Data Snapshot: District of Columbia Health Care Alliance Demographics and Cost Drivers, FY2013 to FY2017

SEP 2018

Summary

This snapshot examines District of Columbia Health Care Alliance (Alliance) program enrollment, age demographics, and cost driver trends from FY2013 to FY2017. During this period of time, Alliance program spending has grown significantly, even as enrollment has remained flat. By comparison, Medicaid program spending growth has been proportional with enrollment growth.[1] DHCF's analysis shows that increased expenditures for hospital-based, pharmacy, and End Stage Renal Disease (ESRD)-elated services from FY2013 to FY2017 could be tied to an aging Alliance population, expanded benefits, and increased utilization.

KEY FINDINGS

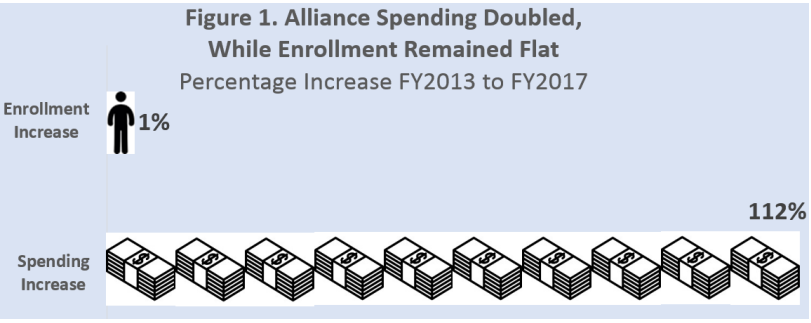
- Alliance enrollment was stable between FY2013 and FY2017 while enrollment for a comparable group of Medicaid adults increased.
- The number of Alliance beneficiaries age 65 and over increased by 42 percent from FY2013 to FY2017.
- Expanded benefits, and an aging population contributed to increased spending and utilization for hospital-based, pharmacy, and ESRD-related services in the Alliance program from FY2013 to FY2017.

Background

The District of Columbia Department of Health Care Finance (DHCF) provided health care coverage to 22,158 District residents at a cost of $63M through its locally-funded Alliance program in FY2017.[2] The Alliance is a health care safety net program for uninsured adult residents of the District of Columbia, with incomes up to 200 percent of the federal poverty line who are ineligible for Medicaid, regardless of immigration status.[3] The majority of DHCF spending on Alliance beneficiaries is in the form of per-member, per-month capitation payments to three Managed Care Organizations (MCOs).[4,5]

Figure 1. Alliance Spending Doubled, While Enrollment Remained Flat

Percentage Increase FY2013 to FY2017



From FY2013 to FY2017, enrollment in the Alliance program remained relatively flat, increasing only one percent (See Figure 1). Despite this relatively flat enrollment trend, Alliance program spending increased dramatically, by 112 percent over the same time span. This rapid growth in spending is not entirely explained by medical care inflation, which increased by only an average of 2.8 percent annually between FY2013 and FY2017.[6] Furthermore, the annual growth rate for Medicaid expenditures from FY2012 to FY2016 was only five percent.[7] To understand the root causes of this trend, DHCF conducted several analyses to examine enrollment, spending and utilization trends, including an analysis of enrollment churn and demographic trends. This snapshot seeks to build upon this research to examine other factors contributing to this increase, including Alliance beneficiary age, spending and utilization trends from FY2013 to FY2017.

Methodology

DHCF used District of Columbia Medicaid Management Information System (MMIS) data to analyze Alliance program spending and enrollment trends from FY2010 to FY2017. This research found that enrollment decreased dramatically from FY2010 to FY2013, the point at which the District transitioned Medicaid-eligible adults into the new Medicaid expansion childless adult category created by the Affordable Care Act. Once this transition was complete, Alliance enrollment decreased significantly and then stabilized.

Alliance spending began increasing after FY2013, by approximately 26 percent from FY2013 to FY2014, and increased every year thereafter. To investigate these trends, DHCF researchers chose to analyze beneficiary enrollment, age, spending, and service utilization beginning in FY2013 and ending in FY2017, the most recent complete fiscal year for

which data are available. To accurately reflect actual spending by DHCF, findings on FY2017 Alliance program spending and spending growth from FY2013 to FY2017 reported in the background section were calculated by summing FFS payments to providers and per-member, per-month capitation payments to MCOs. In contrast, to accurately depict spending by type of service, findings on spending reported in the results section include all payments to providers, whether they were directly from DHCF or from MCOs. These totals exclude capitation payments.

When comparing Alliance utilization to that of the Medicaid program, researchers restricted the Medicaid population to a comparable group of Medicaid-enrolled adults age 21 and over. Unlike Alliance beneficiaries, this group of Medicaid adults have access to long-term care services. DHCF analyzed the prevalence of chronic conditions among the study group and comparison groups using the Agency for Healthcare Quality and Research (AHRQ) Chronic Condition Indicator (CCI) algorithm, which is based on ICD-9 and ICD-10 diagnosis codes. When analyzing spending by service type, researchers separated hospital-based treatment of ESRD-related services from other hospital-based treatment, so that the ESRD-related services and the hospital-based services would be mutually exclusive.[8]

Results

Alliance Enrollment was Stable between FY2013 and FY2017 While Enrollment for a Comparable Group of Medicaid Adults Increased

Alliance enrollment has remained relatively stable, increasing by less than one percent from FY2013 to FY2017. In contrast, Medicaid adult enrollment has increased by 32 percent over the same time (See Table 1).

Table 1. Medicaid and Alliance Enrollment Trend by Age, FY2013 and FY2017

		Medicaid			Alliance		
		2013	2017	Percent Change	2013	2017	Percent Change
Age	**21-64**	178,958 (90%)	237,095 (90%)	32%	20,438 (93%)	20,015 (90%)	-2%
	65+	20,508 (10%)	26,032 (10%)	27%	1,508 (7%)	2,135 (10%)	42%
Total Annual Enrollment[9]		199,466	263,127	32%	21,946	22,150	1%

Enrollment of Alliance Beneficiaries Age 65 and Over Increased by 42 Percent From FY2013 to FY2017

Table 2. Alliance Hospital-Based and ESRD-Related Services Spending and Per-Person Utilization, FY2013 to FY2017

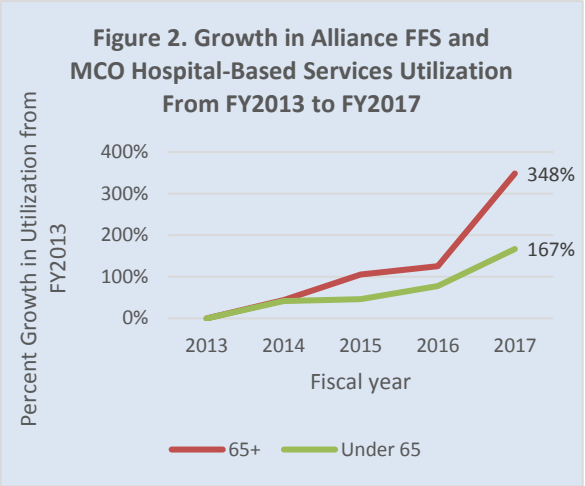
	Percentage Change from FY2013 to FY2017		
	Hospital-Based Services	**Pharmacy Services**	**ESRD-Related Services**
Total Spending	200%	161%	75%
Per-Person Utilization	171%	Not Available*	15%

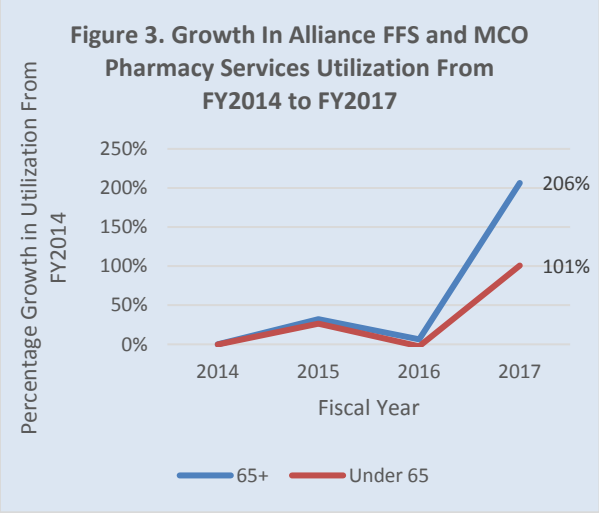
**Data on number of beneficiaries utilizing services were unavailable for FY2013.[10]*

An aging Alliance population appears to be one of the factors driving increased costs for the program from FY2013 to FY2017. Although the majority (90 percent) of adults enrolled in the Alliance program were under age 65 in FY2017, the number of Alliance beneficiaries who were 65 and over grew by 42 percent from FY2013 to FY2017 and the proportion of Alliance beneficiaries age 65 and over grew from seven percent to 10 percent over that time span (See Table 1). In addition, MCO and FFS spending for older Alliance beneficiaries nearly tripled from FY2013 to FY2017: spending for Alliance beneficiaries age 65 and over increased by 256 percent, while spending for non-elderly adult beneficiaries increased by only 100 percent during that timeframe. DHCF's analysis of chronic conditions for Alliance beneficiaries also documents increased risk among older beneficiaries. The number of Alliance beneficiaries age 65 and older with at least one chronic condition increased by 34 percent from FY2013 to FY2017, compared to a 10 percent decrease for non-elderly adult beneficiaries.

Expanded Benefits and an Aging Beneficiary Population Contributed to Increased Utilization and Spending for Hospital-Based, Pharmacy, and ESRD-Related Services in the Alliance Program from FY2013 to FY2017[11]

Hospital-based services accounted for approximately 28 percent and 39 percent of total Alliance program MCO and FFS spending in FY2013 and FY2017, respectively, making them the costliest services in the program (See Table 2).[12] In addition to accounting for a sizable percentage of total spending, hospital-based services spending grew by 200 percent from FY2013 to FY2017. Beneficiary age was also an important factor contributing to increased hospital-based services spending. MCO and FFS spending increased by 348 percent for beneficiaries age 65 and older from FY2013 to FY2017, but only 167 percent for non-elderly adult beneficiaries over the same time period (See Figure 2). In general, elderly health care consumers are more likely to utilize costly services, such as hospital-based services, to treat a higher incidence of multiple chronic conditions.[13]





Pharmacy services were also a factor contributing to increased spending for Alliance beneficiaries. Despite accounting for only seven percent and 10 percent of services in FY2013 or FY2017, respectively, MCO and FFS spending on pharmacy services grew by 161 percent during that period (See Table 2). Further, pharmacy services spending growth for older beneficiaries was two times greater than spending growth for younger beneficiaries. For example, pharmacy services costs for beneficiaries age 65 and older increased by 206 percent from FY2014 to FY2017, but only 101 percent for non-elderly adult beneficiaries over the same period (See Figure 3).[14] This sharp increase in pharmacy services costs may be due to several factors, including increased prescription drug utilization for an increasing elderly population, increased access to prescription drugs due to a formulary expansion in FY2017, an expanded provider network, and/or increasing drug prices.[15,16]

ESRD-related services also contributed to an increase in Alliance costs between FY2013 and FY2017. While ESRD-related services accounted for only nine percent and seven percent of total MCO and FFS spending in FY2013 and FY2017, respectively, spending for services related to ESRD was the largest cost on a per person basis by far, at $52,304 per person in FY2013 and $60,226 per person in FY2017 (See Table 2). ESRD-related service spending increased by 113 percent for beneficiaries age 65 and older from FY2013 to FY2017 and only 69 percent for non-elderly adult beneficiaries over the same period. In FY2014, DHCF added dialysis, a costly treatment for ESRD, as an Alliance benefit, which may have contributed to an increase in costs. Prior to this policy change, Alliance beneficiaries received coverage for dialysis through the Emergency Medicaid program, which is a federally-matched FFS program.[17]

Implications for Medicaid and Alliance Programs

DHCF findings suggest an urgent need to review coverage and program operations to improve cost-efficiency and determine whether additional care coordination or other interventions are needed to limit spending growth, especially among older beneficiaries. Consistent with United States Census estimates regarding the aging of the population overall, the aging trend among Alliance beneficiaries will likely continue. In light of this, it will be even more critical for DHCF to

coordinate care for this group of beneficiaries, or develop other strategies to improve outcomes and constrain costs. Over time, cost increases of this magnitude may not be sustainable for the program.

Conclusion

DHCF found that, unlike a comparable group of Medicaid adult beneficiaries, enrollment was not a major cost driver for the Alliance program from FY2013 to FY2017. Instead, expanded benefits and an aging population, contributed to increased hospital-based, pharmacy, and ESRD-related services spending and utilization.

The Alliance program remains an important safety net program to support vulnerable District residents who would otherwise be uninsured. The District is committed to serving these residents within a sustainable program that offers high quality, efficient and effective care. DHCF will continue to work with MCOs, the Department of Human Services, and community stakeholders in developing improved policies and procedures to ensure the continued viability of the Alliance program.

Notes: The data shown here are drawn from enrollment data in the District's Medicaid Management Information System (MMIS), extracted in August 2018. The data provided here were compiled by staff in the Division of Analytics and Policy Research, Health Care Policy and Research Administration, District of Columbia Department of Health Care Finance. For more information, contact DHCF at 202-442-5988.

1. Government of the District of Columbia Department of Health Care Finance. (2017, April 20). DHCF Annual Budget Presentation for FY2018: Presentation for Medical Care Advisory Committee (MCAC), Slide 13. Retrieved from https://dhcf.dc.gov/sites/default/files/u23/DHCF%20Annual%20Budget%20Report%203-2018%20%28MCAC%20Final%29.pdf
2. This number is a combination of per-member, per-month capitation payments to MCOs and fee-for-service payments to providers for the Alliance program. DHCF also spends federally matched dollars on Alliance beneficiaries through the Emergency Medicaid program. These dollars, a total of $11.4M in FY2017, are not included $63M spending figure. In addition, the District of Columbia Department of Health provides some prescription drug benefits to eligible Alliance program beneficiaries through the District of Columbia AIDS Drug Assistance Program. Spending on these services are also excluded.
3. Authorized through the District of Columbia Health Care Privatization Amendment Act of 2001, the program is funded solely with local dollars and is promulgated in Title 22B, Chapter 33 of the District of Columbia Register. District of Columbia Register, Title 22-B Chapter 33 (2001).
4. Alliance coverage includes inpatient hospital care, outpatient medical care (including preventive care), emergency services, urgent care services, prescription drugs, home health care, dental services, specialty care, and wellness programs that include mother and baby care. District of Columbia Government. (2018, September 11). DC Medicaid / Alliance and Me. Retrieved from https://www.dc-medicaid.com/dcwebportal/nonsecure/medicaidAndMe
5. Prior to FY2016 pharmacy services for Alliance beneficiaries were provided under a program using a Department of Health administered prescription drug purchasing warehouse. Under this program, Alliance pharmacy services were carved out of the per-member, per month capitation payments to MCOs and paid for through FFS.
6. United States Department of Labor Bureau of Labor Statistics. (2018, September). CPI-All Urban Conumers (Current Series) 12 Month Percentage Change, Medical care in U.S. city average, all urban consumers, not seasonally adjusted, 2013 to 2017. Retrieved from https://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths
7. Government of the District of Columbia Department of Health Care Finance. (2017, April 20). DHCF Annual Budget Presentation for FY2018: Presentation for Medical Care Advisory Committee (MCAC), Slide 13. Retrieved from https://dhcf.dc.gov/sites/default/files/u23/DHCF%20Annual%20Budget%20Report%203-2018%20%28MCAC%20Final%29.pdf
8. Spending on ESRD-related services includes MCO and FFS payments to hospital-based and free-standing hemodialysis providers, FFS claims and MCO encounters with procedure codes 90951 to 90999 and FFS claims and MCO encounters with revenue codes 821, 831, 841, and 851.
9. Annual enrollment includes a count of the unique number of beneficiaries who were enrolled over the course of the year, whether it was for one month or 12 months. For this reason, the number of beneficiaries is typically higher than any point-in-time count of unique beneficiaries.
10. DHCF provided FY2013 pharmacy services to Alliance beneficiaries through a special contract with the District of Columbia Department of Health and does not have access to data on the number of beneficiaries who utilized these services. Without these data, researchers could not calculate per-beneficiary spending in FY2013.
11. Hospital Based services include inpatient and outpatient services provided by hospitals. They exclude hospital-based dialysis services, which were identified using revenue codes 0821, 0831, 0841, and 0851.
12. Researchers defined spending as any payments to providers for Alliance program beneficiaries in the fiscal year, regardless of payor source. This includes services paid for by MCOs and by DHCF. It does not include capitation payments made by DHCF to MCOs.
13. Mirel, L.B., Karper, K. (2014, January). Trends in Health Care Expenditures for Elderly, Age 65 and over: 2001, 2006, and 2011. Retrieved from https://meps.ahrq.gov/data_files/publications/st429/stat429.pdf

[14] DHCF provided FY2013 pharmacy services to Alliance beneficiaries through a special contract with the District of Columbia Department of Health and does not have access to data on the number of beneficiaries who utilized these services or their ages. Therefore, researchers calculated growth for Alliance pharmacy services spending by age beginning in FY2014, when data were available.

[15] Mirel, L.B., Karper, K. (2014, January). Trends in Health Care Expenditures for Elderly, Age 65 and over: 2001, 2006, and 2011. Retrieved from https://meps.ahrq.gov/data_files/publications/st429/stat429.pdf

[16] Toward the end of FY2016 (July 2016), DHCF modified its contracts with the three MCO programs which provided services for the Alliance program and gave Alliance beneficiaries access to the same prescription formulary as Medicaid MCO beneficiaries. Alliance beneficiaries also received access to an expanded provider network.

[17] Government of the District of Columbia Department of Health Care Finance. (2013, September 23). Transmittal No. 13-15, Dialysis Coverage for DC Health Care Alliance. Retrieved from https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Dialysis%20Coverage%20for%20DC%20Health%20Care%20Alliance.pdf