Overview Of District’s Budget For FY2015

- Budget Development For DHCF
- Medicaid And Alliance Enrollment Trends
- Status Of Automated Medicaid Eligibility System
- Medicaid Acute Care Expenditure Patterns
- Medicaid Long-Term Care Expenditure Patterns
- DHCF’s Major Activities Planned For FY2017
The Approach: A Priority Driven Budget

- Engage with the public and solicit their input about community priorities
- Challenge Agency Directors to Fund Priorities First, like:
  - Job Training, Affordable Housing and Education
- Target underspending, vacancies, and program inefficiencies, not across-the-board cuts
- Maintain and invest in the District’s workforce
- Preserve middle class tax reductions
Sources of Gross funds for FY 2017
($13.4 Billion, Excluding Intra-District Funds)

- Local: $7.3 billion (55%)
- Federal Grants and Medicaid: $3.3 billion (25%)
- Federal Payments: $0.1 billion (1%)
- Special Purpose Revenue: $0.6 billion (4%)
- Enterprise Funds: $1.8 billion (13%)
- Private Grants and Private Donations: $0.0 billion (0%)
- Dedicated Taxes: $0.3 billion (2%)

*Private Grants & Donations is $1.3 million
Gross funds Expenditure Budget for FY 2017
(Excluding Intra-District Funds) ($13.4 Billion)
Budget Growth

FY2011 - FY2017 LOCAL FUND BUDGET GROWTH

- FY 2011 (Actual): 6.86%
- FY 2012 (Actual): 6.36%
- FY 2013 (Actual): 5.36%
- FY 2014 (Actual): 5.48%
- FY 2015 (Approved): 5.11%
- FY 2016 (Proposed): 3.15%
COSTS PROJECTED TO RISE 4.3%,

- Personnel, Fringe & Retirement - $75.9 million
- Contract inflation - $70.8 million
- Medicaid - $25.8 million
- DCPS and DCPCS - $28.1 million
- Debt Service - $12.8 million
- PAYGO not in CSFL - $46.4 million
- Other - $10.9 million

REVENUES PROJECTED TO INCREASE 1.3%
- Retirement Savings of $64.4 million
- Special Purpose Revenue Sweeps of $50 million
- One Time Savings Consisting of $76 million in CSFL Reductions, including:
  - Department of General Services, $31 million alignment of fixed costs
  - Health Care Finance, $7.2 million from efficiency savings due to processing some Federally Qualified Health Center payments by DHCF’s claims vendor instead of through the Medicaid managed care plans.
  - Public Libraries, $2 million from supplies, materials, contractual services, and vacancy savings
  - Aging, $1.3 million from re-alignment of DCOA’s transportation program
  - Disability Services, $2.6 million from vacancies, shifts to Medicaid, and rightsizing contracts
  - DDOT - $12 million shift fund shift (Local to O-Type funds)
  - WMATA - $6.3 million shift to SPR and dedicated taxes
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<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY16 Approved Budget</th>
<th>FY17 Proposed Budget</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel Services</td>
<td>25,955</td>
<td>25,336</td>
<td>-2.39%</td>
</tr>
<tr>
<td>Fixed Costs</td>
<td>756</td>
<td>978</td>
<td>29.4%</td>
</tr>
<tr>
<td>Other Non-Personnel Services</td>
<td>2,061</td>
<td>3,204</td>
<td>35.7%</td>
</tr>
<tr>
<td>Contractual Services</td>
<td>71,478</td>
<td>79,439</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Increase driven by higher assessments for occupancy, security services, electricity, and water.

Increase due mainly to the OCTO IT Assessment, Telecommunication costs, and IT Hardware Acquisitions.

Increase due mainly to OCP MOU (+$1.1M), higher contract costs in HCDMA (+$3.5M) and Long Term Care (+$1.3M), and larger contracts in support of the HIT/HIE PMO (+$2M).
### Proposed FY 17 Budget

**Funds** | FY2016 Approved | FY2017 Proposed | % Change
---|---|---|---
Local Funds | 700,011 | 706,421 | 0.92%
Dedicated Taxes | 71,345 | 81,907 | 14.80%
Special Purpose Revenue | 2,605 | 3,493 | 34.09%
Total General Funds | 773,961 | 791,821 | 2.31%
Federal Grant Funds | 1,000 | 2,916 | 191.61%
Federal Medicaid Funds | 2,146,166 | 2,188,106 | 1.95%
Total Federal Funds | 2,147,166 | 2,191,023 | 2.04%
Intra District Funds | 84,327 | 89,063 | 5.62%
Gross Funds | 3,005,454 | 3,071,906 | 2.21%

### Notes
- **Local fund increase** is the net of savings in provider payments, and a technical adjustment for the change in federal Medicaid reimbursement for the childless adults.
- **Increase driven by higher anticipated revenue** for Healthy DC ($12.1M). This increase was slightly offset by a lower budgeted amount for the Nursing Home Quality of Care fund.
- **Health Care Bill of Rights Assessment** increased to capture entire District funded cost of the DHCF Ombudsman program. TPL budget higher in FY17 based on FY15 revenue collected.
- **Federal grant funding** has a net increase of $1.9 million or 191.61% in FY 17. Two new grants, Money Follows the Person and Mobile Technology and Integrated Care, are budgeted while the state innovation model (SIMM) grant is not budgeted in FY 17.
- **Federal Medicaid match** to General Fund spending above.
- **This category** reflects the local share that is supported by Other District agencies. Intra-District agreements for the DD Waiver and MHRS programs.
FY16 Budget $700,010,624

FY17 Current Service Funding Level $713,584,166
The CSFL increased by 1.9% from FY16
- Pay raises and adjustments of $396,645
- $554,221 increase in Consumer Price Index
- $108,816 increase in Fixed Cost Inflation
- $10,613,860 increase in Medicaid provider payments

FY17 Budget Adjustments -$7,163,178
The net effect of 3 changes
- $22,275,256 reduction for provider payment savings
- $592,325 increase in contracts cost beyond the CSFL
- $14,519,753 increase for federal reimbursement shift for Childless Adults from 100% to 95% effective January 1, 2017 – this was a Technical Adjustment

FY17 DHCF Local Proposed Budget $706,420,988
### Proposed FY 17 Budget

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Increase and Description</th>
</tr>
</thead>
</table>
| Medicaid Provider Payments | • Increase of $54 million  
  • Significant increase in the Dedicated Taxes and Intra-District budget estimates                                                                                 |
| Public Provider Payments | • Increase of $2.2 million  
  • Revision of budget estimates for CFSA & St. Elizabeth’s Hospital                                                                                             |
| Alliance Provider Payments | • Increase of $6.8 million  
  • Significant increase in the MCO rates                                                                                                                     |
<table>
<thead>
<tr>
<th>Medicaid Mandatory Service</th>
<th>FY15 Expenditures</th>
<th>FY16 Budgeted Amount</th>
<th>FY17 Budget Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>246.81</td>
<td>265.80</td>
<td>250.78</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>236.91</td>
<td>303.51</td>
<td>283.67</td>
</tr>
<tr>
<td>Physician Services</td>
<td>35.55</td>
<td>45.51</td>
<td>39.46</td>
</tr>
<tr>
<td>Outpatient Hospital, Supplemental &amp; Emergency</td>
<td>41.87</td>
<td>70.55</td>
<td>65.73</td>
</tr>
<tr>
<td>Durable Medical Equip (including prosthetics, orthotics, and supplies)</td>
<td>21.70</td>
<td>24.38</td>
<td>25.08</td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>14.10</td>
<td>21.45</td>
<td>26.16</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>50.81</td>
<td>21.98</td>
<td>55.71</td>
</tr>
<tr>
<td>Lab &amp; X-Ray</td>
<td>13.50</td>
<td>13.32</td>
<td>13.18</td>
</tr>
</tbody>
</table>

Budget and spending information is based on SOAR which includes all adjustments. Data presented in subsequent slides is based exclusively on MMIS claims and may not include adjustments occurring at the provider level (FTs) or adjustments in SOAR.
## Medicaid Optional Services

<table>
<thead>
<tr>
<th>Medicaid Optional Services</th>
<th>FY15 Expenditures</th>
<th>FY16 Budgeted Amount</th>
<th>FY17 Budget Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Services</td>
<td>1,030.56</td>
<td>1,117.61</td>
<td>1,215.97</td>
</tr>
<tr>
<td>DD Waiver (FY 2015 includes intra-district funds from DDS)</td>
<td>184.02</td>
<td>199.33</td>
<td>206.95</td>
</tr>
<tr>
<td>Personal Care Aide</td>
<td>176.09</td>
<td>191.81</td>
<td>195.6</td>
</tr>
<tr>
<td>EPD Waiver</td>
<td>36.72</td>
<td>73.65</td>
<td>75.18</td>
</tr>
<tr>
<td>Pharmacy (net of rebates)</td>
<td>32.21</td>
<td>36.93</td>
<td>28.77</td>
</tr>
<tr>
<td>Mental Health (includes DBH intra-district for MHRS)</td>
<td>108.7</td>
<td>98.56</td>
<td>89.6</td>
</tr>
<tr>
<td>Day Treatment / Adult Day Health</td>
<td>7.14</td>
<td>13.57</td>
<td>13.21</td>
</tr>
<tr>
<td>Home Health</td>
<td>12.16</td>
<td>17.24</td>
<td>18.39</td>
</tr>
</tbody>
</table>
- **Fund Shift:** Shift expenses from local to dedicated tax ($9.9 mil)

- **Capture Living Wage Savings:** Reduce rate increases driven by the Living Wage based on January 2016 increase of 0.3% ($1.5 mil)

- **Alter Payment Processing For FQHCs:** Shift processing of wrap payment for Federally Qualified Health Centers (FQHCs) from Managed Care Organizations (MCOs) to claims processor ($7.2 mil)

- **Curtail Inflation Adjustments:** Eliminate inflations for institutional providers – nursing homes and ICF/IIDs ($1.8 mil)

- **Insurance Tax Moratorium:** Moratorium on premium tax levied on health insurance plans from Feds ($1.5 mil)

- **Updated Utilization Projections:** Net effect of updated utilization projections for all provider-types since the CSFL ($0.3 mil)

**Total:** $22.3 million
Key Facts Regarding Living Wage Initiative

- The proposed budget reduction for the FY2016 Living Wage does not eliminate the planned rate increase to account for the FY2017 Living Wage

- DHCF adjusted the estimate of the cost for the FY2016 Living Wage in FY2017 based on the actual increase experienced in FY2016

- If the actual increase in the Living Wage is determined to be higher than expected, DHCF will look for savings from other service lines to cover the gap
Key Facts Regarding Inflation Adjustment Savings

- While the proposed inflation adjustment alters plans to pay nursing homes and ICF/IIDs a separate add-on to their rates for inflation, any required Living Wage increase is unaffected.

- The full Living Wage increase that is mandated in January of each year will still be paid.
Why Did DHCF Request Only $3 Million To Draw Down $10 Million In Disproportionate Share Hospital (DSH) Payments For Private Hospitals?

- The District’s federal DSH limit is more than $95 million – this requires a local match of nearly $29 million

- However, an expected reduction in the level of uncompensated care that hospitals will experience in FY2017 obviates the need for a large draw down of DSH funding. Key factors are:

  - High level of insurance coverage in the District
  - Robust Medicaid fee-for-service payment rates for hospitals
  - Comparably robust MCO payment rates for hospitals
Note: From December 2010 to December 2015, the federal portion of the funds used to cover the cost of the Medicaid Expansion population were drawn from the DSH fund through a CMS Waiver. In December 2015 the Waiver expired and CMS approved the use of State Plan funds to pay for Medicaid Expansion.
## Hospital Inpatient Medicaid Payments Are Near Cost

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Charges</th>
<th>Total Cost</th>
<th>Total Paid</th>
<th>Payment To Cost Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's National</td>
<td>$38,370,642</td>
<td>$13,427,866</td>
<td>$15,558,644</td>
<td>116%</td>
</tr>
<tr>
<td>George Washington Hospital</td>
<td>$131,306,225</td>
<td>$31,285,350</td>
<td>$34,820,002</td>
<td>111%</td>
</tr>
<tr>
<td>Georgetown University Hospital</td>
<td>$70,906,347</td>
<td>$20,845,476</td>
<td>$18,718,971</td>
<td>90%</td>
</tr>
<tr>
<td>Howard University Hospital</td>
<td>$82,323,681</td>
<td>$48,820,708</td>
<td>$40,438,564</td>
<td>83%</td>
</tr>
<tr>
<td>Providence Hospital</td>
<td>$45,272,890</td>
<td>$19,330,309</td>
<td>$23,205,286</td>
<td>120%</td>
</tr>
<tr>
<td>Sibley Memorial Hospital</td>
<td>$5,159,265</td>
<td>$2,352,982</td>
<td>$1,985,035</td>
<td>84%</td>
</tr>
<tr>
<td>United Medical Center</td>
<td>$36,560,375</td>
<td>$16,850,309</td>
<td>$16,520,221</td>
<td>98%</td>
</tr>
<tr>
<td>Washington Hospital Center</td>
<td>$218,202,456</td>
<td>$63,957,933</td>
<td>$59,861,889</td>
<td>98%</td>
</tr>
<tr>
<td>National Rehab. Hospital</td>
<td>$7,681,930</td>
<td>$4,653,713</td>
<td>$4,200,075</td>
<td>94%</td>
</tr>
<tr>
<td>Psychiatric Institute of Washington</td>
<td>$2,663,299</td>
<td>$1,630,205</td>
<td>$1,865,337</td>
<td>114%</td>
</tr>
<tr>
<td>DCA Capitol Hill LTACH</td>
<td>$9,882,676</td>
<td>$3,392,723</td>
<td>$4,825,868</td>
<td>142%</td>
</tr>
<tr>
<td>DCA Hadley LTACH</td>
<td>$11,419,915</td>
<td>$3,834,807</td>
<td>$7,245,715</td>
<td>189%</td>
</tr>
<tr>
<td>HSC Pediatric Center</td>
<td>$6,018,843</td>
<td>$4,284,212</td>
<td>$3,708,679</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$665,768,544</td>
<td>$234,666,593</td>
<td>$232,954,286</td>
<td>99.3%</td>
</tr>
</tbody>
</table>

Notes: Cost is based on FY15 cost report factors applied to year-to-date FY 2015 claims, assuming 94% completion through October 19, 2015 for DRG hospitals and 90% for Specialty hospitals. Costs are estimated using preliminary FY 2015 Cost-to-Charge Ratios (CCR). DHCF estimated CCRs for Capitol Hill and Hadley.

Source: Xerox Consulting Services, March 2016.
Summary Of Factors Impacting The Need For DSH Funds Directed To Private Hospitals

Factors Affecting DSH Need

- FFS inpatient payments at 98% of cost
- FFS outpatient payments at UPL
- MCO inpatient payments comparable to FFS
- MCO outpatient payments exceed FFS significantly
- Virtually no uninsured District residents

FY 2011 DSH

- $7.2M could not be redistributed after audit
- FY 2011 was prior to outpatient rate increases and UPL payments
Note: From December 2010 to December 2015, the federal portion of the funds used to cover the cost of the Medicaid Expansion population were drawn from the DSH fund. These numbers include local dollars that were used to draw down federal DSH payments from December 2010 to December 2015. This figures also include Healthcare Alliance total of $5.6 million in FY 2011 and $1.4 million in FY 2012.
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Medicaid And Alliance Enrollment Trends

Status Of Automated Medicaid Eligibility System

Medicaid Acute Care Expenditure Patterns

Medicaid Long-Term Care Expenditure Patterns

DHCF’s Major Activities Planned For FY2017
More than four in 10 District residents are either enrolled in Medicaid or the Alliance Program.

- DC Residents on Medicaid or Alliance: 42%
- Other DC Residents: 58%

*Total Residents: 672,228

Source: District population estimate from United States Census Bureau. Medicaid and Alliance data reported from DHCF’s Medicaid Management Information System (MMIS).

Note: These data exclude District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated.
The District Has Significantly Higher Medicaid Eligibility Thresholds Compared To Federal Requirements, The Experience In Other Expansion States And The National Average.
The District’s Medicaid Enrollment Growth Rates, Post-Expansion, Are Moderating But Remain Higher Than Pre-Expansion Rates

Sources and Notes: Excludes ineligible individuals (individuals who failed to recertify due to lack of follow-up, moving out of the District, excess income, or passed away), the Alliance, and immigrant children. Data for 2000-2009 data was extracted by Xerox from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports.
Source: FY08-FY11 totals extracted from Cognos by fiscal year (October, 1 through September, 30), using variable Clm Hdr Tot Pd Amt (total provider reimbursement for claim). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance Line of Business or Immigrant Children's group program code. Only includes claims adjudicated through MMIS; excludes expenditures paid outside of MMIS (e.g. pharmacy rebates, Medicare Premiums).
Annualized Growth Rate For Expansion Population Is Substantially Higher Than Witnessed For Other Medicaid Groups, FY2011-FY2015

- Enrollment Level In September 2015: 10,495
- Childless Adults With Incomes From 133% to 210% Of FPL: 83,612
- Children Under 21: 175,689

Growth Rate:
- 57%
- 2%
- 3%
Alliance Enrollees

Immigrant Children

Alliance Members Move To Medicaid

Enrollment Trends For Alliance Adult Population Is Moderating

Sources: Excludes ineligible individuals – persons who failed to recertify due to lack of follow-up, moving out of the District, or had excess income, or passed away. Data for 2000-2009 data was extracted by ACS from tape back-ups in January, 2010. Data from 2010-forward are from enrollment reports.
While Alliance Enrollment Has Dropped Over the Past Five Years, Many Members Continued Receiving Coverage Through Medicaid

- July 2010: 31,000 Alliance Members Moved to 0-133% Group
- December 2010: 2,808 Alliance Members Moved to 134-200% group

The Remaining Alliance Population Consists of Individuals Who Were Not Eligible for Medicaid Due to Citizenship Requirements

Source: historical enrollment numbers were compiled by the Division of Analytics and Policy Research.
And Alliance Cost For Adults Are Spiking

Expenditure Trends For Alliance And Immigrant Children, 2005-2015

Source: FY08-FY11 totals extracted from Cognos by fiscal year (October, 1 through September, 30), using variable Clm Hdr Tot Pd Amt (total provider reimbursement for claim). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance Line of Business or Immigrant Children's group program code. Only includes claims adjudicated through MMIS.
Most Alliance Applicants Are Terminating The Recertification Process Before Completion
Longer Wait Times For Alliance Applications And Recertifications Are Potentially A Problem

Average Wait Time in Minute by Program’s Visit Purpose in 2015
Alliance, MAGI Medicaid and Non-MAGI Medicaid
Data Source: DHS ESA Service Center Intake Log
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DHCF’s Major Activities Planned For FY2017
High Level Overview of the DCAS System in FY 2017

Customers
- Medicaid
- SHOP
- Unassisted

DC Health Link
- Seeking Financial Assistance
- Small Business
- Not Seeking Financial Assistance

DCAS Systems
- Curam HCR
- APTC / UQHP Eligible
- SNAP Eligible
- TANF Eligible

DC Link
- Seeking SNAP / TANF
Current Functionality For Automated Medicaid System As Of April 2016 Is Limited

- Functionality Exists
  - MAGI Eligibility
  - CHIP Eligibility
  - Electronic Verifications
  - Streamlined Application
  - HBPE Medicaid
  - MAGI Eligibility
  - MAGI Passive Renewals
  - MAGI Notices
  - Pre-Populated Form

- Partially Automated or in Process
  - Pregnant Women Presumptive Reporting
  - Former Foster Care Medicaid
  - Life Events
  - On-Line Renewals

- Functionality Planned for Release 3
  - Pre-Screening
  - ER Medicaid
  - Retroactive Medicaid
  - Transitional MA

All Non-MAGI Work [App Intake Eligibility Verifications Notices]
However considerable progress has been made on clearing backlogs in FY 2016 due to system defects.
An Additional $334.0 Million Will Be Needed To Complete Work On The DCAS Eligibility System

Total Past And Projected Spending For DCAS, by Release

By Release - Past
Total $178,205,556

By Release - Future
Total $334,070,574

- Release 1
- Release 2
- Release 3
- Cross Functional
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DHCF’s Major Activities Planned For FY2017
Acute Care Services Account For Nearly Six Of Every 10 Medicaid Dollars Spent

$2,387,856,353

Source: Data extracted from MMIS, reflecting claims paid during FY2015
Seven Of Every 10 Medicaid Enrollees Are In The Managed Care Program

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Monthly Enrollment</th>
<th>Fee-For-Service</th>
<th>Managed Care (Medicaid)</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2009</td>
<td>63%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2010</td>
<td>63%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2011</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2012</td>
<td>68%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2013</td>
<td>73%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2014</td>
<td>73%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2015</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: DHCF staff analysis of data extracted from the agency’s MMIS.
Actual MCO Revenue At Target Rate For January 2015 to June 2015

AmeriHealth
- Revenue: $226.0m
- Medical Loss Ratio: 85%
- Administrative Expenses: $62.8m
- Profit: 7%

MedStar
- Revenue: $102.7m
- Medical Loss Ratio: 91%
- Administrative Expenses: $102.7m
- Profit: 6%

Trusted
- Revenue: $62.8m
- Medical Loss Ratio: 85%
- Administrative Expenses: $226.0m
- Profit: 11%

Actuary Model
- Administrative Expenses
- Profit: 13%

Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking.
Managed Care Medicaid Expenses, January 2015 – September 2015

- Hospital Services: 42%
- Physician Services: 15%
- Administrative Cost: 11%
- Pharmacy: 11%
- Other: 21%

Inpatient: $143m
Outpatient: $42m
Emergency: $65m

Source: Expenses incurred from Jan 1, 2015 to Sep 30, 2015 and paid as of February, 2016. Expense data are based on self-reported MCO Quarterly Financial Data submitted to DHCF.
Use Of ER For Low Acuity Conditions Remains Problematic

*Total Emergency Room Visits

Other Emergency Visits

**Low Acuity Non-Emergency (LANE) Visits

Was LANE Visit Avoidable?

Yes

No

AmeriHealth

71,504

29%

71%

27%

73%

MedStar

28,702

39%

61%

25%

75%

Trusted

22,474

34%

66%

27%

73%

*Total emergency department visits consists of all visits to the emergency room regardless of diagnosis which did not result in an inpatient admission. **Low acuity non-emergency (Lane) visits are emergency room visits that could have been avoided based on a list of diagnosis applied to outpatient data. Practicing ED physicians and Mercer clinical staff reviewed each LANE code and assigned a target utilization percentage of visits that a highly efficient managed care plan could prevent.

Source: Encounter data submitted by MCOs to DHCF.
Cost Of Low Acuity Visits Calculated During The Period From January 2015 to June 2015 Reaches $7.6 Million

Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

Source: MCO Encounter data reported by the health plans to DHCF.
Over Six Of Ten Inpatient Admissions Are Potentially Avoidable Costing $10.6 Million

Adjusted Potentially Avoidable Admissions As A Percent Of Inpatients Admits

<table>
<thead>
<tr>
<th>Managed Care Plan</th>
<th>Cost Of PPA</th>
<th>Adjusted Avoidable Admits Per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth</td>
<td>$4,803,496</td>
<td>5.26</td>
</tr>
<tr>
<td>MedStar</td>
<td>$3,999,526</td>
<td>8.2</td>
</tr>
<tr>
<td>Trusted</td>
<td>$1,916,151</td>
<td>6.6</td>
</tr>
<tr>
<td>Total</td>
<td>$10,619,173</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Note: Results are based on prevention quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) that can be used with hospital discharge data to identify potentially preventable admissions for adults.
Source: MCO Encounter data provided by MCOs to DHCF.
Note: All-cause 30-day hospital readmissions are “hospitalizations that occur, for any reason, within 30 days of discharge from an index admission.” An index admission is defined as any inpatient stay that might produce an avoidable readmission (Mathematica, 2011). Index admissions are derived from the set of unique hospital stays, and are determined by excluding specific categories of admissions from the set of unique hospital visits such as transfer cases and deaths. Readmission rates are computed as the ratio of admissions that occur within the specified readmission time period to the number of index admissions.

**Hospital Readmissions Within 30 Days Carry Considerable Cost**

<table>
<thead>
<tr>
<th>Managed Care Plan</th>
<th>Ratio Of Hospital Readmissions To Index Hospital Admissions</th>
<th>Total Cost Of Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>AmeriHealth</td>
<td>1 to 12.6</td>
<td>$9,543,434</td>
</tr>
<tr>
<td>MedStar</td>
<td>1 to 11.1</td>
<td>$6,255,786</td>
</tr>
<tr>
<td>Trusted</td>
<td>1 to 9.9</td>
<td>$2,313,035</td>
</tr>
<tr>
<td>Total</td>
<td>1 to 11.3</td>
<td>$18,112,256</td>
</tr>
</tbody>
</table>

The Average Cost Per Readmissions For Each Health Plan

- AmeriHealth: $16,312
- MedStar: $19,940
- Trusted: $16,428
- Total: $11,820
FFS Medicaid Hospital Spending Is Almost 15% Of Total Medicaid Expenditures

$2,387,856,353

Non-Hospital Spending
86%
($2,050,292,823)

Hospital Spending
14%
($337,463,530)

Inpatient
$264,629,110
(79%)

Outpatient and Emergency
41,894,812
(12%)

Disproportionate Share Payments
$30,939,609
(9%)

Source: Data extracted from MMIS reflect final claims, including adjustments, and DSH payments made during FY15
Fee-For Service Hospital Admissions Are Growing Faster Than Observed For Managed Care

Note: Index hospital admissions are obtained by subtracting non-candidates for readmissions from total hospital admissions

Source: DHCF staff analysis of data extracted from MMIS
Fee-For-Service Recipients Are Responsible For A Disproportionate Share of Medicaid Spending

<table>
<thead>
<tr>
<th>Is Beneficiary in Fee-For-Service Program?</th>
<th>*Medicaid Recipients</th>
<th>Total Medicaid Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26%</td>
<td>75%</td>
</tr>
<tr>
<td>No</td>
<td>74%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Total: N = 228,644

Total Medicaid Expenditures: $2,296,649,398

Source: Data from DHCF MMIS system. *Only persons with 12 months of continuous eligibility in CY2015 are included in this analysis.
A sub-group of high utilizers within the fee-for-service population account for nearly 80 percent of all spending on this group.

Did recipient have claims costs of $50,000 or more in 2015?

- Yes: 17%
  - N = 59,254
- No: 83%
  - N = 59,254

Total Medicaid expenditures:
- Yes: $1,731,424,575 (75%)
- No: $1,731,424,575 (25%)

Note: Data from DHCF MMIS system. *Only persons in the Fee-For-Service program with 12 months of continuous eligibility in CY2015 are included in this analysis.
## Comparison of High And Low Cost FFS Recipients

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>High Cost Group</th>
<th>Low Cost Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>57</td>
<td>49</td>
</tr>
<tr>
<td>Average Hospital Admissions</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Average Length of Stay (In Days)</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Average Emergency Room Visits</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Mean Prescriptions Per Person</td>
<td>54</td>
<td>27</td>
</tr>
<tr>
<td>Percent with Multiple Chronic Conditions</td>
<td>86%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Note: High cost is defined as having continuous eligibility for 12 months and at least $50,000 in claims.
Overview Of District’s Budget For FY2015

Budget Development For DHCF

Medicaid And Alliance Enrollment Trends

Status Of Automated Medicaid Eligibility System

Medicaid Acute Care Expenditure Patterns

Medicaid Long-Term Care Expenditure Patterns

DHCF’s Major Activities Planned For FY2017
Total Medicaid Program Expenditures, FY2015
$2,387,856,353

- Primary & Acute Care: 59% ($1,411,576,929)
- Long-Term Care: 31% ($739,615,805)
- Other: 5% ($116,725,773)

Source: Data extracted from MMIS, reflecting claims paid during FY2015
Though High, Waiver Program Cost Compare Favorably To Institutional Spending

<table>
<thead>
<tr>
<th>Program Service</th>
<th>Total Number of Recipients</th>
<th>Total Cost for Services</th>
<th>Average Cost Per Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD Waiver*</td>
<td>1,671</td>
<td>$190,701,895</td>
<td>$114,124</td>
</tr>
<tr>
<td>ICF/DD</td>
<td>345</td>
<td>$95,143,327</td>
<td>$275,778</td>
</tr>
<tr>
<td>EPD Waiver</td>
<td>2,856</td>
<td>$35,302,483</td>
<td>$12,361</td>
</tr>
<tr>
<td>State Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td>5,300</td>
<td>$176,035,626</td>
<td>$33,214</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>3,707</td>
<td>$232,783,948</td>
<td>$62,796 56</td>
</tr>
</tbody>
</table>

Source: Data extracted from DHCF’s MMIS. *DD Waiver costs do not include DDS local funds for the waiver.
- Overview Of District’s Budget For FY2015
- Budget Development For DHCF
- Medicaid And Alliance Enrollment Trends
- Status Of Automated Medicaid Eligibility System
- Medicaid Acute Care Expenditure Patterns
- Medicaid Long-Term Care Expenditure Patterns
- DHCF’s Major Activities Planned For FY2017
<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Goal of Project</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Homes Care Coordination</td>
<td>Develop a program to test the efficacy of care coordination for Medicaid beneficiaries with chronic illness.</td>
<td>To strengthen primary care services and improve health outcomes for individuals with chronic illness. This program targets approximately 25,000 FFS and MCO beneficiaries with chronic illness and high costs.</td>
<td>SPA is being designed and will be submitted to CMS for approval; expected launch date is January, 2017.</td>
</tr>
<tr>
<td>Medicaid Long-Term Care Reform</td>
<td>Develop an improved system of long term care using a NO WRONG DOOR approach to program entry, streamline eligibility, conflict-free, comprehensive, and automated assessments of patient need, alignment of eligibility criteria with assessments, and improved program monitoring and oversight</td>
<td>Improve the timeliness of the application process, eliminate fragmentation in the long-term care system, reduce inappropriate growth, strengthen program oversight and services</td>
<td>ADRC established as the entry point for EPD waiver – will expand to other LTC services in FY17; DHCF is developing EPD waiver renewal application, to be effective 1/1/17</td>
</tr>
<tr>
<td>Pay For Performance Program for Managed Care Plans</td>
<td>Establish a program that requires the three full risk-based health plans to meet performance thresholds or lose a portion of their capitated payments.</td>
<td>Improve care coordination outcomes</td>
<td>Program implemented in February 2016; DHCF will monitor MCOs to determine if benchmarks are met or if funds will be withheld.</td>
</tr>
</tbody>
</table>
## Key Activities Planned For FY2017

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Goal of Project</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of the DCAS Eligibility System</td>
<td>In conjunction with DHS, develop and implement a new health and human services eligibility system for Medicaid and other public assistance programs</td>
<td>Establish an automated eligibility system that allows applicants to Medicaid and other assistance programs to apply for benefits through an online automated process.</td>
<td>DHCF, DHS, and Exchange staff are presently working to improve functionality; preparing for the third phase of the project</td>
</tr>
<tr>
<td>Rate-Setting for Several Provider Groups</td>
<td>Through the recently established Office of Rates, Reimbursement and Financial Analysis, DHCF will implement cost report audits on several major providers to more accurately identify their Medicaid allowable cost in support of the development of updated rate methodologies</td>
<td>Establish or refine the rate methodologies for the personal care program, ICF/IDD providers, and Federal Qualified Health Centers.</td>
<td>Cost reports for FQHCs, ICF/IDDs, and Home Health Care agencies have been collected and are now being audited</td>
</tr>
<tr>
<td>Access to Healthcare Services</td>
<td>Develop an access plan demonstrating beneficiary access to providers, provider availability, service utilization, and compare Medicaid and private rates in accordance with new CMS requirements</td>
<td>Ensure access to healthcare services for Medicaid beneficiaries</td>
<td>DHCF access plan will be submitted to CMS in June. Access to care reviews will be conducted every 3 years for primary, specialty, behavioral health, obstetric, and home health services</td>
</tr>
</tbody>
</table>
