

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**



Department of Health Care Finance

FY 2019 Budget Oversight Hearing

Testimony of

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Before the

Council of the District of Columbia

Committee on Health and Human Services

April 19, 2018

John A. Wilson Building

1350 Pennsylvania Avenue, NW

## **Introduction**

Good morning Chairman Vincent Gray 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 report on Mayor Muriel Bowser's FY2019 budget for the agency, entitled "A Fair Shot". My written testimony has been submitted for the record and I will rely upon the PowerPoint presentation you have in your possession to guide my remarks for the hearing.

As you are aware, Mayor Bowser's budget is constructed to invest in six priority areas which are anchored to the following goals: (1) expand funding for infrastructure initiatives; (2) accelerate investments in education; (3) grow affordable housing; (4) strengthen public safety; (5) ensure access to jobs and economic opportunity; (6) increase investments in our senior citizens; and, (7) extend the reach of vital health and human services programs. With this as the operating framework, this budget is strategically positioned to drive progress and promote prosperity while giving a hand to those who live on the economic margins of this city.

The public and agency-level engagement involved in the development of the Mayor's budget has been substantial, including numerous community meetings, agency budget roundtables with the City Administrator and his staff, and significant input from members of the Council. Regarding the proposed budget for DHCF, we regularly met with our Medical Care Advisory Committee, comprised of providers, the District's MCOs, and other stakeholders in the community, in part, to hear their views on important Medicaid and Alliance issues. And, as in previous years, the Mayor challenged agency directors to target underspending, eliminate staff vacancies, and streamline program inefficiencies as a means of identifying funds that might be redirected to a higher use instead of across the board reductions.

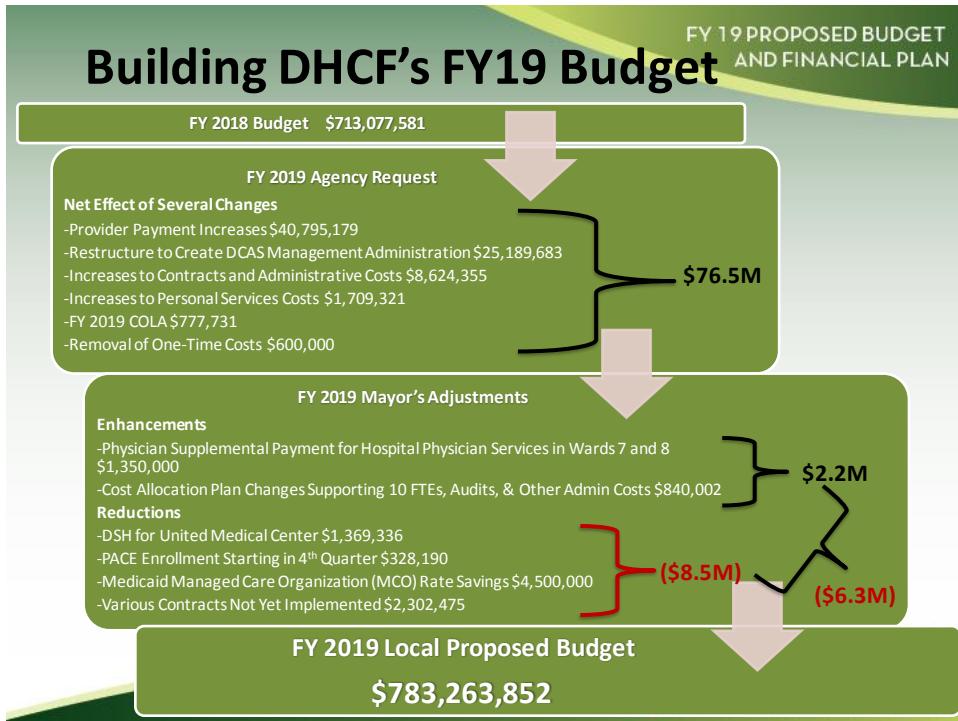
I am pleased to report that Mayor Bowser's proposed FY2019 budget fully embraces the District's long-standing commitment to preserving eligibility levels for both the Medicaid and Alliance programs – eligibility thresholds that remain among the highest in the United States. Additionally, this proposed budget requires no major reductions in Medicaid or Alliance benefits, thereby protecting the full range of preventive, primary, acute, and specialty health care services funded through these two programs. Finally, the Mayor has allocated sufficient funding in the six-year capital plan to build a new hospital in Ward 8 and, equally important, outlined a reasoned and deliberate implementation plan to bring this project to fruition by FY2023.

My presentation today will decompose the budget development process for DHCF, outline the \$8.5 million in savings that were strategically realized, highlight some of the major spending plans reflected in the Mayor's proposed budget for this agency, discuss the Mayor's proposed capital funding plan for the new hospital, and share information on several critical fiscal challenges that DHCF faces in the coming year.

### **DHCF's Budget Development Process**

*Budget Development.* Mr. Chairman, as you are aware, budget development is a highly structured process involving multiple steps and iterative interactions between the agency and the Mayor's budget team. This portion of my testimony outlines the steps that were implemented to construct the Mayor's budget for DHCF.

As shown by the illustration on page 4, DHCF began the process with an approved FY2018 budget of slightly more than \$713 million. As a part of our agency request, DHCF asked for an additional local \$76.5 million to meet our specific needs. The largest of this request was \$40.7 million to fund the expected increase in provider payments for FY2019. This increase is due to a combination of price inflation and projected beneficiary utilization levels which are the major



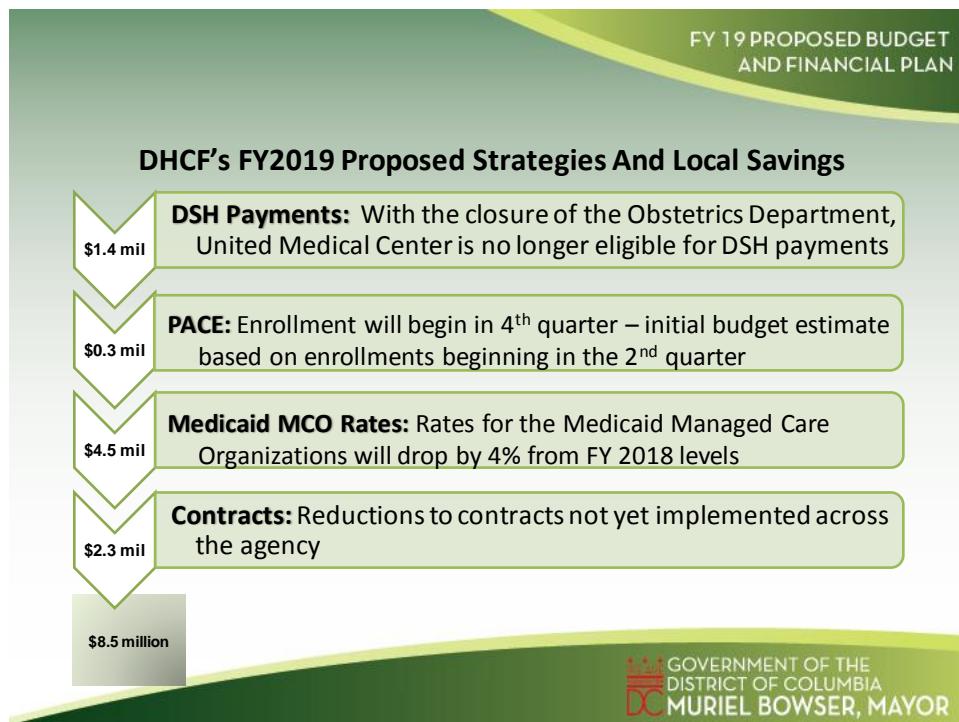
determinants of the size of our payments to providers. Following this, was a request for \$25.2 million that is needed to support the development of a project management office to oversee the remaining work on the District of Columbia Access System (DCAS). Recall that in FY2018, the City Administrator directed DHCF to assume control of DCAS for all phases - Release I, II, and III. Thus, this requested funding will support the project management and development work attendant to the City Administrator's directive that DHCF undertake the responsibility for DCAS implementation.

Finally, through a series of increases and offsetting reductions, DHCF's local fund budget was reduced by a net amount of \$6.3 million, leaving a total budget for FY2019 of \$783.3 million. This net amount reflects the impact of two program enhancements worth \$2.2 million and four savings adjustments which total \$8.5 million. The most significant of the enhancements is a \$1.35 million local fund allocation which, with the federal contribution included, supports a \$4.5 million total fund supplemental payment to the George Washington Medical Faculty Associates

(GWMFA) physicians practice plan. This is a conditional payment, structured to cover the Medicaid losses in GWMFA's practice plan in furtherance of two goals:

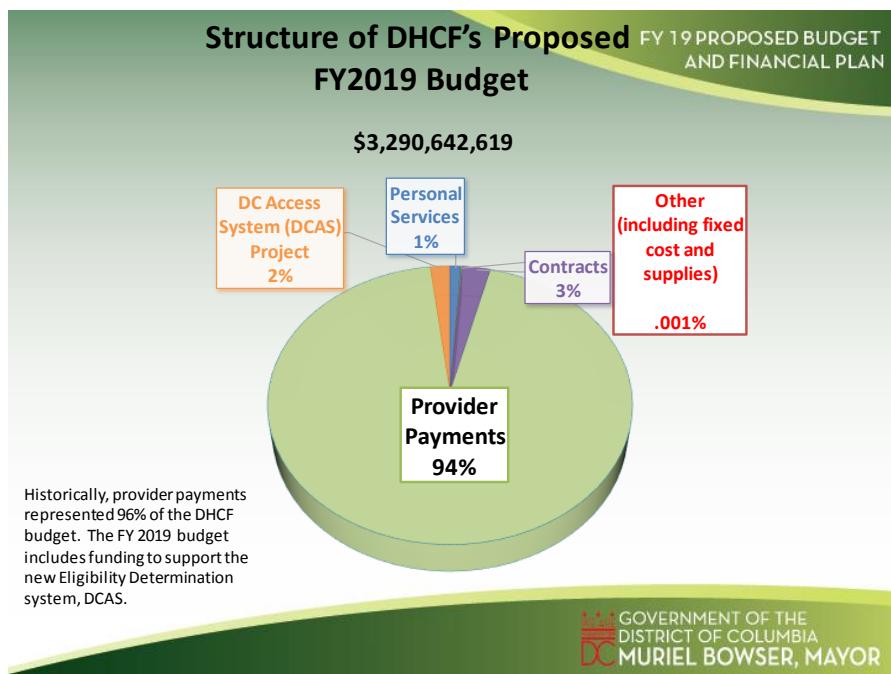
1. Guarantee GWMFA's coverage of both the Emergency Department and hospitalists (inpatient department) at United Medical Center (UMC); and,
2. Establish the framework for an incentive fund in future years to help attract a partner to operate the new hospital when United Medical Center is shuttered.

*DHCF Proposed Savings Initiatives.* The illustration below reveals the details of the Mayor's proposed savings initiatives for DHCF. Due to a projected decline in the actuarially determined Medicaid rates for FY2019, DHCF captured \$4.5 million in local savings by agreeing to pay the health plans at the lower bound of the rate range established by our actuary, Mercer Consulting. While DHCF customarily pays at the middle point of the rate range, significant profits earned by the managed care plans over the past three years made this a practical savings option for FY2019.



Savings from contracts (\$2.3 million) that will not be fully executed for FY2019, a delayed start to the PACE program (\$300,000), and Medicaid Disproportionate Share Fund savings (\$1.4 million) from the closure of the Obstetrics Department at UMC round out the proposed savings initiatives in the Mayor's proposed budget for DHCF.

*Structure of DHCF Budget.* Through a series of federal dollar matching formulas, the Mayor's proposed local fund budget for DHCF of \$783.3 million generates a total of \$3.2 billion for FY2019. Most of these proposed funds will cover projected payments to the various health care providers that deliver a full range of services to Medicaid and Alliance beneficiaries (see graph below). Specifically, DHCF is allocating 94 percent of the \$3.2 billion for this purpose. As noted earlier, these payments are directly influenced by a variety of factors including beneficiary utilization levels, the scope of authorized benefits, and the varying levels of provider reimbursement rates. Of the remaining amounts, funding for contractual services that support our administration of Medicaid benefits, and the resources needed for DCAS implementation consume the largest shares.



## **Proposed Funding Levels for Critical Medicaid Mandatory and Optional Benefits**

As a jointly funded federal-state program, the Centers for Medicare and Medicaid Services (CMS) provides federal Medicaid matching funds for the costs of approved health care services identified in Medicaid State Plans. As a condition of participation, states must cover certain services which are referred to as “mandatory”, while having the discretion to provide a range of “optional” benefits. Each year, as a part of budget development, DHCF projects the anticipated spending levels for both mandatory and optional services, based on historical utilization patterns.

The FY2019 funding levels for Medicaid mandatory services provided in the Mayor’s budget are shown in the table below. As in past years, the largest funding amounts are allocated for fee-for-service hospital inpatient acute care services and nursing home care. The Mayor’s budget fully funds the anticipated need for primary, mental health, and dental clinic services – though smaller in amount – that are delivered by the Federally Qualified Health Centers (FQHC),

FY 19 PROPOSED BUDGET AND FINANCIAL PLAN			
Budget Request For Medicaid Mandatory Services			
Medicaid Mandatory Service	FY17 Expenditures*	FY18 Budgeted Amount*	FY19 Budget Request*
Inpatient Hospital	250.76	239.62	219.23
Nursing Facilities	251.39	275.48	291.60
Physician Services	34.49	39.79	30.72
Outpatient Hospital, Supplemental & Emergency	48.93	61.81	35.11
Durable Medical Equip (including prosthetics, orthotics, and supplies)	24.44	24.78	27.29
Non-Emergency Transportation	27.12	30.08	29.33
Federally Qualified Health Centers	36.20	54.14	55.91
Lab & X-Ray	16.60	26.24	17.96

\* In Millions

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as well as hospital outpatient, emergency care, and primary physician care services provided outside of the FQHC environment.

Likewise, as in previous years, the amounts in the Mayor's proposed budget for hospital inpatient and outpatient services are significantly less than the amounts budgeted in FY2017. These funding levels reflect payments that are designed to cover 86 percent of the hospital's cost for delivering inpatient care to Medicaid beneficiaries and 77 percent on the outpatient side. This translates into amounts which are less than the reported expenditure levels in FY2016 and the budgeted figures for FY2017, but these are not funding reductions.

The proposed funding for FY2019 does not include the higher payment levels which are funded by hospital provider taxes and fees. However, as in past years, the District of Columbia Hospital Association has indicated that it will request that these assessments be established by the Council for FY2019 which will raise the funding amounts for inpatient and outpatient care to levels that equal or exceed the amounts spent in previous years.

With respect to optional benefits, the scope and cost of these services in the Mayor's proposed budget are significant. When total funds are considered, the Mayor's proposed FY2019 budget allocates more than \$2 billion to programs and benefits that are not mandated under federal law. Most significantly are the dollars reserved to fund the District's four managed care contracts. As shown on page 9, the largest allocation is the managed care payments for these plans. The District funds these payments based on the actuarially sound rates and, in FY2019, the Mayor is providing over \$1.2 billion to support the optional program - the largest expenditure in DHCF's budget.

In addition, to these payments, the Mayor's proposed budget sets aside over \$500 million in total funds for various long-term care services, including the waiver for persons with intellectual

**Budget Request For Medicaid Optional Services**

Medicaid Optional Services	FY17 Expenditures*	FY18 Budgeted Amount*	FY19 Budget Request*
Managed Care Services	1,165.32	1,293.68	1,218.31
DD Waiver (all FY 2017-19 includes intra-district funds)	222.71	208.31	226.17
Personal Care Aide	206.96	196.53	224.39
EPD Waiver	68.67	48.78	86.16
Pharmacy (net of rebates)	29.24	62.43	23.06
Mental Health (includes PRTFs & DBH intra-district for MHRS)	88.71	86.19	106.52
Day Treatment / Adult Day Health	4.88	5.95	9.22
Home Health	7.12	16.01	16.21

\* In Millions



disabilities (\$226 million), personal care services to support persons who need help performing basic activities of daily living (\$224 million), and DHCF's EPD waiver program for the elderly and persons with physical disabilities (86.2 million). These programs comprise a robust mix of services to help Medicaid recipients age at home, as opposed to nursing home and ICF/IID institutional settings.

### **Budget and Planning for A New Hospital in Ward 8**

In March 2018, Mayor Bowser announced plans to secure a partner to build a new hospital on the St. Elizabeths campus. The goal of this partnership is to create a state-of-the-art hospital that will provide residents with a first-class facility to be operated by a hospital partner -- not the government -- which will ensure that the hospital is eventually managed free of public operating subsidies.

*Community Need and Planning.* While the District boasts one of the highest rates of insurance in the nation, significant health disparities such as diabetes, asthma, heart disease, and

cancer persist, especially among the residents of Wards 7 and 8. The lack of ambulatory and specialty care services, an absence of a coordinated network of care among existing providers, and the historical operational and fiscal challenges of the current acute care community hospital, make it difficult for residents East of the River to receive the quality medical care they need in their community.

Notwithstanding this problem, as we plan for a new hospital in Ward 8, there are several realities that must be factored into the deliberative process for this project. First, this must be a venture that is controlled by health care experts. While governments can and should play a critical role in regulating the delivery of health care to ensure quality and protect patients, public agencies are not properly equipped to run hospitals.

Second, the planning must reflect the evolution underway in the delivery of health care. Notably, hospitals are reducing the scale of inpatient services in favor of more ambulatory or outpatient services which allow patients to heal in their homes, reduce hospital-acquired infections, and decrease the cost of hospital operations. Obviously, a large inpatient facility would imprudently cut against this emerging trend.

Finally, market conditions are no longer favorable for stand-alone hospitals such as UMC. Tightening federal health care reimbursements and a growing shift to value-based payment models, limited opportunities for economies of scale to drive down operating cost, the ever-expanding use of clinical integration strategies where hospital systems employ their physicians and align them with community physicians, and the ruinous competition in the health care marketplace create perilous challenges that stand-alone hospitals cannot easily overcome.

These factors were considered by the Mayor's team which worked with the Huron Consulting Group and Healthcare Building Solutions (HBS) to develop a plan for an integrated

medical campus at the St. Elizabeths East location. The comprehensive plan calls for a new acute hospital, ambulatory pavilion, diagnostic and imaging services, retail services, parking, medical office space, public space, and community partnerships.

Unlike previous efforts that were focused on finding a management solution for the existing community hospital, Mayor Bowser is seeking to build a new hospital with a financially strong, high-quality partner that has established expertise in delivering medical services. Such a partnership will increase the probability that the new hospital will be viable and sustainable, while best positioning the city to address its health disparities.

Based on the work of our consultants, as well as the expertise of the DC Health and DCHC staff regarding the health needs and payor mix of the community, the Mayor has offered a capital budget plan that is sufficient to build a 100 to 150 bed acute care hospital. The new hospital will have an emergency department and other core hospital services. Once a partner is identified, the full suite of service lines, including obstetrics, will be determined as the partner works closely with community stakeholders.

It is important to reemphasize that the city does not intend for the hospital to be stand-alone; it will be part of a larger system or network of care consisting of the partner's available health services and those offered by other local community providers, thereby enabling residents of Wards 7 and 8 to have a true continuum of care where they live.

*Budget Plan.* Mr. Chairman, the FY2019 budget for this project includes a detailed 5-year plan to fund, construct and deliver a new, centrally located, state-of-the-art, medical center on the St. Elizabeths East Campus by FY2023, significantly faster than previously contemplated. The proposed FY2019-24 capital budget for the entire project is separated into smaller components and represents a thoughtful approach to the full scope of the work that needs to occur at the campus to

support this project and continue the progress at the campus. The components, timing, and cost of each are provided in the table below.

Approved FY18-23 "East End" Hospital Capital Budget		Mayor's Proposed FY19-24 Capital Budget*						
		New 801 East Shelter	St. E's Infrastructure	Garage 2 – ESA Parking	Hospital Planning and Design	Hospital, Ambulatory and Garage 1 Construction	Sub Total Hospital, Ambulatory and Garages	To speed up hospital we increased pace of funding
FY18	\$0.0	N/A	\$15.0	N/A	N/A	N/A	N/A	N/A
FY19	\$0.0	\$18.0	\$14.0	\$3.0	\$4.0	\$2.0	\$9.0	+\$9.0
FY20	\$0.0	\$22.0	\$20.0	\$18.0	\$8.0	\$20.0	\$46.0	+\$46.0
FY21	\$10.8	-	\$35.0	-	\$8.0	\$64.0	\$72.0	+\$61.2
FY22	\$83.0	-	\$35.0	-	\$3.0	\$84.0	\$87.0	+\$4.0
FY23	\$206.2	-	-	-	-	\$35.0	\$35.0	-\$171.2
FY24	N/A	-	-	-	-	\$51.0**	\$51.0**	+\$51.0
Total	\$300.0	\$40.0	\$104.0	\$21.0	\$23.0	\$256.0	\$300.0	

*Project Financing.* The District continues to consider all financing options for the project. Once a partner is identified and negotiations begin, the exact financing structure will be determined. However, an immutable condition of the partnership is that the entity selected to operate the new hospital, must contribute a fair and reasonable investment to the project -- whether in the form of capital investments or the assumption of operating risks.

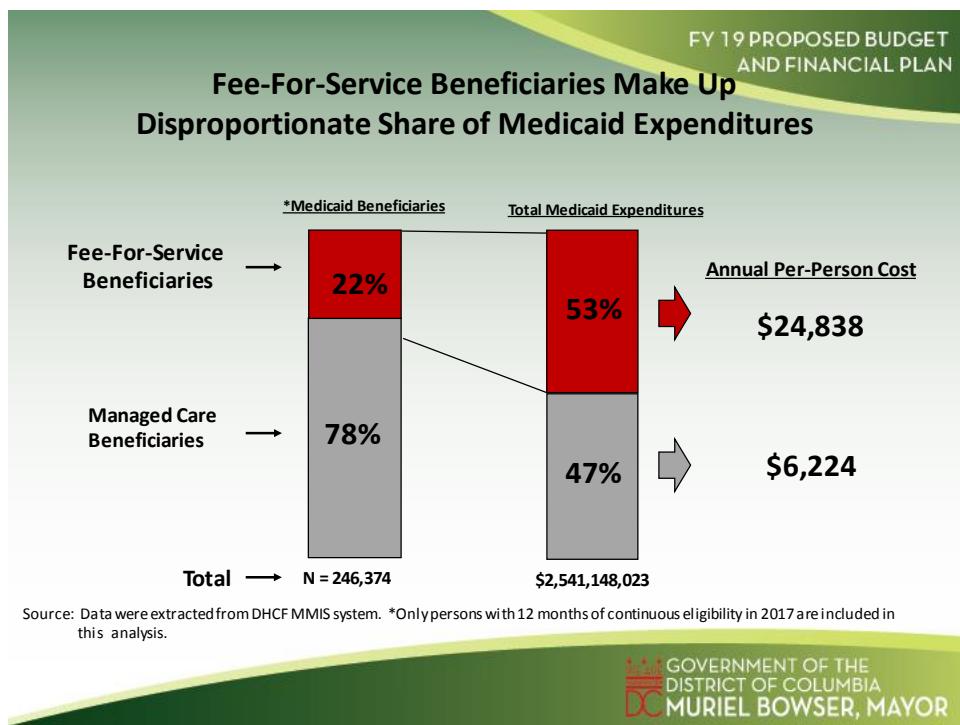
*The UMC Transition.* United Medical Center will continue to provide full services for the foreseeable future. When the partnership agreement is completed for the new hospital on St. Elizabeths campus, the District, in coordination with UMC's Board and the community, will begin discussions on the appropriate transition activities, including the possibility of transforming UMC to an ambulatory or clinic setting in the final months of operation.

### Medicaid and Alliance Challenges for FY2019

Mr. Chairman, the last section of my testimony focuses on three major challenges that DHCF faces with the Medicaid and Alliance program as we prepare for FY2019. These challenges are: (1) managing the surging cost of care delivery for our fee-for-service population; (2) bringing the District's home and community-based services (HCBS) program back into compliance with federally-mandated cost neutrality standards; and (3) developing a greater understanding of

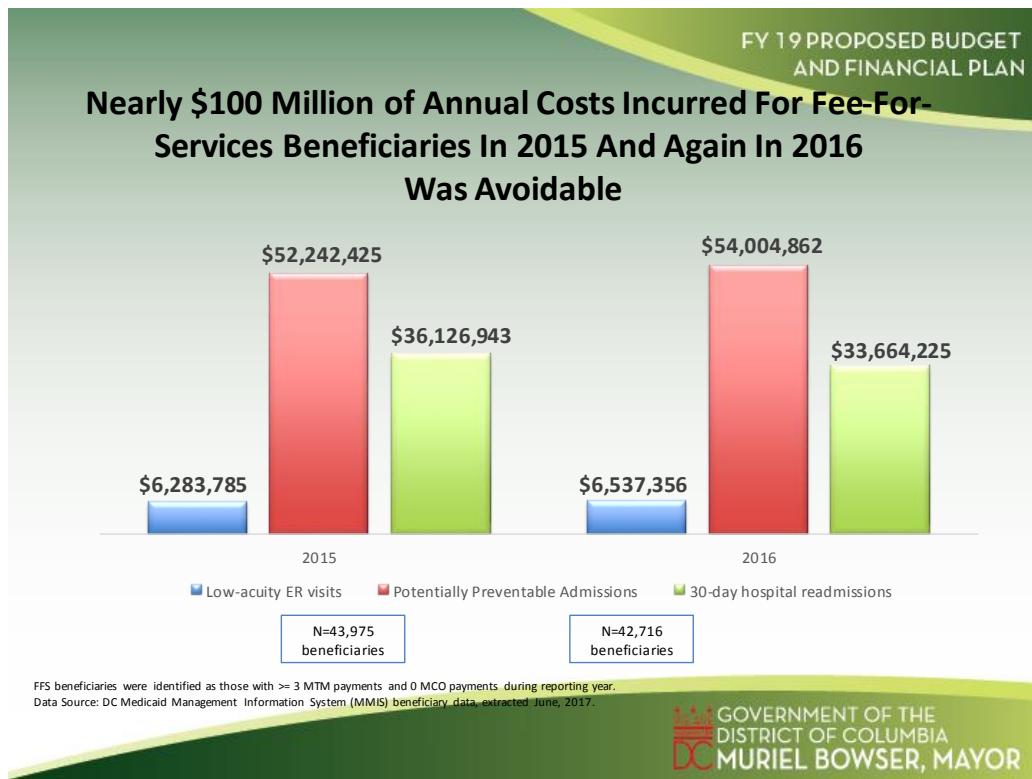
enrollment issues and factors underpinning the growth in Alliance cost. Unaddressed, these three issues have the potential to create significant spending pressures at DHCF, while exposing the District to a potential loss of its EPD waiver program.

*Managing the Fee-For-Service Population.* One of the persistent features of Medicaid programs across the country is the disproportionate expense associated with care delivery for beneficiaries who are not in a program of managed care but, instead, receive their health care based on a fee-for-service (FFS) arrangement. In the District, this problem is especially acute. Notably, FFS beneficiaries represent only 22 percent of total number of beneficiaries in the program but account for 53 percent of total program spending (see below). On a per-beneficiary basis, we spend roughly four times more on this population than their peers in managed care.



The profile for the adult population reveals high morbidity rates – six in 10 have diagnosed hypertension; roughly one-third have diabetes and high cholesterol; at least one quarter have personality disorders, depression, and asthma; and smaller but sizeable numbers are obese.

Clearly these illnesses require consistent medical attention. But still, we have learned from extensive research that more than \$100 million of the funds annually spent on health care for this Medicaid population is avoidable, spent on unnecessary trips to the emergency room, hospital readmissions from lack of attention to discharge protocols, and hospitalizations that could have been prevented with a proper plan of primary care (see below).



As reported earlier this year, we have established a program called My Health GPS to improve health outcomes while reducing the inappropriate use of health care resources among these beneficiaries. Start-up for My Health GPS was launched in 2017 and today we have 12 providers and 33 participating sites, serving beneficiaries in all eight wards. Current enrollment is at 3,900 members, so FY2019 will be pivotal as my staff works to grow the reach of this program – a task that program operators consider challenging. If we do not find a way to arrest the growth

in unnecessary health care spending, the cost pressures placed on DHCF's budget and, ultimately, the city's finances will undoubtedly worsen.

*Compliance Issues For HCBS.* Under present federal law, state Medicaid agencies can request waivers of certain Medicaid requirements to offer community-based services as alternative to the institutional care provided in three different settings: (1) nursing homes; (2) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID); or, (3) hospitals. The widely acclaimed benefit of these waiver programs is that they afford the provision of services in the community to beneficiaries who otherwise would be receiving care in often personally undesirable institutional settings.

These programs can be implemented statewide or limited to certain geographical regions. Moreover, they have flexible rules along with allowances for various service models. Additionally, the services delivered through these waivers can either be broadly targeted to the elderly and disabled or more narrowly linked to a specific medical condition such as traumatic brain injury.

Likewise, states have significant flexibility in setting provider rates under these waiver programs. As in the District of Columbia, rates can be established on a fee-for-service basis. Other states might pay using a cost-based methodology or thoroughly negotiated payment rates. Regardless the payment methodology, CMS requires that the cost of a waiver program, when factoring in all the Medicaid services that the program recipients receive, must be equal to or less than the related institutional cost on a per-member basis. States that fail to meet this requirement, face the loss of the authority to continue their waiver programs.

As illustrated on page 16, DHCF currently has a very robust program of long-term care and waiver services, spending over \$834 million on these services in FY2017—approximately 31

percent of total Medicaid spending. When only examining the cost within these program on a per-recipient basis, the institutional programs are clearly more expensive than the associated waiver program. For example, the per-member cost of nursing home care at \$50,610 is significantly higher than similar cost for the related EPD Waiver at \$20,617. Similarly, the per-member cost for the IDD Waiver at \$117,554. While high, the cost is substantially less than the per-person amount revealed for the ICF/IIDs at \$288,310.

FY 19 PROPOSED BUDGET AND FINANCIAL PLAN			
<b>Consistent With Recent Years, Home and Community Based Services Account for the Largest Share of Long-Term Care Spending</b>			
<b>Medicaid Institutional And Waiver Spending, FY17</b>			
Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
Nursing Facilities	4,832	\$244,545,347	\$50,610
EPD Waiver	3,311	\$68,261,625	\$20,617
State Plan Personal Care	5,795	\$203,207,886	\$35,066
IDD Waiver	1,905	\$223,939,805	\$117,554
ICF/MR	329	\$94,854,145	\$288,310
<b>Total</b>	----	<b>\$834,808,808</b>	----

Source: Data extracted from MMIS, reflecting claims paid during FY2017

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Nonetheless, when we examined cost trends over the most recent waiver service period for the EPD program and included all other Medicaid State Plan services as required by federal regulations, a different picture is revealed. Specifically, on a per-member basis, the cost of the waiver program is more expensive than nursing home care (see page 17). Stated differently, it is now more expensive to care for Medicaid recipients who are in the District's EPD program and

## FY 19 PROPOSED BUDGET AND FINANCIAL PLAN

# EPD Waiver Budget Neutrality

April 4, 2017 thru March 23, 2018

### The District Offers a Robust EPD Waiver Benefits Package

CMS requires that a Waiver program must be equal to or less than the Institutional cost per member in order for the State to maintain the Waiver service.

$$\begin{array}{r} \text{EPD Waiver Cost Per Person} \\ + \\ \text{State Plan Services Utilized} \\ = \\ \text{Total EPD Waiver Cost per Person} \end{array}$$



$$\begin{array}{r} \text{NH Rate Cost Per Person} \\ + \\ \text{State Plan Services Utilized} \\ = \\ \text{Total NH Cost per Person} \end{array}$$

### The District's Current EPD Waiver to Date

$$\begin{array}{r} \$22,843 \\ + \\ \$36,468 \\ = \\ \$59,312 \text{ per person} \end{array}$$



$$\begin{array}{r} \$57,096 \\ + \\ \$959 \\ = \\ \$58,055 \text{ per person} \end{array}$$

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live in the community, than it is to provide for their care in a nursing home setting. This is a not complaint with federal requirements for cost neutrality and must be remedied if the city hopes to retain the EPD waiver.

While work is still underway to more deeply investigate the cause of this problem, early evidence suggests that the growing use of personal care aides through the Medicaid State Plan is the key contributory factor to this problem (see page 18). State Plan cost for persons in the waiver add \$100 million in cost to its total costs, amounts that are not otherwise incurred for persons in nursing homes.

In the coming weeks, DHCF staff will explore several viable solutions to this problem. A provision in the Deficit Reduction Act of 2005 provides states the option to offer community-based services through a State Plan amendment rather than a waiver without the constraint of budget neutrality. This includes permission to offer services to beneficiaries that do not need an institutional level of care. However, additional requirements that include eliminating an upper

# FY 19 PROPOSED BUDGET EPD Waiver Budget Neutrality AND FINANCIAL PLAN

EPD Waiver		Nursing Home	
EPD Waiver Service Cost		Nursing Home Rate Cost	
Assisted Living	1,437,609	Nursing Home Rate Cost	206,345,404
Case Management	6,656,983		
Participant Directed Services	23,874,516		
Personal Care Aide Services	44,003,775		
Personal Emergency Response Service	320,530		
Respite	94,114		
<b>Total EPD Service Cost</b>	<b>76,387,527</b>		
State Plan Services used by EPD Members		State Plan Services used by NH Members	
Personal Care Aide Services	100,538,552	Pharmacy	574,062
Skilled Nursing Visits	4,053,159	MCO Cap	536,290
Durable Medical Equipment (DME)	7,003,842	Outpatient/Medicare Part B Crossover	479,992
All Other Services	22,279,876	All Other Services	1,645,557
<b>Total State Plan</b>	<b>133,875,429</b>	<b>Total State Plan</b>	<b>3,235,901</b>
EPD Waiver Service Cost	76,387,527	Nursing Home Rate Cost	206,345,404
EPD Patient State Plan Cost	133,875,429	NH Patient State Plan Cost	3,235,901
<b>Total EPD Patient Care Cost</b>	<b>210,262,956</b>	<b>Total NH Patient Care Cost</b>	<b>209,581,305</b>



limit on income, while tightening needs-based criteria for access to institutional services, reduces the practical appeal of this option.

Once we complete our work -- which includes community and stakeholder engagement -- and present recommendations to address this problem to the City Administrator and Mayor for consideration, any approved solution will be communicated to the Committee on Health.

*Understanding Alliance Enrollment and Cost Trends.* Mr. Chairman, the final topic for testimony today is the Alliance program. Beginning in 2016, DHCF initiated the first in a series of research projects to inform decision-making about the Alliance program. As you are aware, in a market that is largely closed to insurers that do not participate in the District's state-based exchange, the Alliance program is the only link to coverage for District residents who cannot establish United States citizenship, or, are legal immigrant residents within the five-year period

after their arrival in the United States. Such legal immigrants are barred from receiving Medicaid benefits for a 5-year period following their legal immigration status.

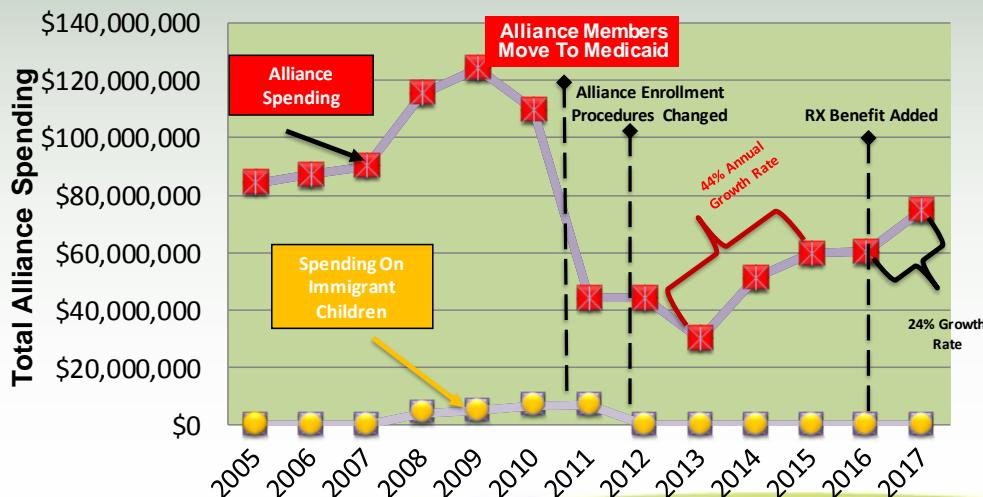
Created in 2001 and converted to a managed care program in 2006, the Alliance has played a key role in promoting health coverage and improved access to a broad array of health care services among District residents. Ten years ago, in FY2007, the cost of the Alliance program was \$90 million as the program provided coverage to just over 44,800 members on average monthly basis. Both the expansion of Medicaid in 2010 and more stringent enrollment requirements adopted in 2011, sharply reduced the number of beneficiaries who enrolled in the program, such that by 2017, only 15,985 adults were being served through Alliance on an average monthly basis.

However, focusing on the period since 2011, we have learned that the sharp decline in program enrollments did not result in a commensurate decrease in program cost. Rather, since 2011, there has been a 64 percent decline in beneficiary enrollment, while the cost for Alliance has *increased* by 70 percent from \$44.1 million to \$74.9 million. What might explain this?

As the graphic on page 20 shows, Alliance program cost spiked in two separate periods since 2011. From 2013 to 2015, cost increased by 44 percent with no changes to the benefits for the program. In fact, during this period, DHCF shifted the emergency health care cost for Alliance members to the Medicaid program as allowed by law, yet cost spiked.

After relatively flat growth from 2015 to 2016, cost surged once again over the next two years. While the loss of federally-discounted pharmacy prices for the program in 2016 can explain some of the year-over-year cost growth, the surge that occurred after 2013 through 2015 and the persistent higher spending levels juxtaposed against a scenario of virtually no enrollment growth raises several questions.

## Alliance Costs Grew From 2016 to 2017, Driven in Part by Increases in Pharmacy and Outpatient Hospital Spending



Source: Spending totals extracted from Cognos by fiscal year (October 1 through September 30). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance 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).

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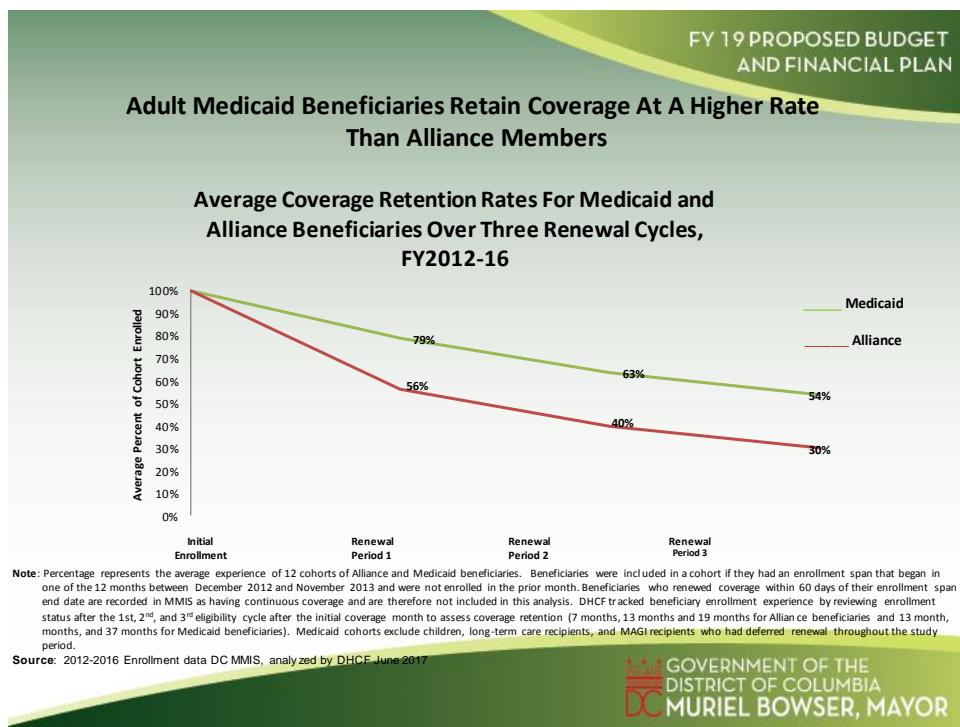
To better understand these patterns and the possible link to enrollment trends, a DHCF research team conducted several analyses, focusing on the following questions:

- How do the program retention rates for members in the Alliance program compare to that of their peers in Medicaid;
- For members who separate from coverage—regardless of reason—how do the reenrollment rates for former Alliance members compare to persons formerly on Medicaid; and,
- What factors appear to influence decisions by Alliance members to disenroll from the program?

*Program Retention Rates.* In conducting the analysis of program retention rates, DHCF first tracked the Alliance and Medicaid program retention rates following the 2011 implementation of the face-to-face recertification policy to determine whether meaningful differences existed in the rates in which these groups disenrolled from their respective programs. Methodologically, we

identified the initial eligibility period for beneficiaries in both groups and then tracked their enrollment levels over three renewal cycles. Since Medicaid members are not required to submit to face-to-face recertifications and, can in fact, be renewed passively without ever entering a service center, there was interest in testing whether these very different processes would create dissimilar reenrollment outcomes.

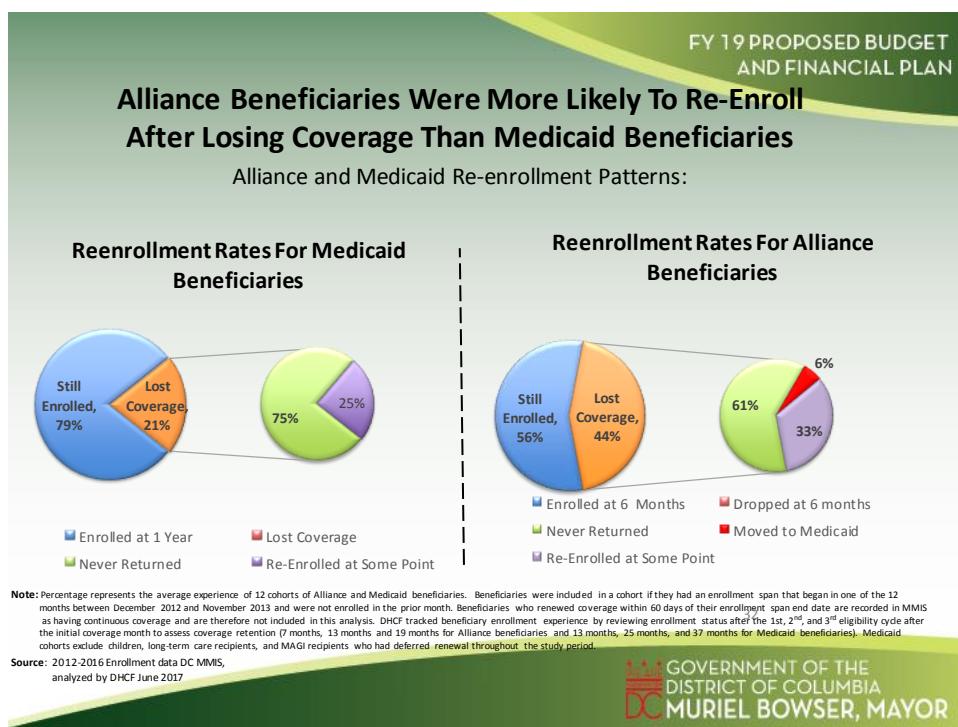
The findings from this analysis reveal that Alliance members experienced enrollment declines at significantly higher rates than Medicaid members. As shown on page 21, by the end of the third renewal cycle and following their initial enrollment, only 30 percent of the Alliance members remained in the program. This compares unfavorably to a 54 percent retention rate for Medicaid beneficiaries.



*Program Reenrollment Rates.* Next, we explored what happened to those members who disenrolled from the Alliance program. Did they come back to the program? How do their

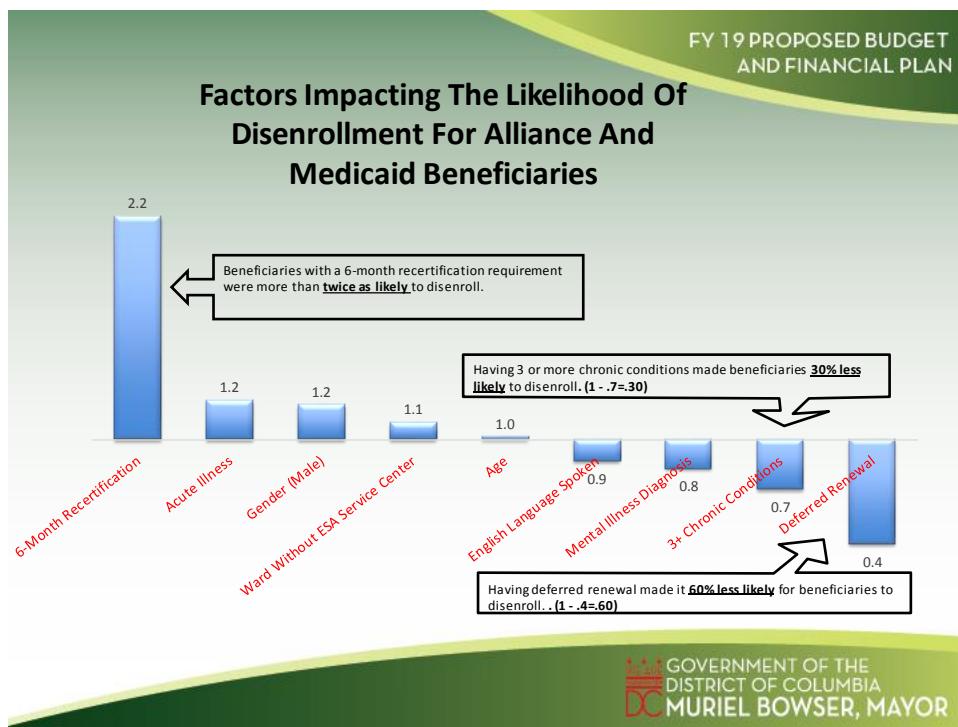
reenrollment rates compare to their counterparts in Medicaid? Again, we tracked the beneficiary enrollment experience over three different renewal cycles following the initial period of eligibility.

The data presented in the graph below show that though Alliance members lost coverage at a higher rate, they also were significantly more likely to either reenroll in the program (33 percent) or secure coverage through Medicaid (6 percent). This means that nearly four in 10 Alliance members who lost coverage during the observation period, were able to reestablish eligibility in either Alliance or Medicaid. By comparison, only 25 percent of those losing coverage to the Medicaid program decided to reenroll in the District's program.



*Factors Impacting Decision to Disenroll.* Finally, we examined what measurable factors increased the odds that Alliance members would disenroll from the program. Using a statistical technique called logistic regression, we could, among multiple factors, identify which independent variables raised the likelihood of disenrollment, net of the influence of the other variables that were explicitly considered in the regression model.

Most notably, the analysis revealed that after controlling for beneficiary demographics, complexity of medical problems, and access to an Employment Security Administration (ESA) service center, Alliance members who faced the six-month certification requirement were 2.2 times more likely to disenroll from the program than those who did not, net of all other considered factors (see below). Conversely, beneficiaries who were struggling with three or more chronic medical conditions, net of other factors, were 30 percent less likely to have disenrolled compared to those who were not as ill. Finally, and not surprisingly, beneficiaries who experienced the benefit of deferred renewals for some period, were 60 percent less likely to disenroll.



Combined, these findings may partially explain the rising per-member cost of the program as it suggests a potential selection basis. Alliance members who are sicker, may be more inclined to disregard any perceived hurdles created by the face-to-face to recertification requirement and reestablish their eligibility for health care benefits.

However, caution is warranted in interpreting these results. While these findings plainly suggest that the face-to-face certification process is slowing Alliance program reenrollments, we are less sanguine of the underlying reasons. There are multiple motivations that might possibly explain the observed decisions by Alliance members to disenroll from the program that have no association with the face-to-face recertification requirement. For example, while some may be struggling with the enrollment process and its perceived barriers, others may have moved outside of the District, effectively relinquishing residency. Still others may have secured employment at wage levels that are disqualifying for continued Alliance participation. And others may have secured employer-funded private coverage, eliminating the need for continued participation in Alliance.

As DHCF does not collect data on the reasons for Alliance disenrollment, we cannot reliably speak to whether the negative enrollment effect observed for the face-to-face certification requirement is appropriate to beneficiary circumstances. Were data available on reasons for disenrollment and included in this analysis, it is possible that the observed impact of the face-to-face certification would dissipate. And, we do know from this analysis that beneficiaries with multiple chronic medical conditions are significantly less likely to disenroll, notwithstanding the certification requirements.

Collecting the type of systematic data on Alliance disenrollment decisions that would provide clarity on this question, creates many challenges that cannot be easily addressed. Thus, any plans to blindly eliminate the recertification policy to reduce the administrative burden of the program, must be weighed against the real possibility that benefits will be extended to persons who do not reside in the District.

This seems especially true considering findings from other DHCF research indicating that even with the face-to-face policy, about 11 percent of Alliance members have non-District addresses; just over 10 percent receive services in other jurisdictions; and at least 20 percent are currently in the program without documented District residency – in other words, there is no record of their address.

Work continues by ESA to modify and shorten the enrollment process for applicants to the Alliance program. This includes establishing a process to make it easier for individuals who appear at a service center for enrollment to have their applications accepted and processed without return trips. Nonetheless, responsible stewardship of this program requires that all factors be objectively weighed before a policy change is made that will likely add an additional \$17 million to the cost of the program.

## **Conclusion**

In closing Chairman Gray, it is important to restate that Mayor Bowser's proposed FY2019 budget makes no changes to Medicaid and Alliance beneficiaries' eligibility, thus preserving the District's strong tradition of coverage. The Mayor fully funds the contracts for the District's managed care plans while adequately supporting DHCF's fee-for-service program, which serves Medicaid's most fragile and highest cost beneficiaries. Moreover, this budget offers a well-reasoned and strategic approach for the construction of a new hospital and buttresses these plans with sufficient funding to pay for the construction of the facility within the proposed six-year capital plan.

As DHCF prepares to execute the Mayor's budget in FY2019, following its approval by the Council, we are mindful of the significant challenges we face with the responsible stewardship of what is now a \$3 billion enterprise. Revisiting the cost parameters of the EPD waiver, reigning

in the surging cost of our FFS population without adversely impacting the members' access to quality health care services, and continuing our efforts to better understand the forces behind the rapid growth in Alliance program cost but not its membership, are the issues that will define our work in the next year.

Thank you for the opportunity to offer this testimony and I, along with my talented team, welcome the questions of the Committee.