

GOVERNMENT OF THE DISTRICT OF COLUMBIA



Department of Health Care Finance

FY 2017 Budget Hearing

Testimony of

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Before the

Council of the District of Columbia

Committee on Health and Human Services

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John A. Wilson Building

1350 Pennsylvania Avenue, NW

Introduction

Good morning Chairwoman Alexander and members of the Committee on Health and Human Services. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF) and it is my pleasure today to report on Mayor Bowser's FY2017 budget entitled "A Fair Shot." The major premise underpinning the Mayor's budget is that through targeted investments by the District in education, the city's infrastructure, public safety, and its people, a pathway to the middle class is established for residents of the city, regardless of the geographic area in which they happen to live.

In the development of her FY2017 budget, Mayor Bowser executed a priority-driven approach while confronting projected cost increases from FY2016 that were more than three times larger than the anticipated growth rate for future total revenue. Consequently, the Mayor and her budget team needed to implement gap closing measures to address a more than \$190 million difference between projected FY2017 costs and expected revenues.

Eschewing the blunt instrument of across the board cuts, the Mayor challenged agency directors to target underspending, staff vacancies, and program inefficiencies as a means of identifying sufficient funds to help close the budget gap while aligning agency budgets with her major priorities for the District.

Similar to last year, the Mayor held three budget engagement forums attended by hundreds of residents who described how they would allocate resources towards key issues facing the District. The Mayor's budget staff also met with Councilmembers and their staff to incorporate their priorities in the budget. The benefit of this front end work is a budget that incorporates the priorities of the Bowser Administration while reflecting the input of a diverse cross section of District residents. Similarly, DHCF regularly met with our Medical Care

Advisory Committee, in part, to hear the members' views on important Medicaid and Alliance budget issues.

As you are aware, the budget for the Department of Health Care Finance -- at more than \$3 billion -- is a critical component of the Mayor's proposed budget. With an excess of \$700 million in budgeted local funds, DHCF accounts for a significant share of the city's portfolio of spending, second only to the District of Columbia public schools. This means that the gap closing measures pursued by the Administration must, by necessity, touch the programs or activities funded through DHCF.

Although DHCF can play a vital role in identifying cost savings and thereby provide relief from some of the District's fiscal pressures, the nature and structure of DHCF's budget introduce a number of complications that must be considered as these gap closing measures are pursued. Notably, though we annually spend over \$3 billion in combined federal and local dollars, fully 96 percent of this spending can be traced to Medicaid provider payments which are directly influenced by beneficiary utilization levels, the scope of authorized benefits, and provider reimbursement rates. The remaining four percent of the budget funds personnel costs and contractual services that are central to the operation of our programs. As with provider payments, these costs are significantly subsidized with federal funds.

In practical terms, this underlying financing scheme means that major savings in Medicaid -- and to a lesser degree the much smaller Alliance program -- can only be realized through either reductions in participant eligibility levels, policy changes that narrow the scope of recipient benefits, or decreases in provider reimbursement rates. If these options are not considered, smaller savings opportunities can sometimes be achieved through the capture of

administrative efficiencies and the opportunistic pursuit of any one time savings actions that can be identified.

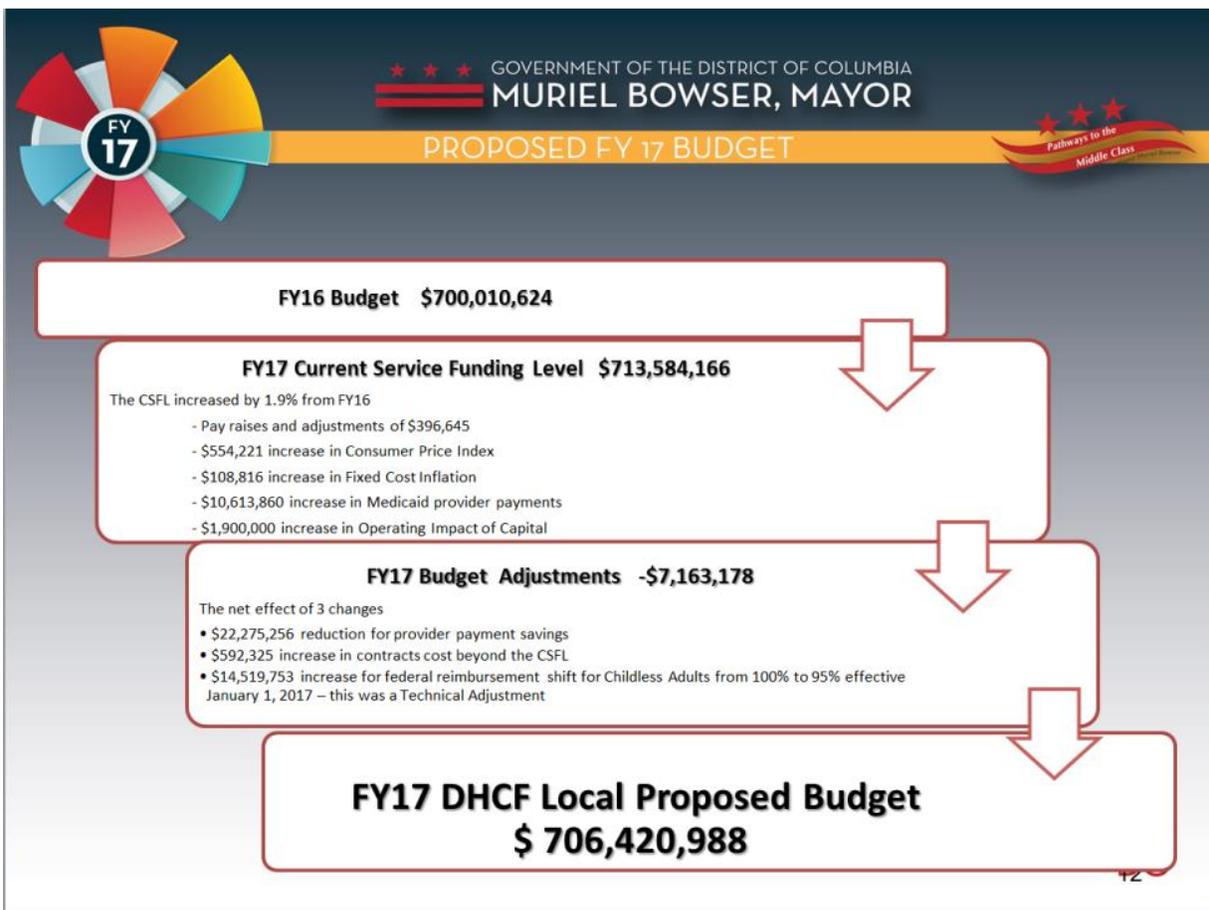
I am pleased to report that Mayor Bowser's FY2017 proposed budget ensures continued access to health care services by preserving the District's eligibility levels for both the Medicaid and Alliance programs – eligibility thresholds that are among the highest in the country and now extend coverage to more than 40 percent of all District residents. In addition, the Mayor's budget protects the health care benefits made available through these programs, providing beneficiaries with access to a full range of preventative, primary, acute, and specialty health care services.

Rather than restrict access to care, the Mayor has proposed several actions that reduce the payments made to providers through internal fund shifts, the planned pursuit of administrative efficiencies associated with claims processing, and the elimination of inflation adjustments for two provider groups that are supported by robust rate reimbursement methodologies. Together the proposed actions offer the promise of more than \$22 million in savings for FY2017, but are constructed in such a way to have a negligible impact on beneficiary access to care.

My remarks today initially focus on the three major issues that shaped our budget development for FY2017. First, I discuss how DHCF's FY2017 budget was formulated taking into account the FY2016 authorized budget and the impact of the FY2017 Current Services Funding Level (CSFL). Second, I will provide some detail on several of the key savings strategies authorized by Mayor Bowser to generate \$22.3 million in local fund savings. Finally, I close out my testimony with a report on the changing enrollment patterns in the Medicaid and Alliance program and discuss the implications for DHCF's budget.

DHCF'S Budget Development Process

Madam Chairwoman, the illustration on page 5 of my testimony outlines the steps we implemented to construct the Mayor's proposed budget for DHCF. As shown, the Mayor relied upon DHCF's current year's budget of \$700 million to set the base funding level in FY2016. Next, this budget amount was inflated by employee salaries and fringe benefits, anticipated growth in Medicaid direct services, and changes in the Consumer Price Index. This produced an estimate of our CSFL which, in this case, is defined as the cost of providing the same Medicaid and Alliance services in FY2017 that were funded in FY2016.

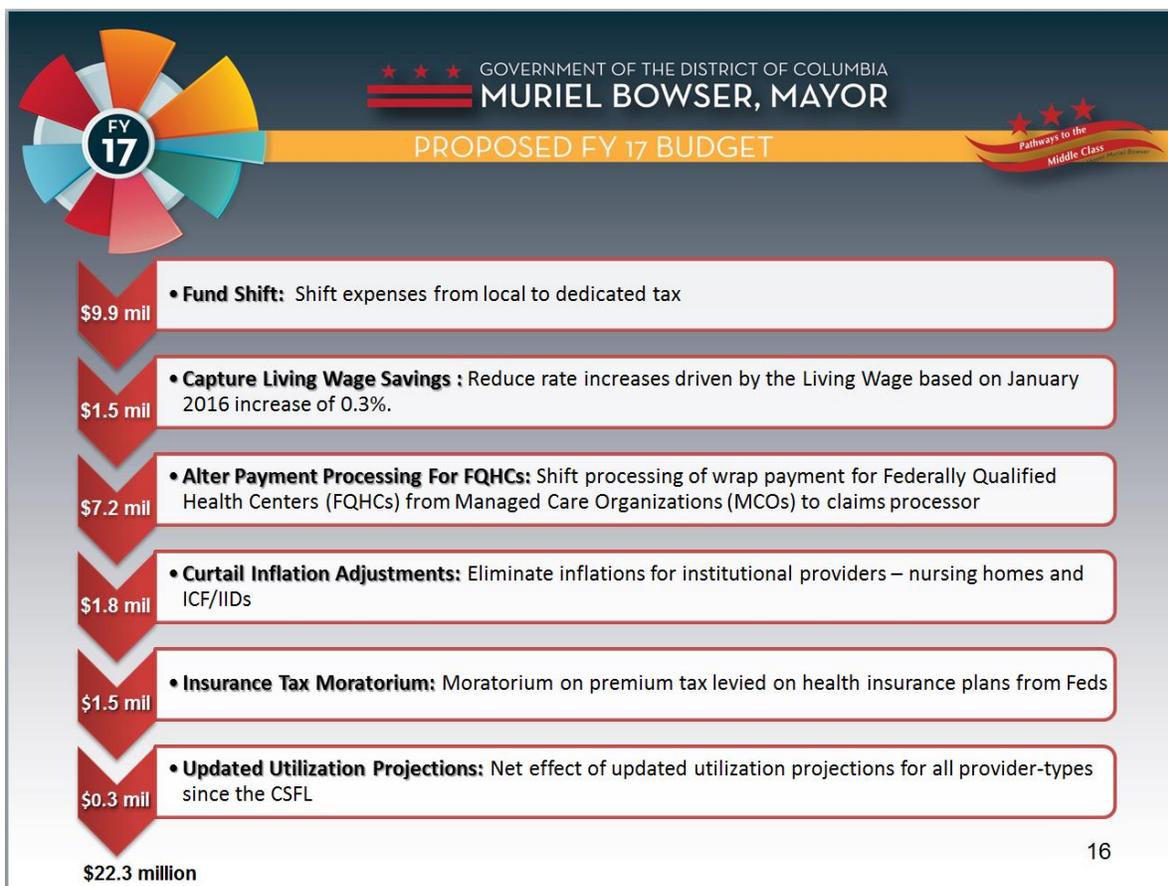


The increase in the CSFL from the FY2016 base budget was a modest 1.9% from FY16 or \$13.5 million. Not surprisingly, the majority of this increase -- over 80% -- reflected the additional projected cost of funding more than \$10.6 million in Medicaid direct care services.

This represents the combined effect of the anticipated growth in beneficiary enrollment, utilization, and health care inflation. By a considerable margin, this projected growth reflects the greatest absolute increase in actual dollars, pushing the FY2017 proposed local budget to \$713.5 million.

DHCF Proposed Savings Initiatives

As the graphic on this page illustrates, the Mayor authorized three major budget actions for DHCF, which reduced the agency’s proposed budget to \$706.4 million – a net reduction of \$7.2 million. Two of the budget actions required an increase in local funding with the most significant being the amount needed to offset the decline in federal support for the District’s Medicaid expansion population. This policy change, which is effective January 1, 2017, reduces the federal match rate for a portion of the District’s childless adult eligibility group by 5% and comes with a \$14.5 million price tag.



As revealed in the chart on page 6, the increased cost of these three budget actions were offset by several strategies which are projected to produce \$22.3 million in payment reductions. The strategy associated with the largest such reduction of \$9.9 million is a proposal to shift expenses from provider payments to the agency's non-lapsing dedicated tax fund called Healthy DC.

Another \$7.2 million was generated through an administrative efficiency involving the payment of claims. By adjudicating certain invoices made by the Federally Qualified Health Centers (FQHCs) through DHCF's claims processor, the District effectively reduces the revenue to the health plans that would have otherwise been allocated to pay these claims. Specifically, this action allows DHCF to avoid distributing \$7.2 million to the private health care plans otherwise needed to pay the taxes associated with the additional revenue they would have received if the MCOs had been made responsible for payment of these particular claims.

The most notable of the remaining initiatives is a \$1.8 million savings generated by eliminating a planned 1.6% inflation adjustment for nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). For the ICF/IID facilities, the loss of the inflation add-on is moderated by DHCF's plans to pay the annual living wage increase mandated by District law each year.

With regards to nursing homes, DHCF audit results generally indicate that the cost of providing care to Medicaid beneficiaries in these facilities has not grown as rapidly as predicted and many of the homes will be required to return significant payments as a result of the most recent rate update – this is a prima facie indication that the loss of the inflation add-on for perhaps one year will be of limited impact to this industry.

Medicaid and Alliance Spending Patterns: Trends and Future Challenges

Madam Chairwoman, for the last part of my testimony, I would like to turn your attention to a few important trends in the Medicaid and Alliance programs and speak briefly about the challenges inherent in these numbers as we plan for the coming year. With the series of eligibility changes approved by the DC Council over the past six years, the District of Columbia has emerged as the national leader in providing access to publicly-sponsored health care for persons with low-incomes. Due to this commitment to coverage, national data show that for every beneficiary category, the District has established significantly higher eligibility levels than the average thresholds observed for other states.

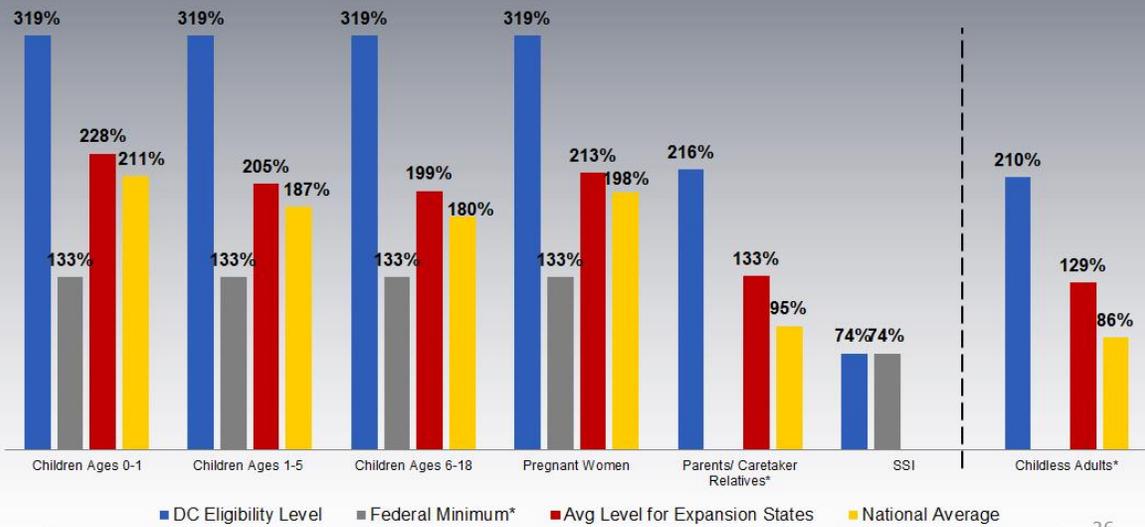
The graphic on page 9 reveals that for children of all age groups, Medicaid eligibility levels in the District are set at 319 percent of the federal poverty level (FPL). As reported in the figure, this exceeds the federal minimum requirement, the national average for all States, and the average level for jurisdictions that have expanded their Medicaid programs.

For adults, the differences reported in the graphic are more striking. While the District extends eligibility for parents and childless adults to 216 percent and 210 percent of the FPL respectively, the average for other expansion states does not exceed 133 percent. Within this group of states, the highest eligibility threshold for childless adults is 138 percent of FPL. Further, no individual State provides access to Medicaid-funded health care to families with incomes that exceed 148 percent of FPL.

As would be anticipated, the impact of these policies for the Medicaid program can be seen in the enrollment trends for program beneficiaries which spiked quickly following the District's policies implementation of expansion policies, first pursued in 2010. Prior to the



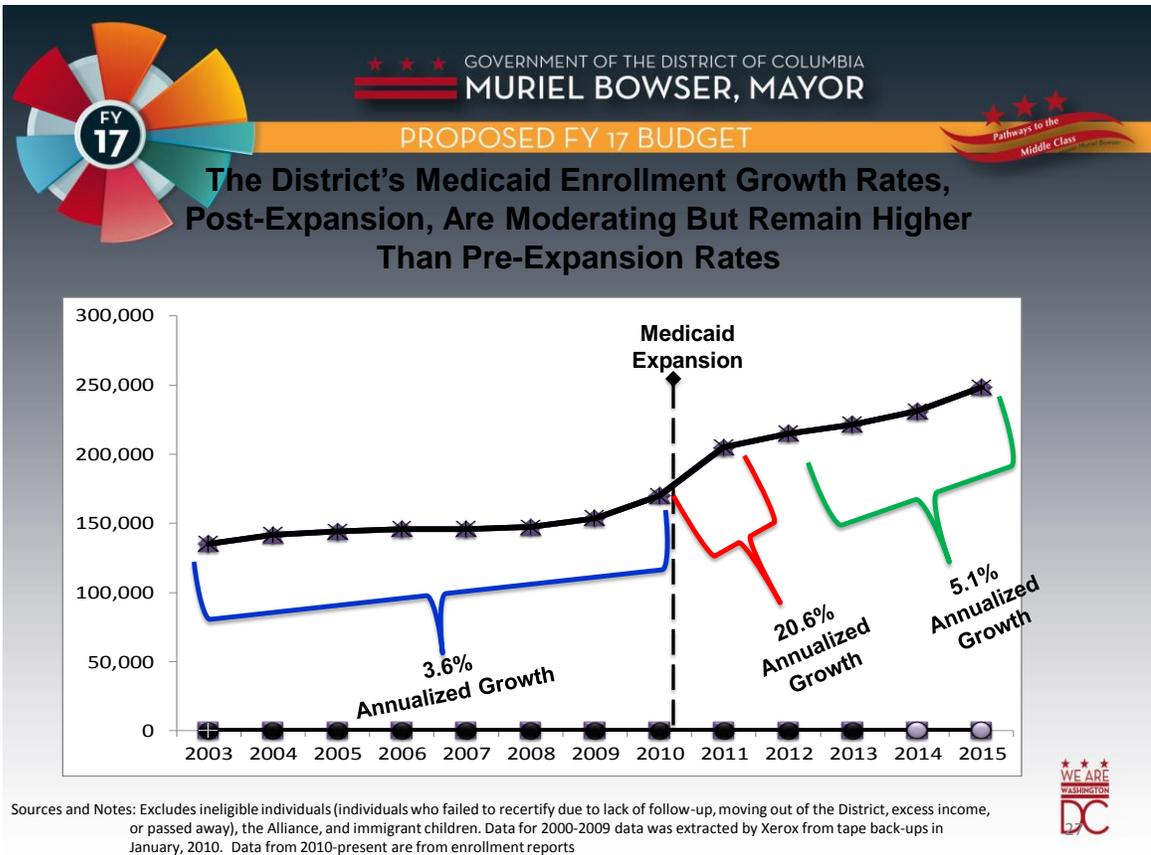
A Comparison Of District Medicaid MAGI Group and SSI Eligibility Levels With Federal Minimum And National Averages



*There is no federal minimum for the parent or childless adult category and childless adults is a federal option for states.

adoption of these policies, the enrollment growth in Medicaid averaged 3.6 percent annually, as shown by the graphic on page 10. In the first year after expansion, the growth rate jumped to more than 20 percent. While this increase moderated over the time period from 2012 through 2015, the annualized growth rate for this period of 5.1 percent remains higher than observed in the years prior to expansion.

This post-Medicaid expansion growth has produced significant upward pressure on total program cost. During the pre-expansion era, Medicaid spending in the District grew on average by less than one percent. Since that time, on an annualized basis, Medicaid expenditures have grown by nearly four times that amount. When this type of growth is applied to a base of

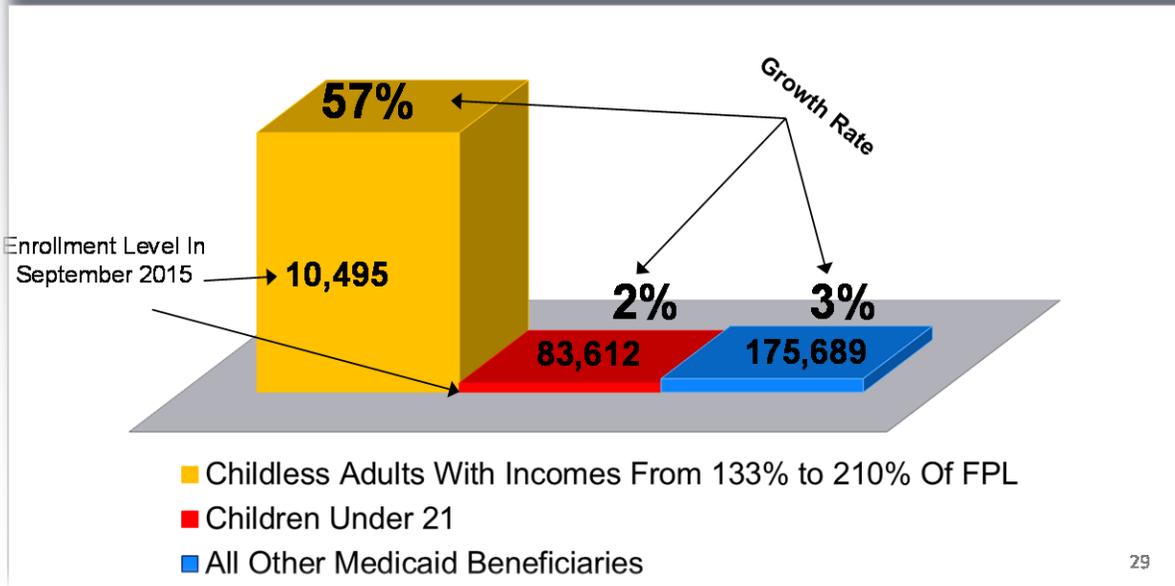


spending that was just over \$2.0 billion in FY2012, it is easy to understand why the District will spend more than \$3.0 billion on Medicaid by the end of FY2017.

Also, there can be little doubt that the childless adult population is adding significantly to the cost of the program. In the summer of 2010, the District was allowed to extend eligibility to childless adults with incomes up to 133% of FPL. Later that year, the program was further expanded to include childless adults with incomes from 133 percent to 200 percent of FPL – no other state has implemented this policy. While only about 10,400 childless adults from this latter group were enrolled in Medicaid at the end of FY2015, their numbers have grown at rate that is substantially higher than observed for other categories of Medicaid beneficiaries (see graphic on page 11).



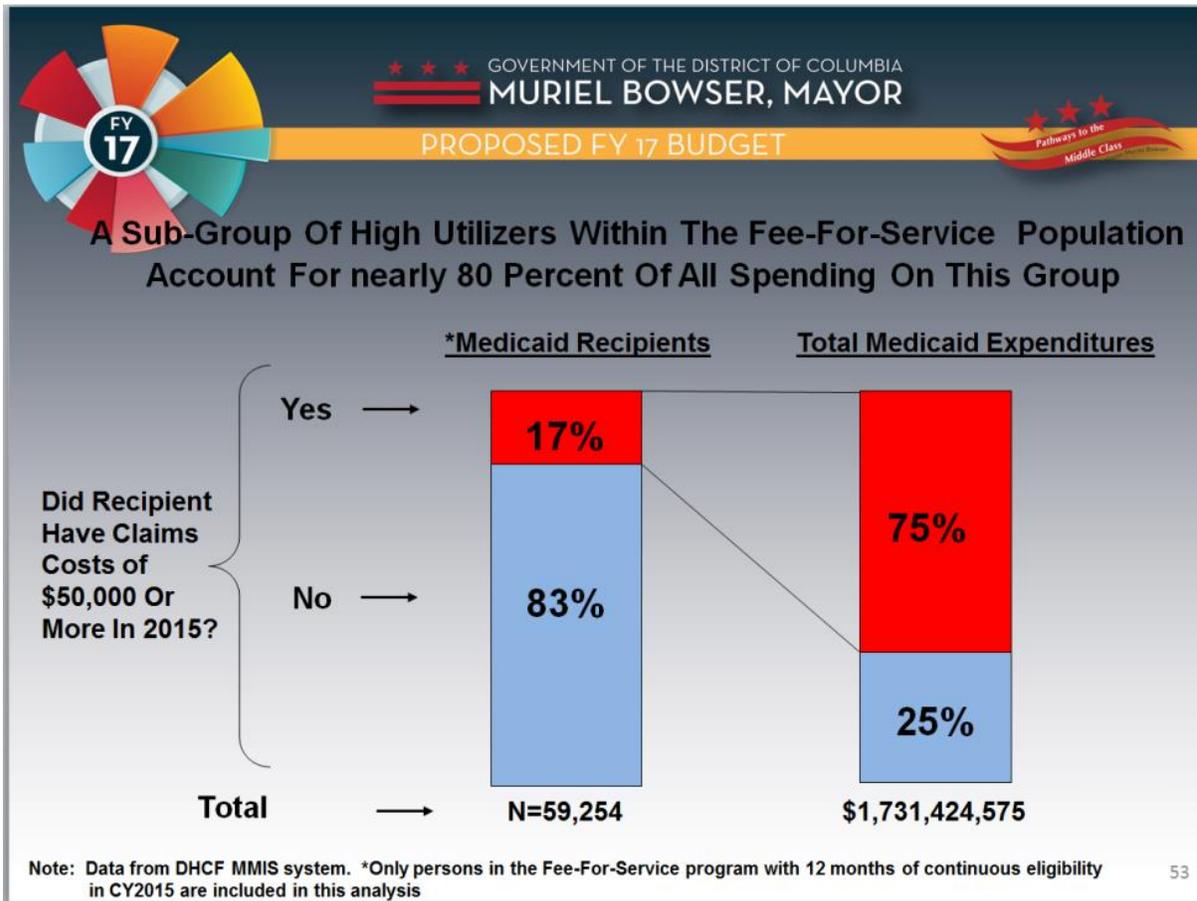
Annualized Growth Rate For Expansion Population Is Substantially Higher Than Witnessed For Other Medicaid Groups, FY2011-FY2015



More significant, the cost for insuring this population is substantially higher than the other major subgroups of participants in the Medicaid program. In FY2017 for example, DHCF will pay the MCOs premiums of \$519.80 per-member, per-month for this sub-group of adult Medicaid beneficiaries without children. By comparison, the health plans will receive \$455.65 per-member, per-month for all other adults, and only \$223.60 for children.

While the Medicaid enrollment growth rate for other adult beneficiaries (3 percent) is considerably less than witnessed for childless adults with incomes from 133 percent to 200 percent of FPL, we know from prior research that this group includes those enrollees who suffer from multiple chronic conditions and do not receive their health care services through a care network organized under any of the District's four health plans. Due to this confluence, a small

group of beneficiaries (17 percent) are responsible for three-quarters of the *total* expenditures in the fee-for-service program. That amounts to more than \$1.3 billion in spending on 10,073 beneficiaries – or roughly \$128,915 per person on an annual basis (see graph below).



In the coming months, DHCF will need to critically examine the underlying cost-drivers for this population as well as for childless adults who are assigned to our private health plans. Mayor Bowser has included funding in her FY2017 budget to support a program that will test the efficacy of care coordination for Medicaid beneficiaries with chronic illnesses. This effort will be complimented by a similar program that is designed to coordinate care and drive quality outcomes for persons with serious mental illness.

At the same time, we are in the process of launching new value-based reimbursement systems for our health plans and FQHCs that will offer enhanced payments to those providers that show evidence of improved outcomes for the beneficiaries they serve. The design and goals of both systems are the same – reduce unnecessary use of the emergency room, slow the rate of avoidable hospital admissions, and limit the number of hospital readmissions that occur within 30 days of a previous admission. Our hope is to expand this value based payment system to all of our major Medicaid providers in the near future.

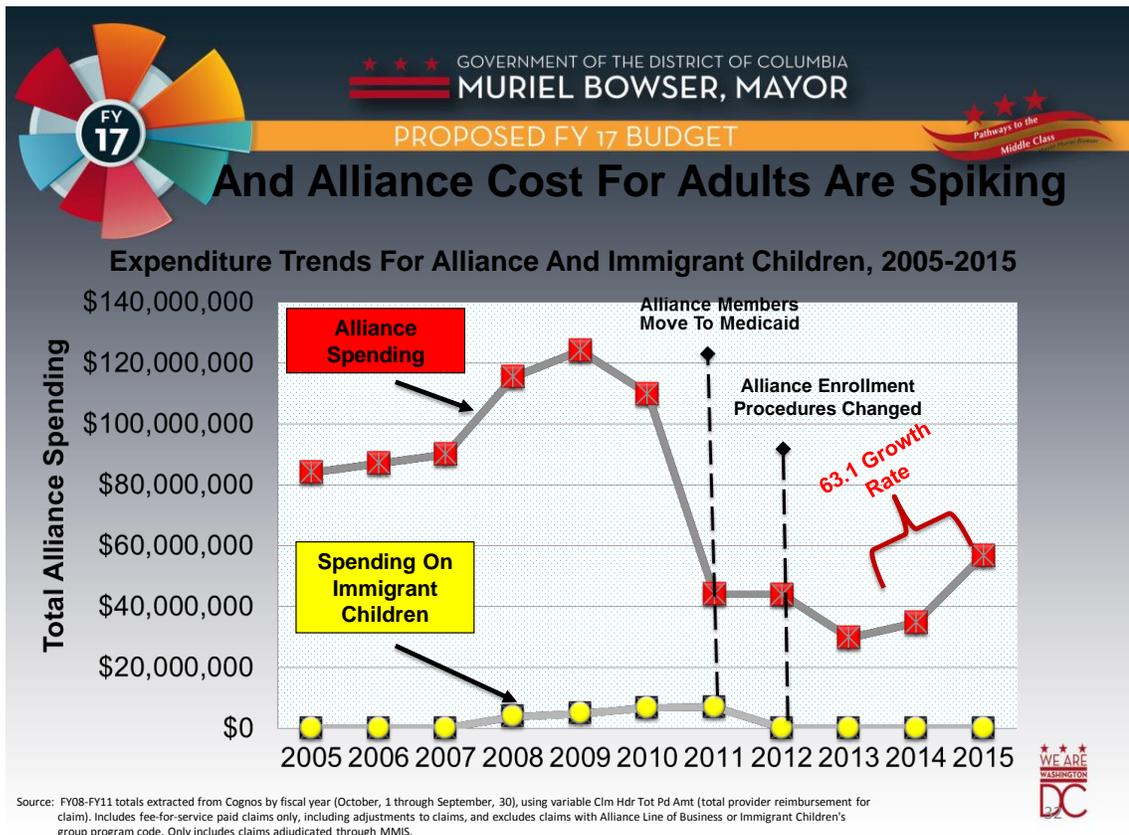
Madam Chairwoman, the final topic of my testimony focuses on the Alliance program. By fully funding the anticipated cost of coverage for persons with incomes up to 200 percent of FPL, Mayor Bowser’s budget continues the District’s support for health care access to individuals who are residents of the District but are not eligible for Medicaid. While a few other states offer some level of coverage to small segments of this population, no other jurisdiction comes close to fully funding the health care cost for non-citizens in the manner employed by the District.

As this program is entirely locally funded, an even greater premium is placed on the proper stewardship of this benefit. As recent as 2009, Alliance served more than 60,000 immigrants and United States citizens at a local cost that exceeded \$120 million. This was a wrenching budget pressure for the city that prompted key policy changes in 2010, effectively shifting many former Alliance members into the jointly-funded Medicaid. Specifically, with the expansion of Medicaid eligibility, more than 30,000 Alliance members were moved to that program, dropping Alliance enrollment to approximately 25,000 beneficiaries.

Two years later, the District established the often debated six month face-to-face requirement for Alliance which was believed necessary to slow the rate at which non-District

residents were impermissibly accessing Alliance funded health care services. Since that change, membership in the Alliance program declined by another 10,000 beneficiaries over the next three years.

During the period of most of this significant enrollment change between 2009 and 2015, we saw a marked decrease in the cost of the program – dropping from \$120 million in 2009 to just under \$36 million by 2013 as shown by the graphic on page 14. However, in 2014, despite data from the Economic Security Administration indicating that most persons seeking Alliance benefits terminate the process prior to completion, the enrollment declines appear to have ended, leveling off through 2015 at 15,000 enrollees. Meanwhile, however, the costs associated with the program have begun to spike upwards showing a 63 percent growth rate from 2014 through 2015, with projected cost for FY2017 at almost \$60 million.



Given the pressure on the District's local fund budget, we are particularly mindful of this recent trend and have initiated plans to explore why program cost are increasing so sharply without a corresponding rate of growth in enrollments. We will spend some effort examining this phenomenon into FY2017 and may develop recommendations for possible consideration in the next budget season.

Conclusion

In closing Madam Chairwoman, the District's operating budget is growing at a rate that is more than three times faster than the revenues used to support the budget. Mayor Bowser addressed this issue in her FY2017 budget through the use of thoughtful and strategic gap closing measures which were scored at more than \$190 million.

At the same time the Mayor's budget proposes no changes to the Medicaid or Alliance insurance coverage levels, thus preserving the District's strong tradition of comprehensive coverage to persons with low income. These robust eligibility levels reflect the Mayor's genuine commitment to ensuring that the lack of health care insurance will not stand as a barrier that obstructs the pathway her budget has constructed as a bridge to the middle class for District residents.

Because these coverage levels extend care to such a high percentage of the District's population, DHCF staff must work diligently to ensure that beneficiaries appropriately utilize these health care resources while ensuring that providers deliver the best possible value to the District per health care dollar spent. This will continue to be our focus as we head towards and into FY2017 and we promise to work closely with your team to accomplish these goals.

This concludes my remarks and I, along with members of my management team, are happy to address your questions.