GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2016-17 Performance Oversight Hearing

Testimony of
Wayne Turnage
Director

Before the
Committee on Health
Council of the District of Columbia
The Honorable Vincent Gray, Chairperson

John A. Wilson Building
Room 500
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Washington, DC 20004

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11:00am

Introduction

Good morning Chairperson Gray and members of the Committee on Health. My name is Wayne Turnage and I am the Director of the Department of Health Care Finance (DHCF). Thank you for inviting me to testify on behalf of Mayor Muriel Bowser in today's hearing to discuss the activities and accomplishments of DHCF in Fiscal Year 2016 (FY2016) and the first quarter of Fiscal Year 2017 (FY2017).

Mayor Bowser's administration remains committed in its support of pathways to the middle class through targeted investments in education, infrastructure, public safety, and people. The Fair Shot Budget for FY2017 was the first developed wholly under Budget Autonomy. For the first time since Home Rule was passed in 1973, the District was able to spend our local dollars without having to wait on Congress to pass the federal budget. This brings us one step closer to operating like the 51st state.

Before discussing the activities of DHCF, I would like to acknowledge the guidance and support provided by the Deputy Mayor for Health and Human Services, Hyesook Chung, and my wonderful team at DHCF. The leadership at DHCF works closely with the Deputy Mayor and her executive team to pursue the priorities and goals established for this agency. My team and I also work closely with our sister agencies including the Department of Health (DOH), Department of Behavioral Health (DBH), the DC Office on Aging (DCOA), and the Department on Disability Services (DDS) to name a few.

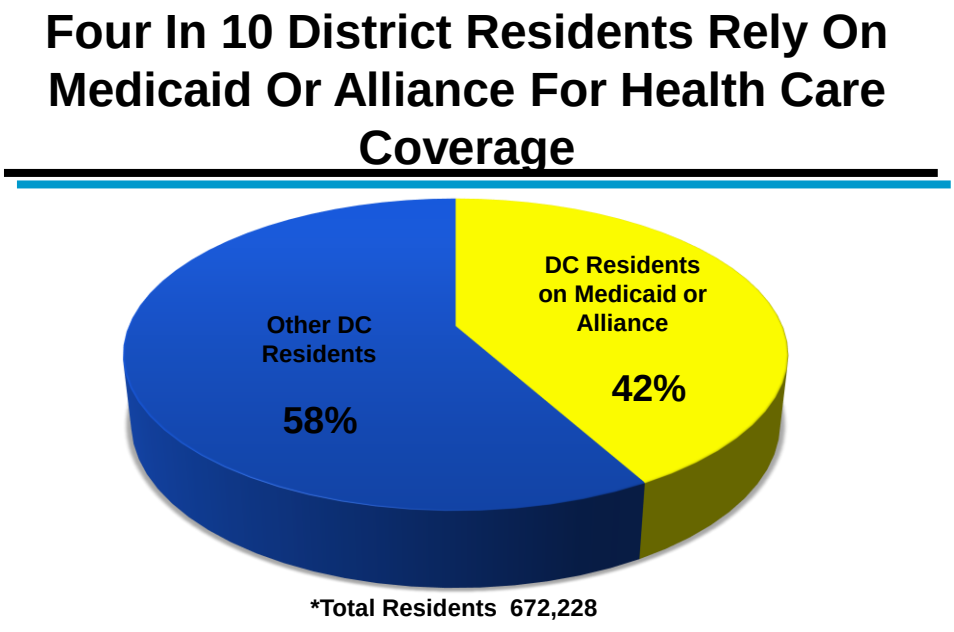
Regarding my team, DHCF is a complex agency with weighty responsibilities and I am especially pleased to have an executive team and senior managers that have deep experience in health care. Working with this experienced group, we approach the challenges each day with detailed planning and sound reasoning. We also rely heavily on data analytics to inform our

problem solving, program implementation decisions, policy development proposals, and support our ongoing efforts to evaluate the efficacy of the initiatives we have established.

Agency Mission and Program Structure

As you know, DHCF was established as a cabinet-level agency on October 1, 2008 to operate the District's Medicaid, Health Families, and Alliance programs. The mission of the agency is to improve the health outcomes of low-income residents of the District by providing access to a full range of primary, secondary, and tertiary health care services.

The reach of these programs in the District, as shown by the graphic below is considerable. Presently, 42 percent of District residents rely on either Medicaid or the Alliance program for their access to comprehensive health care.

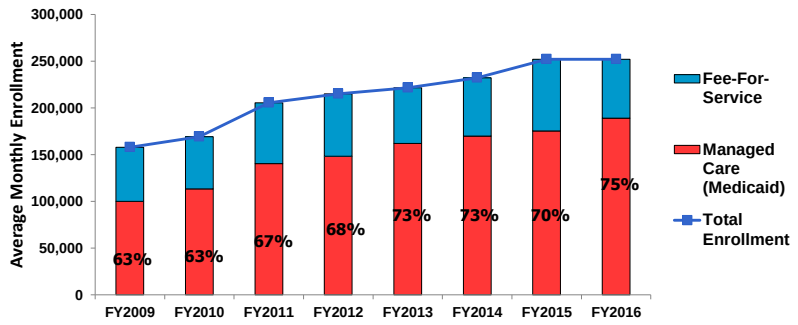


Source: District population estimate from 2015 United States Census Bureau. Medicaid and Alliance data reported from DHCF's Medicaid Management Information System (MMIS).
Note: These data excludes some District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated..

DHCF's Managed Care Program. Our program organizes the delivery of care to these beneficiaries in two ways. First, like most state Medicaid programs, the majority of the beneficiaries who are enrolled in Medicaid and Alliance participate through a managed care

organization (MCO). As shown on the chart below, 75 percent of the beneficiaries receive services organized through managed care plans. In exchange for the payment of federally-certified, actuarially sound per-member, per-month rates, the four MCOs that contract with the District agree to establish an adequate provider network, manage the care of its beneficiaries in their network, and timely pay the physicians, clinics, and hospitals that submit invoices for the services delivered to their members.

Seven Of Every 10 Medicaid Enrollees Are In The Managed Care Program



Source: DHCF staff analysis of data extracted from the agency's Medicaid Management Information System

As we do each year, in FY2016, DHCF closely monitored the administrative and management activities of the MCOs which included a detailed review of the plan's financial health judged against a standard and widely accepted set of industry metrics. As a part of this quarterly review, we evaluate the experiences of the health plans in executing the fundamental administrative requirements of the program – timely claims adjudication, successful reporting of patient encounter data, and beneficiary utilization outcomes. But, we are especially vigilant with respect to the financial health of each plan because of the insolvency of our largest MCO in 2013

– a collapse that required the District to pay out more than $37 million in local funds to health care providers with unpaid claims from Chartered Health Plan.

The District's health plans are currently in very good financial condition as clearly shown in the Revenue and Expense Table below. As contractually required, and based on the first nine months in 2016, each of the MCOs spent 85 percent of the revenues received from DHCF on member medical expenses. Nonetheless, all three plans were able to generate positive operating margins during this time period. In establishing the capitated payment rates for the plans each year, we build in a 2 percent profit margin but reserve the right to take back earnings gains that exceed this amount if the plans fail to meet the 85 percent spending requirement for its members.

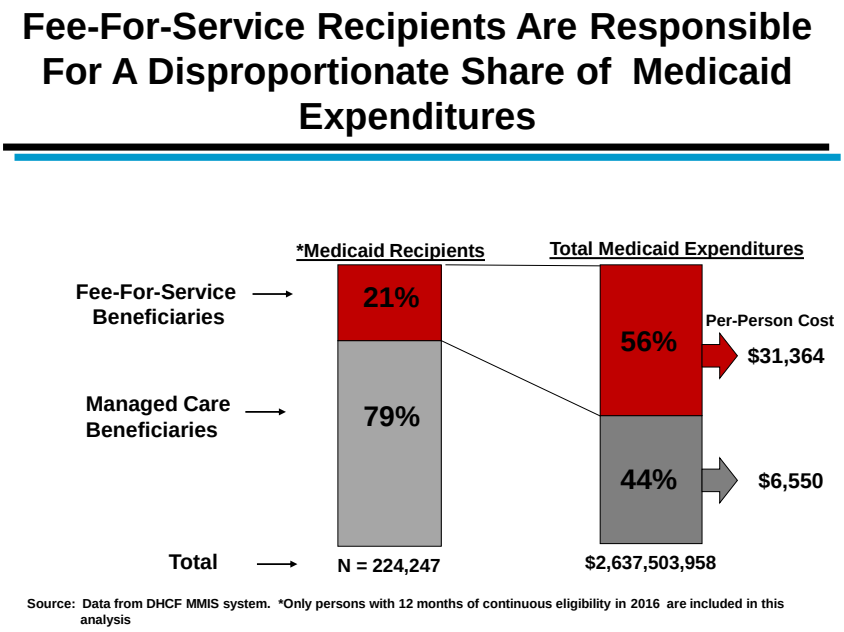
MCO Revenue and Expense Data for January 2016 to September 2016				
Health Plan	**Revenue**	**Claims** (Medical Loss Ratio)	**Administrative Cost**	**Net Gain** (Operating Margin)
AmeriHealth	$352.5M	$300.2M (85%)	$26.0M	$24.2 (7.4%)
MedStar	$187.8M	$171.6M (91%)	$11.2M	$5.0M (2.6%)
Trusted	$105.7M	$90.0M (85%)	$10.5M	$8.6M (8.1%)
HSCSN	$129.6M	$115.1M (89%)	$10.8M	$3.7M (2.8%)

Fee-For-Service Program. For the remaining 25 percent of our beneficiaries who are not enrolled in a health plan, their care is provided on a fee-for-service basis (FFS). In a FFS delivery system, beneficiaries have complete independence in choosing among the existing pool of Medicaid-eligible providers rather than from a network prescribed by the plans. After serving beneficiaries who are in the Medicaid FFS program, health care providers submit claims directly

to DHCF and are reimbursed based on a fee scale for any medically necessary service included in the District's State Plan.

As is the case nationwide, the District's FFS Medicaid beneficiaries account for a small portion of total Medicaid enrollment but they are responsible for a disproportionate amount of spending. One reason for this is the District's long-term care program which often serves persons with complex disabilities and is funded on a FFS basis. Still, there are many FFS beneficiaries who are not receiving long-term care but are high utilizers of health care resources in the District.

Data examined for 2016 confirm historical patterns showing disproportionate spending on the FFS service population. Specifically, as shown by the graphic below, beneficiaries with one year of continuous eligibility represent 21 percent of Medicaid enrollment but they account for 56 percent of nearly $2.6 billion in spending. This amounts to average per-person annual cost of $31,364 which is almost five times higher than the $6,550 average cost figure observed for persons who are in managed care.



As noted, these cost differences are driven by a number of factors but, on average, the FFS population tends to be older, more medically fragile, and frequently suffers with multiple chronic conditions. Consequently, they are considerably more likely to need and access high cost secondary and tertiary medical care services. This phenomenon and our efforts to better understand and control the growth in avoidable health care expenses, drive a considerable amount of our programming work during the year.

Focus of DHCF's Oversight Activities

My testimony today reflects our efforts in administering the Medicaid and Alliance program in FY2016 through January of 2017. My goal is to provide a high level summary of a few of our most significant projects, offering remarks on the progress we have made and our next steps for advancing the important work of the agency. I specifically would like to discuss five primary projects that we enthusiastically embraced in FY2016 to improve the delivery of health care to the District's most vulnerable residents. They are as follows:

1. The ongoing and challenging systems development work to create an integrated eligibility system that will provide Medicaid beneficiaries an efficient vehicle to both apply for and renew their coverage to the program;

2. An aggressive push to build a culture of value-based purchasing in DHCF's Medicaid MCO program for our three full risk health plans as well as DHCF's new care coordination initiative designed to serve our sickest beneficiaries;

3. The work we completed to renew and upgrade our federal waiver program which allows us to provide community based health care services through our Elderly and Persons with Disabilities program (EPD); and,

4. Execution of the agency's oversight responsibility for the health care consulting firm, Veritas, which has been hired to ensure that United Medical Center is not forced to rely upon repeated subsidies from the District to fund its hospital operations; and,

5. Careful attention to and regular analysis of the national proposals to reform the Medicaid program as a part of larger changes to the Affordable Care Act (ACA).

Building an Integrated Eligibility System. Based on current provisions in the ACA, states that adopted Medicaid expansion through the health care reform law were required to either build or buy into an integrated eligibility system for application processing. In the District, DHCF has been working with three of its sister agencies to develop the DC Access System (DCAS). The vision of DCAS is to provide an integrated eligibility and enrollment platform for health care and human services programs, including a health insurance marketplace, transparency around health plan rates, and enhanced case management capabilities. Once completed, DCAS will facilitate seamless access to health care and human service benefits to all District residents, regardless of income.

To manage the complexity of this project, DCAS is being developed through three major phases. Phase I of the project, which focused on building and deploying the Medicaid functionality needed to determine eligibility for individuals using the program's new income standards, was rolled out on October 1, 2013.

However, in deploying DCAS, we encountered a number of challenges to achieving full deployment of the system. Given the challenges posed, we took the following steps to address the critical problems in FY2016.

1. Released the original vendor from the contract and assumed the lead role in executing the changes to fix the system;

2. Established a DCAS Project Management Unit staffed with DHCF to manage the remediation of the system issues;

3. Procured a technical team to fix priority issues in the system, provide programmatic technical expertise, and advise DHCF on how best to

address the ongoing system changes needed to realize the integrated eligibility and enrollment vision for Medicaid beneficiaries.

Working closely with the Department of Human Services, we were able to resolve these issues, eliminating virtually all Medicaid case processing backlogs while executing the required system upgrades in FY2016. Moreover, we instituted new reports to track pending applications before they exceeded the case processing timeline of 45 days, and implemented new processes that close cases when beneficiaries failed to complete an application within the 45-day timeline.

With respect to application processing for renewals, DHCF worked with a new vendor to fix the defects and greatly improve the system's functionality. As a result, during the first four months of FY 2017, 85 percent of individuals who renewed their eligibility did so through an automated "passive renewal" process that checked their status using other electronic data sources – they did not have to visit a service center or submit any documentation.

Still, much work remains on what ultimately will be a more than $535 million project. Over the next 18 months, we will work with the Office of the Chief Technology Officer and DHS to execute the final phase of the project and fully modernize the application process for all of human services in the District.

DHCF's Push For Value-Based Purchasing. Driven by the reform-focused language of the ACA, Medicaid officials across the country have been increasingly turning to new payment models for providers. While the nature of these value-based purchasing (VBP) models varies significantly, the goal is the same – to reverse the incentives in the health care system for Medicaid beneficiaries by encouraging a more efficient delivery of care by providers that improves patient outcomes.

Manage Care Pay-For-Performance. Historically, a substantial portion of the payments made by Medicaid have been based on the volume of care provided. Even when payments were organized through managed care as capitated rates, the health plans failed to demonstrate any meaningful links between the rates they were paid and patient outcomes. As a result, state Medicaid programs -- especially in the 1990s -- witnessed precipitous, double digit increases in year-to-year spending while showing no evidence of gains made in health care outcomes per dollar spent. This prompted the Centers for Medicare and Medicaid (CMS) to launch its first value-based purchasing experiment in 2005.

In FY2017, DHCF adopted several policies designed to condition a portion of our Medicaid provider payments on specific patient outcomes. The most significant example of this is the pay-for-performance program that we adopted in our managed care program. After two years of planning, we now require the District's three full-risk health plans to meet specific performance goals in order to receive their full capitated payment rate. These performance goals will require the MCOs to reduce the incidence of the following three patient outcomes:

- Potentially preventable hospital admissions;
- Low acuity non-emergent visits to hospital emergency rooms; and
- Hospital readmissions within 30 days of previous admissions.

The program will be funded in FY2017 using a two-percent (2%) withhold of each health plan's actuarially sound capitation payments for the corresponding period. As noted earlier, this withhold reflects the profit margin for each MCO and is factored into the base per-member, per-month payment rate. The Table on page 11 uses data from 2015 to illustrate the potential loss of revenue that can occur for each plan if they fail to meet the standards required by the new policy.

Medicaid Health Plan	Total 2015 Revenue	Impact of 2% Withhold
AmeriHealth	$454.6M	$9.0M
MedStar Family Practice	$219.4M	$4.3M
Trusted	$128.5M	$2.5M
Total	**$802.5M**	**$15.8M**

As shown, this new plan puts nearly $16 million at risk for the plans if they fall short of the performance thresholds which were set at the beginning of FY2017.

***Medicaid Care Coordination*.** In addition to the managed care pay-for-performance program, we have initiated work on a program called "My Health GPS" that offers an enhanced benefit to participating providers that agree to coordinate care for a group of Medicaid beneficiaries who have multiple chronic conditions. We know from data presented earlier that, as a group, the FFS population is generally sicker, has higher rates of health care utilization, and experiences disproportionately higher cost relative to members enrolled in managed care plans.

In an effort to better isolate and encourage a more cost-effective use of the health care system, this program will target persons in Medicaid who have multiple chronic conditions and are high utilizers of health care. For these beneficiaries, the program will fund a different model of service coordination. Although eligible persons who are assigned to one of three full-risk MCOs will be allowed to participate in this program, the model will disproportionately serve those high utilizers in Medicaid who are not assigned to a health plan.

The table on page 12 compares the characteristics and health care utilization of beneficiaries who are eligible for My Health GPS to all other adults in the Medicaid program who are not institutionalized or enrolled in either of the District's community-based waivers. As

The Eligible Population For "My Health GPS" Has Significantly Higher Utilization And Cost

Characteristic	"My Health GPS Eligible Population	All Other Medicaid Beneficiaries
Average Age	52	41
Average Hospital Admissions (at least one admission)	3.1	1.8
Average Length of Stay (In Days)	17.2	6.3
Average Emergency Room Visits	3.8	1.4
Mean Prescriptions Per Person	35	10
Percent with Multiple Chronic Conditions	100%	18%
Per-Member Cost	$17,658	$7,241
Total Members	40,666	96,975

Source: DHCF staff analysis of data extracted from the agency's Medicaid Management Information System (MMIS). Utilization measure are based on claims with dates of service in FY2016. Other Medicaid were defined as 21 and over with both groups having 12 months of continuous eligibility in FY2016. Figures exclude data on persons in nursing homes, intermediate care facilities, and the community-based waiver programs.

shown, the data examined for both of these groups reveals a My Health GPS eligible population that, on average, is older and demonstrates much higher rates of emergency room use -- often for non-emergency reasons -- more and longer inpatient hospital stays, greater prescription drug use, and in general, higher annual Medicaid cost.

This problem is addressed by requiring My Health GPS participating providers to integrate and coordinate all primary, acute, behavioral health, and long-term care services of the persons in the program, in exchange for a per-member, per-month payment. The comprehensive care management services offered through the program will be delivered by an interdisciplinary team embedded in the primary care setting, which will be the central point for coordinating patient-centered care for these beneficiaries. If the inter-disciplinary team can successfully

manage cost below the monthly payments, any resulting savings flow to the comprehensive care management team.

Providers will also receive an enhanced one-time incentive payment for each beneficiary as compensation for developing a person-centered care plan. The federal government will finance 90 percent of this incentive payment for the first two years which provides a glide path for providers in their transition to value-based payments. As the program matures, the pay-for-performance component will be added, requiring that we withhold a percentage of the providers' payments each month. At the end of the year, providers that improve quality and show a reduction in unnecessary utilization of services will have the opportunity to earn back the withheld amount, plus an additional bonus payment.

Our previous attempt to address this issue was defeated by a program design that was not infused with the proper incentives. We have learned from our mistakes and have high expectations for success with this effort. With the approval of CMS now secure, we plan to launch this program in July 2017.

Upgrade of Long-Term Waiver for Recertification. In 2016, DHCF completed the work required to upgrade and renew the agency's more than $35 million Elderly and Persons with Disabilities (EPD) waiver. The current EPD waiver expires in April 2017 and we believe CMS approval of our new EPD waiver submission to be imminent.

The renewal application makes a number of improvements to the program – changes that we anticipate will enhance service delivery options for nearly 3,000 District residents. Of note, the waiver adds community transition services that will pay for non-recurring expenses for individuals who are transitioning from an institution or other long term care facility to a more integrated and less restrictive community setting. This service is currently only funded through

our Money Follows the Person Demonstration Grant and moving this benefit into the EPD waiver is part of our approved sustainability plan.

The EPD waiver also significantly increases the reimbursement rate for Assisted Living services (from $60 dollars per day to $155 per day), strengthens provider training requirements, amends existing provider qualification verification standards, and adds sanctions for providers who fail to adhere to the new standards of the EPD waiver.

Most significantly, the application for renewal streamlines the EPD waiver recertification process for continued enrollment in the program. Cumbersome enrollment and renewal processes have been chronic problems for the EPD waiver, dating back many years. This application seeks to reduce the burden on beneficiaries with the expressed purpose of preventing breaks in service, thereby ensuring continuity of care. This is vital for EPD waiver recipients because of their typically fragile health status.

Specifically, once beneficiaries are determined initially eligible for the EPD waiver based upon nurse administered, conflict-free assessments of the members' functional, cognitive and skilled care needs, reassessments shall only be required if there has been a change in the beneficiaries' health status.

Absent a change, case managers shall attest that the beneficiaries continue to meet the nursing facility level of care and communicate the attestation to the Medicaid eligibility unit for financial disposition. As a quality check, beginning one year from the date of approval of the EPD waiver and on an annual basis thereafter, DHCF or its designee will conduct face-to-face reassessments of a random sample of beneficiaries who had no change in health status and whose continued eligibility for the waiver is based upon case managers' attestations.

Oversight of the Hospital Operator for United Medical Center. Since FY2016, DHCF has worked closely with the team at the United Medical Center Not-For-Profit Hospital (UMC) as the contract administrator for a hospital stabilization project. The impetus for this project was the on-going financial challenges plaguing UMC which have necessitated repeated subsidies from the District. Namely, in FY2015, the Board at UMC requested $7 million in local fund subsidies to cover an operating deficit for that year. This was followed by a request in FY2016 for another $10 million to assist the hospital with its efforts to meet payroll.

In response to these problems, Mayor Bowser directed DHCF and the Office of the Chief Financial Officer (OCFO) to work with the hospital on a restructuring plan and secure the services of a consulting firm to manage day-to-day operations. The following steps were initiated in response to this request:

- In March 2016, UMC was required to submit a restructuring plan that sufficiently trimmed operating expenses, bringing these costs in line with existing and projected revenue for the remainder of the fiscal year.

- In April 2016, the UMC Board secured the services of Veritas to work as the hospital operator to finalize the execution of the restructuring plan to ensure the hospital ended FY2016 without losses while conducting an assessment of hospital operations, including the revenue cycle management process.

- By September 2016, Veritas was instructed to develop a management action plan to guide the long-term operation of the hospital, pegging future operations to a Board-approved budget for FY2017 and hopefully eliminating the likelihood that the hospital would require another financial bailout from the District. This plan includes a series of metrics which can be regularly tracked to gauge the condition of hospital operations and provide early warning signs of any financial trouble.

- Each month DHCF and OCFO staff meet with Veritas to review the prior month's performance based on the goals, objectives, and performance metrics outlined in the management action plan.

Currently, the hospital's financial situation is stable but tenuous. Expenses are under control but the hospital has just over 42 days of cash on hand and no meaningful reserves to fund maintenance needs. The opportunities for significant revenue growth remain limited because of long-standing problems that cannot be addressed without a significant investment of both capital and operating funds – investment decisions that, for the most part, are presently being held in abeyance as the future of the hospital at its current site is further contemplated. Until such time that a decision is made about the construction of a replacement hospital, it is imperative that an operator remain on site to prevent a surge in UMC's operating cost that cannot be sustained by patient revenue.

National Proposal to Reform Medicaid. Mr. Chairman, the final issue that I would like to discuss is Medicaid reform which is a major component of the changes being considered for the ACA. There is now, an emerging cloud of uncertainty about the future of health care policy in this country which could directly impact the District and its approach to ensuring access to health care for its residents. Due to an improbable outcome in last year's national election and a promise of change with ominous underpinnings, much hangs in the balance for health care in general and the Medicaid program in particular.

Under the often repeated mantra of "Repeal and Replace" Congress and the White House have sent unambiguous -- if at times conflicting -- signals that the ACA and Medicaid will be fundamentally altered. The White House has yet to offer a formal outline of the president's plans for "Repeal and Replace." However, in the last week, one broad policy brief from House Republicans became public and immediately drew sharp criticism from both sides of the political aisle. More recently -- on March 6, 2017 -- House Republicans introduced in two Committees, what is now being described as their official plan to "Repeal and Replace" the ACA.

Though less draconian than some of the earlier proposals, this latest bill is grounded in conservative orthodoxy which offers that the ACA has distorted the health insurance market and upset the historic federal-state balance in Medicaid by providing enhanced funding for more than 10 million "able-bodied adults." This policy, the Republicans insist, cannot be sustained because the federal government is expected to pay 90 percent of the program's expansion cost in perpetuity.

While more time is needed to fully analyze the recently released bill, the proposed legislation clearly breaks from existing Medicaid policy in two important ways. First, it calls for the elimination of Medicaid expansion in its current form in 2020. Under the authority of the ACA, there are 32 states -- including the District -- that cover Medicaid parents and childless adults up to 138 percent of the federal poverty level (FPL). In the District, we also extend coverage for childless adults from 138 percent to 215 percent of FPL with the standard federal reimbursement of 70 percent.

Under the proposed House Republican plan and effective in 2020, the 90 percent enhanced federal match for Medicaid expansion members will be applied to only persons who were enrolled in Medicaid prior to this effective date. Moreover, if any of these beneficiaries experience a break in service after 2020 and subsequently return to the program, the federal match rate for their health care cost would revert to the standard rate for the state – in the District this would be 70 rather than 90 percent.

The second aspect of the proposed bill makes a sharp break with tradition through the elimination of Medicaid's once sacred entitlement component. Under current law, all persons who meet the eligibility requirements for the program in their state of residence are entitled to

the Medicaid benefits outlined in the State Plan. Moreover, the federal government must pay its predetermined share of these costs.

In an effort to rein in the longer term out year cost for the program, the House bill replaces this more than 50 year-old bedrock feature of the program with "per-capita allotments which set FY2020 allocations for each state based on FY2016 spending levels. These allocations are to be inflated forward to 2020 and each year thereafter. The base year target spending levels will be established using 5 enrollee categories (1) persons who are elderly, (2) persons who are blind and disabled, (3) children, (4) expansion adults, and (5) non-expansion, non-elderly, nondisabled adults. Also, any State with spending higher than their specified target aggregate amount would face annual penalties.

This proposal has the potential to grow the non-federal share of the program unless over time, states roll back eligibility levels, reduce benefits, or lower provider payments especially in years where federal inflation adjustments are insufficient to cover actual utilization and provider payment rate increases.

Growth in the District's Medicaid program has, in some years, been twice as high as the benchmark inflation adjuster referenced in the House Republican bill and our cost for the expansion population has grown by as much as 16 percent in some years. Thus, unless we control enrollment, benefit cost, and spending on provider payments in the same way that the federal government caps our payments -- which is difficult to accomplish prospectively -- any increase in beneficiary enrollment or utilization of services beyond the inflation adjustments utilized by the federal government will expose the District to increased and unbudgeted local spending obligations.

Early proposals for reform of ACA would have imposed significant fiscal challenges for the District as early as 2018. This bill, however, offers what is essentially a two-year transition period before the states initially face the prospect of increased spending or the imposition of program reductions to keep Medicaid cost within the parameters established by ACA reform.

Using data on average Medicaid growth rates for the District, a preliminary estimate can be derived of the additional local fund cost the District would incur under the House Republican plan if the Mayor and Council made no changes to the District's eligibility levels and benefit design in response to the law.

If we assume an average 5.8 percent growth rate in Medicaid spending for the District relative to the Medical CPI in the first five years following the implementation of the bill, the city would witness an additional $1.6 billion in additional local cost beyond the spending levels that would have occurred with no changes to the law over this time period (see table on page 20).

Two policy changes -- the elimination of federal support for childless adults with incomes from 138 to 215 percent of FPL and the constraints imposed by the capped allotments -- would be responsible for nearly 80 percent of this cost.

However, it is important to note that our average annual Medicaid spending growth rate has varied a great deal over the past decade, ranging from 5.8% to 9% annually. The District's Medicaid expansion population has been especially prone to multiple and sharp spikes in cost due primarily to the complex health problems that affect many in this group. Given these fluctuations and the difficulty predicting future spending growth rates, we use both figures to estimate both low and higher growth rates, thus offering the likely range of a possible financial impact from the proposed Medicaid reforms.

Estimated Additional Local Cost Of Retaining Enrollment And Medicaid Benefit Structure Under The House Republican Proposed Reform Of The Affordable Care Act Reform Bill ($ In Millions)						
Medicaid Eligibility/Program Design	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Five-Year Total**
Added Local Cost For Childless Adults Who Newly Enroll Or Reenroll After December 31, 2019	$19.2	$40.2	$65.9	$96.0	$131.3	$352.6
Added Local Cost For Childless Adults above 138% FPL	$71.6	$111.2	$129.6	$150.9	$175.9	$639.2
Added Local Cost Of Exceeding Per Capita Allotment Inflation Adjustment (2012 - 2016 average annual growth)	$62.4	$109.4	$138.2	$169.6	$204.0	$683.6
Total Added Local Impact Under Cap Allotment with phased-out Medicaid expansion	**$153.1**	**$260.8**	**$333.6**	**$416.6**	**$511.2**	**$1,675.3**
Notes: Using information available as of March 7, 2017. To form a basis for comparison DHCF overall spending inflated at the average annual growth rate of all provider payment spending for FY 2012 through FY 2016, and Childless Adult spending inflated at the average annual growth rate for Childless Adult spending for FY 2012 through FY 2016.						

Accordingly, the second table on page 21 offers our preliminary analysis based on a 9 percent growth rate. As shown, this analysis finds that the likely five-year financial impact of the proposed cuts to Medicaid expansion and per capita allotment reforms for the District could be as low as $348.1 million to a high $3.924 billion. Again, this is in addition to what we are currently spending for the base elements of the program not impacted by the reforms.

Estimated Additional Local Cost Of Retaining Enrollment And Medicaid Benefit Structure Under The House Republican Proposed Reform Of The Affordable Care Act Reform Bill ($ In Millions)						
Medicaid Eligibility/Program Design	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**	**Five-Year Total**
Added Local Cost For Childless Adults Who Newly Enroll Or Reenroll After December 31, 2019	$19.2	$40.2	$65.9	$96.0	$131.3	$352.6
Added Local Cost For Childless Adults above 138% FPL	$71.6	$111.2	$129.6	$150.9	$175.9	$639.2
Added Local Cost Of Exceeding Per Capita Allotment Inflation Adjustment (2000-2011 average annual growth)	$257.3	$458.3	$587.9	$733.3	$896.0	$2,932.8
Total Added Local Impact Under Cap Allotment with phased-out Medicaid expansion	**$348.1**	**$609.8**	**$783.3**	**$980.2**	**$1,203.2**	**$3,924.6**
Notes: Using information available as of March 7, 2017. To form a basis for comparison DHCF overall spending was inflated at the average annual growth rate of all provider payment spending for FY 2000 through FY 2011, and Childless Adult spending was inflated at the average annual growth rate for Childless Adult spending for FY 2012 through FY 2016						

Obviously, these types of cost increases are not sustainable in the District's local budget. However, those who support the House Republicans' direction will push back against complaints about this federal devolution of both responsibility and cost to the states by insisting that the expanded flexibility promised under the per capita plan will allow Medicaid programs to cover more people by reducing the scope of benefits offered in the overall program – in effect, using savings from a reduced range of benefits to subsidize higher enrollment levels.

With grants that are adequately funded, this type of flexibility is invaluable, allowing states to nimbly move and dynamically shape the programs as needed. However, in an

underfunded block grant -- which is what this will likely be -- such flexibility is no more than a sharp blade passed down from the federal government to the states with the accompanying permission to impose punishing cuts to the Medicaid program.

Conclusion

Chairperson Gray, this concludes my testimony for today. While I have focused on a few activities, there are a host of program and policy issues that we face each day in the administration of Medicaid and the Alliance programs. As we encounter future program challenges and learn more about the coming reform of Medicaid, I will ensure that the communication channels with the Committee remain open and productive. As always, we strive to operate with complete transparency.

Allow me to close by thanking you for your leadership and support as well as that of other Committee members. At this point, my staff and I are happy to answer any questions that you and other Committee members might have.

Thank you