with high eligibility levels and an expansive set of benefits. This combination of

policies provides valuable coverage to District residents but also creates a cost structure for the program that is not easily sustainable.

Nearly 20 percent of the growth in the District's previously described CSFL was attributable to the Medicaid program. More significant, the rate of Medicaid cost growth in the District is faster than national average, twice the rate of medical inflation in this metropolitan area, and more than 3.5 times the rate of the City's revenue growth. Comparatively speaking, D.C. Medicaid is the 2nd most expensive program in the Nation.

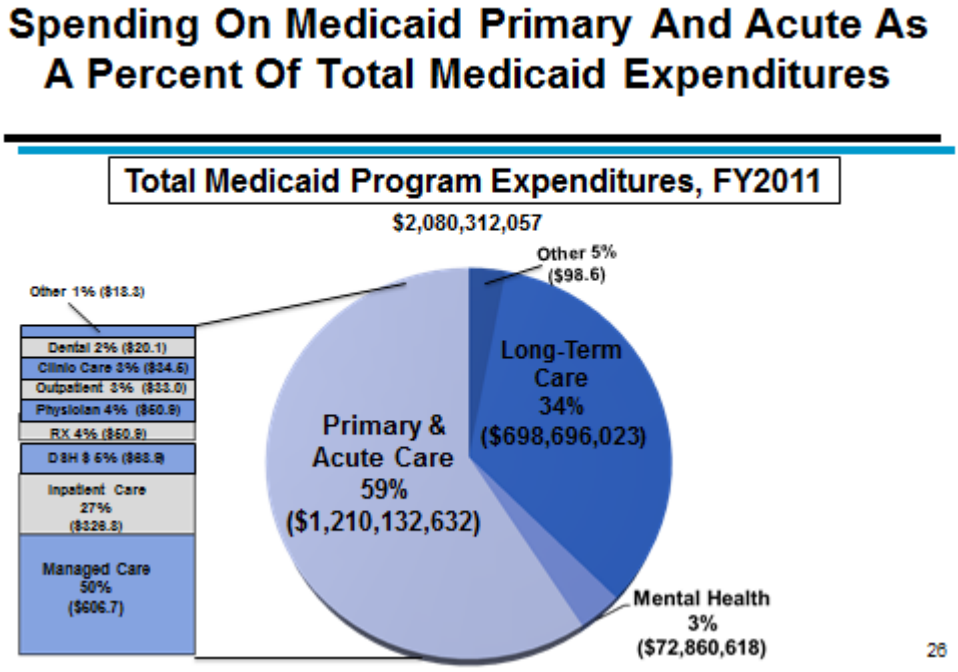
Cost Pressures in the Medicaid Program

Managing these cost pressures is difficult as they can be traced to four primary sources: (1) growing numbers of beneficiaries; (2) increased use of expensive acute care services and the related growing managed care costs; (3) expensive long term care services; and (4) high provider rates. Three of these factors warrant special mention.

Beneficiary Growth. The growth in the number of beneficiaries can be directly tied to the program's higher eligibility levels for children and the extension of coverage to several groups that are optional under federal law. The most significant expansion extended coverage to childless adults in the District in advance of the 2014 federal mandate to increase eligibility for this population to 200 percent of the federal poverty level. Together these policies and the

Medicaid's broad coverage levels for children have extended the reach of the program to nearly a third of all residents in the District, including 45 percent of the District's children.

These eligibility policies have also increased the demand for acute care services. As the graphic below indicates, spending on Medicaid acute care services accounts for 60 percent of total program cost. The figure also reveals that



most of the acute care spending -- more than $600 million -- is paid on behalf of beneficiaries in the District's two managed care programs.

As previously mentioned, together the two plans manage the health care for seven of every 10 Medicaid recipients and more than half of the expenditures incurred for this population are tied to hospital based care. While there is evidence

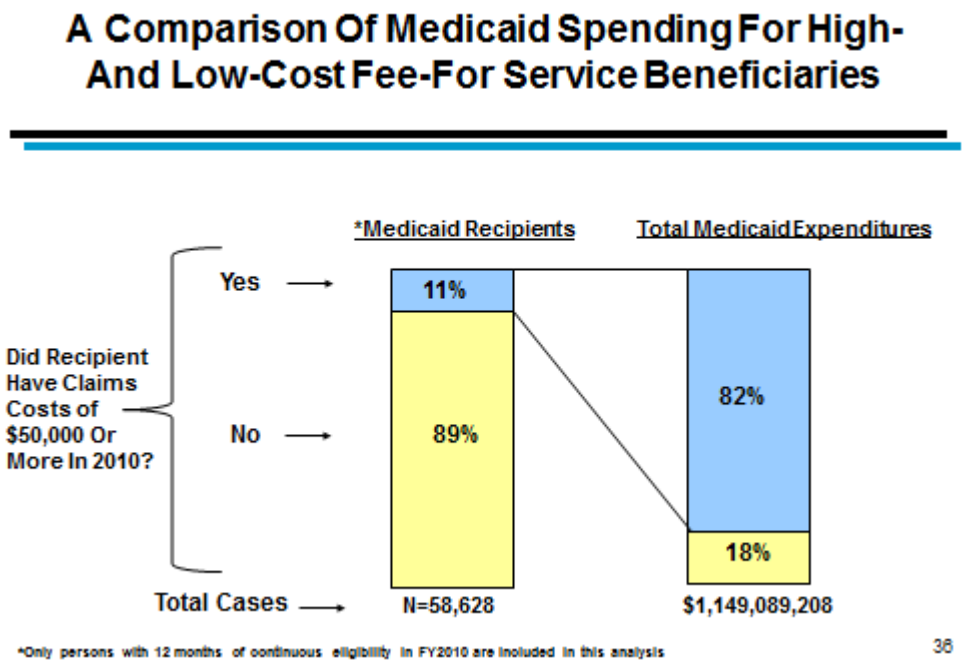
to suggest the eligibility expansions have altered the demographic for the MCOs by bringing in an older and sicker adult population, we also know that the two plans are experiencing difficulty managing the cost growth for its members. Plan expenses are increasing at an annual rate of 10 percent, with an astounding 42 percent yearly growth for emergency care services. This is an issue that we plan to focus on when the new managed care contracts are developed.

Lack of Managed Care For Elderly Population. Although children and adults still represent the majority of the enrollees in Medicaid, on both a total cost and per capita basis, persons who are elderly and or have disabilities pose the most significant cost challenges for the program. As a group, these beneficiaries represent 24 percent of the all Medicaid enrollees but they account for 67 percent of total Medicaid spending. Per capita, these beneficiaries cost as much as six times more to ensure than children and non-elderly adults in the program.

Yet, as in most States, the District has not enrolled these beneficiaries in managed care. This means that the most expensive Medicaid population to insure receives care in a fee-for-service environment with little to no care coordination. The health care consequences of this decision have been significant. In the last three years, for example, the District has spent more than $100 million on these beneficiaries for hospital readmissions within 30 days of the initial admission for

the same illness. Also, another $24 million has been spent on hospital admissions that could have been avoided with proper care.

The graphic below further underscores the problem with this bifurcated approach to managed care. In FY2010, there were nearly 59,000 Medicaid recipients who were not in managed care and had 12 months of continuous eligibility. The health care cost for these individuals totaled $1.1 billion – more



than half of the total cost of the program. Moreover, an even smaller segment of this population (11 percent) accounted for 89 percent of this $1.1 billion cost.

We know from further analysis of our Medicaid claims data that this "high cost" group -- the 11 percent -- is nearly five times more likely to visit an emergency room; is admitted for inpatient care at five times the rate of the "low

cost" group; has hospital stays that are twice as long; averages 10 more prescriptions, and are more likely to suffer from multiple chronic conditions.

Finding better ways to deliver care to this population can save the District significant dollars while having the added virtue of being the right thing to do. This should and will be a focus of DHCF planning as we move into FY2013.

High Cost of Long-Term Care Services. Perhaps there is no bigger challenge with the Medicaid budget than managing the very expensive long-term care services, especially the waiver programs. Although the District's Elderly and Persons with Disabilities (EPD) waiver and the Developmental Disabilities (IDD) waiver are less expensive than their institutional alternatives both overall and on a per-capita basis, from 2008 to 2011, the programs' costs grew at especially rapid rates. During this time, both waivers witnessed annual growth rates of 30 percent. We are beginning to see evidence that these growth rates may have plateaued, but for the IDD waiver, we are still spending more than $100 million on a population of less than 2,000 clients.

At the same time, the District must address the increasing cost of the personal care program. This is an optional benefit for just over 6,000 beneficiaries with an annual cost of nearly $100 million and a growth rate of 15 percent per year.

I have asked the staff in DHCF's Health Care Delivery and Policy and Research Administrations to examine all aspects of our long term care program -- eligibility design, scope of service, program monitoring – and provide me with a comprehensive reform proposal in time for next year's budget development. Finding ways to reduce the per-capita cost of these programs without compromising quality of care is an imperative. To this end, we are working with DDS staff who are fully supportive of implementing aggressive policies to reduce the overall cost of IDD community-based services, including reductions in the expenses associated with support to individuals with life-long disabilities. Together we are mindful that these reductions must occur without compromising access to those waiver services which are critically needed by this medically fragile population.

Preparing For a Possible Repeal of the Affordable Care Act

Mr. Chairman, I would like to close my testimony by offering a few brief thoughts on how the agency is planning for a possible decision by the high court concerning whether to overturn a portion, or all of the Affordable Care Act. While predicting how the Court will decide is speculation of the highest order, any adverse decision for the Affordable Care Act could have serious budget implications for the District as early as FY2013. Depending on the nature of any decision that struck down portions of the law, the District could lose significant

Medicaid funding, as well as federal support for the numerous grants we are presently implementing.

Most legal scholars agree that any Court action that was not an outright affirmance would start with an invalidation of the Minimum Coverage Provision, most commonly cited as the "Individual Mandate". From this point, three broad scenarios are considered possible:

1. The Court strikes the Individual Mandate, Community Rating, and Guaranteed Issue, leaving the remainder of the law intact and presumably the federal funding accompanying these provisions. This would include the State option of establishing exchanges, federal premium subsidies/cost-sharing support, the employer mandate, Medicaid expansion, and more. Thus the issue for the District in this scenario is less about budget and more concerning whether it should pass its own mandate or seek to build the exchange and carry out other aspects of its health reform program without the benefit of law compelling residents to purchase insurance.

2. The Court strikes the Individual Mandate, Community Rating, and Guaranteed Issue, but also strikes those portions of ACA the Court believed were part of Congress' overall plan to achieve universal coverage. In doing so, the Court would have acted on the theory that Congress considered all these parts to be interdependent and that without the Individual Mandate, at least the universal coverage components fail. Under this scenario, the provisions creating the exchange, premium subsidies, cost-sharing, Medicaid Expansion, related funding, and the Employer Mandate would fall and the District would be required to either abandon these concepts due to the lack of federal financial support, or decide to continue with these programs at considerable expense to its local funds budget.

3. The Court strikes the entire law. The theory is that it is outside the judicial role for the Court to decide which portions of the law Congress intended to be connected to the Individual Mandate. If this were to occur, the nation would return to the federal law as it existed before passage of the ACA and all aspects of health care reform, including the underwriting of its cost would be subject to State option.

Internally, I have formed a "Plan B" Task Force team consisting of staff from the Health Care Reform and Policy and Research Administrations, and my executive management team. This interdisciplinary team has been charged with the responsibility of developing a document that addresses the budget consequences to the District of an adverse decision by the Court and provides a series of options for emergency consideration by the Mayor and the Council.

So that the agency is not caught flat-footed, I have directed this team to begin the work now on proposed plans for health reform in the District given a range of possible responses by the Court. Under the general guidance of Linda Elam, the Medicaid Director, this Task Force has already met and developed a process for guiding its future activities. Accordingly, very shortly following the release of the Supreme Court decision, DHCF should be able to quickly respond with an options paper for the Mayor and Council.

Mr. Chairman, thank you for this opportunity to testify before the Committee. My staff and I welcome your questions and those of other members as well.