GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2020 Budget Hearing

Testimony of
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Director Department of Health Care Finance

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

John A. Wilson Building
Room 412
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10:00am

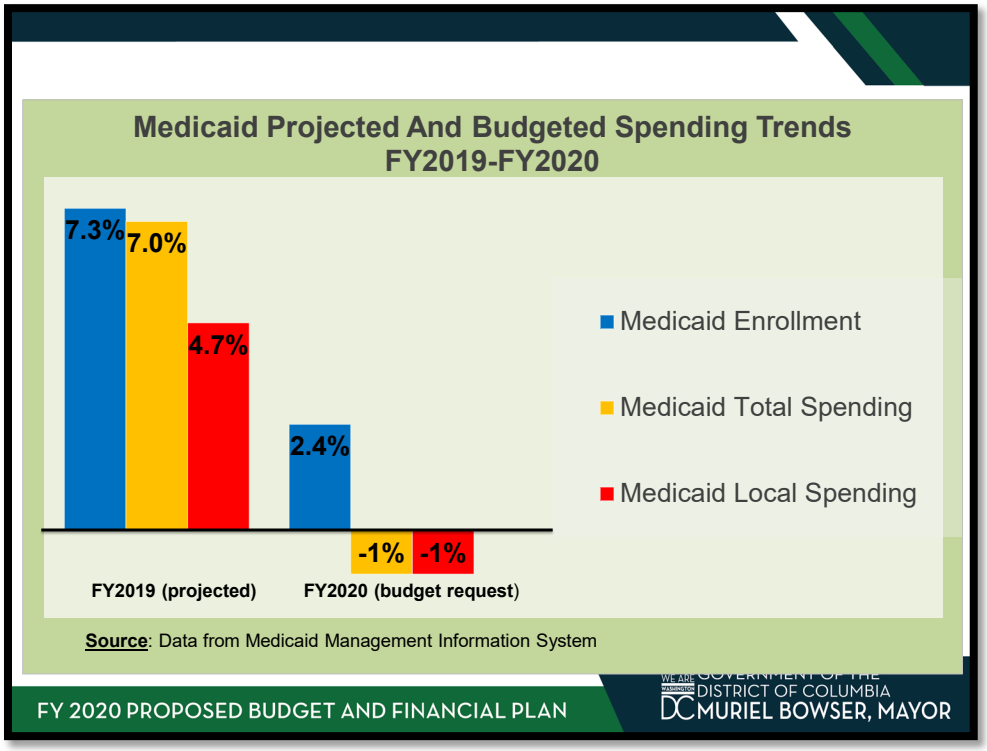
Good morning, Chairman Gray and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure today to report on Mayor Muriel Bowser's Fiscal Year 2020 budget for both DMHHS and DHCF. The first part of my testimony will focus on the budget for DHCF, followed by a discussion of DMHHS' budget and initiatives.

Entitled "A Fair Shot," Mayor Muriel Bowser's budget offers a sweeping plan to fund new initiatives and existing programs that touch on each functional area of government that work to give residents a pathway to the middle class. Underpinning the Mayor's budget development process was a significant level of community engagement. Budget engagement forums conducted across the District gave communities a window into the formulation process and the opportunity to voice their beliefs of how money should be allocated in the budget. These forums attracted over 1,000 residents who participated on calls, in-person, and through a new interactive poll.

One of the seven priorities of the Mayor's budget is to extend the reach of the District's health and human services programs. In terms of total funds, this is the largest proposed expenditure in the Mayor's FY20 budget, accounting for 33 percent of the $15.5 billion in projected spending. If you consider only local funds, spending on health and human services programs represents the second largest allocation in the Mayor's budget at 25 percent.

With respect to DHCF, combined funding for the Medicaid and Alliance programs constitutes most of the local spending in the human services cluster, at 66 percent of total cluster expenditures and 39 percent of local cluster funds. Notably, DHCF's local funding has grown from $784.2 million budgeted amount in FY19 to $831 million proposed for FY20 – a six percent increase. The total funds budget -- federal and local -- shows a net reduction of just over $3 million.

DHCF's proposed $3.3 billion budget for FY20, continues Mayor Bowser's unwavering commitment to the preservation of health care access for its residents, especially in the Medicaid program. This number is a one percent *decline* in federal and local spending as compared to FY19. This is attributed to a modest enrollment growth expected in FY20 and the slowing of Medicaid utilization (see the graphic below). In comparison, DHCF's projected budget for Medicaid in the previous year reflected a growth in enrollment and total Medicaid spending of more than seven percent, with a near five percent increase in projected local spending.



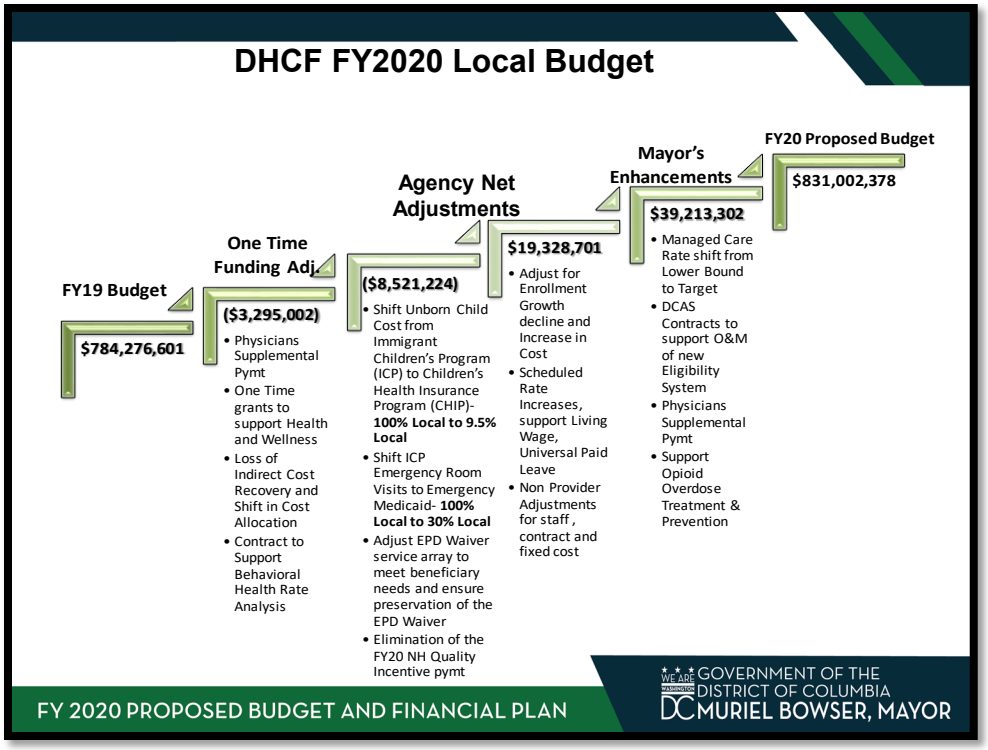
It is important to note that the lower enrollment and spending projections budgeted for FY20 do not reflect any changes to program eligibility rates or reductions in the scope of Medicaid benefits. Accordingly, the District continues to boast some of the highest eligibility levels in the nation, along with a comprehensive program of benefits. With high coverage levels, the District extends health care to nearly four in 10 residents. For almost 90 percent of these residents,

Medicaid is their source of health care insurance. For the remaining residents who are on public insurance, the Alliance (six percent), Children's Health Insurance Program (five percent), and Immigrant Children's Program (one percent), provide their collective path to health care.

Mr. Chairman, the next section of my presentation today outlines key steps in the budget formulation process that were used to set DHCF's FY20 spending plan, including budget enhancements, offsetting adjustments, and savings initiatives. As you recall, budget formulation begins in the summer months and follows an interactive and iterative process between the budget staff for the Executive Office of the Mayor (EOM) and the senior teams in the agencies. As with all Executive Branch agencies, DHCF received its preliminary "budget mark" and then negotiated a plan of reductions to achieve the mark, while also submitting enhancements for consideration by the Mayor.

DHCF's Budget Development Process

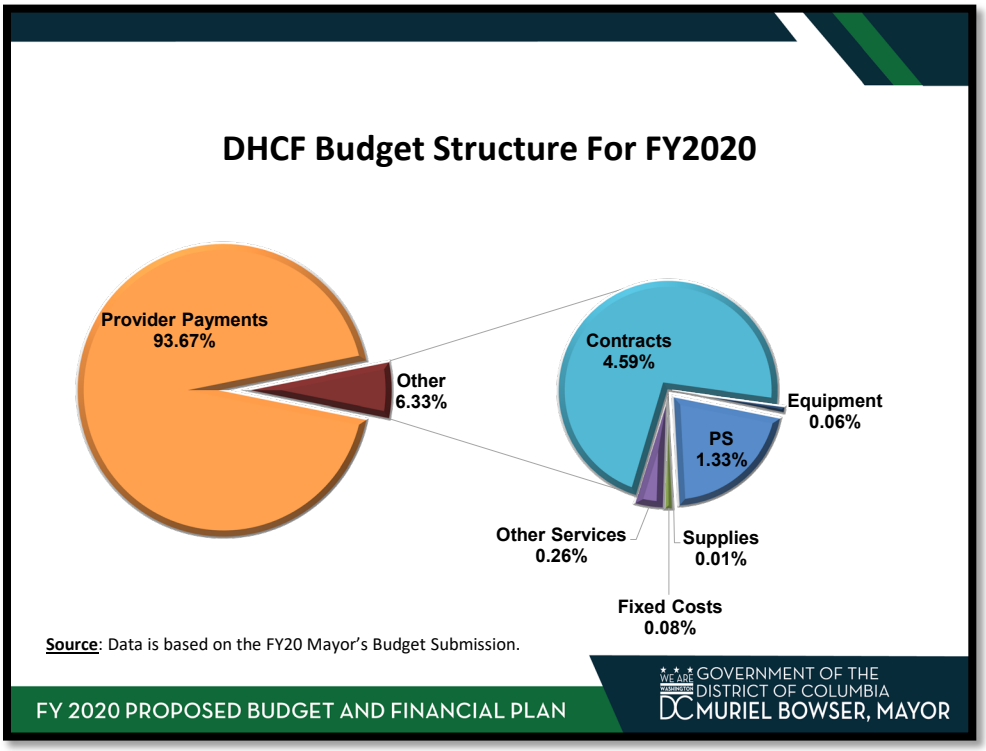
Budget Development. Mr. Chairman, this portion of my testimony outlines the steps that were implemented to construct the Mayor's budget for DHCF, while summarizing the structure of the agency's budget. As shown by the illustration on page 5, the Mayor's budget team required agencies to establish the approved budget for FY19 as the baseline or FY20. This amount was adjusted downward to remove all FY19 enhancements that either would not be carried forward or required new budget actions. Thus, downward adjustments of more than $3.2 million were made to DHCF's budget – most of which was for the supplemental payment DHCF allocated to the George Washington Medical Faculty Associates (GWMFA) to subsidize the Medicaid losses of the practice plan.



DHCF's FY20 budget includes $58.2 million in upward budget adjustments. Roughly $19 million of these adjustments were made to allocate funds for Medicaid cost increases driven by the rising cost of provider services, including rate increases, payments for the Universal Paid Leave program, and DHCF contract and fixed cost increases. Added to these amounts was $39.2 million, most of which is to fund DHCF's plans to pay its managed care organizations a higher rate than was established in FY19, fund GWMFA Medicaid losses in FY20, and support the operations and maintenance contract for the DCAS program.

Structure of DHCF Budget. Through a series of federal dollar matching formulas, the Mayor's proposed local fund budget for DHCF of $813 million generates a total of $3.3 billion for FY20. Most of these proposed funds will cover 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 proposing to allocate 94 percent of its $3.3 billion for this purpose. 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 share.

Proposed Funding Levels for Critical Medicaid Mandatory and Optional Benefits

As a jointly funded federal-state program, 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 FY20 funding levels for Medicaid 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 increased amount for nursing home care is partially driven by the new reimbursement model established by DHCF a model that shifts payments to a patient-based design versus the previous facility-based payments.

Budget Request For Medicaid Mandatory Services

(in Millions) Medicaid Mandatory Service	FY18 Expenditures	FY19 Budgeted Amount	FY20 Budget Request	Explanation
Inpatient Hospital	218.38	247.57	207.08	FY20 supports hospital spending at 86% versus 98% due to Hospital Tax sunsetting
Nursing Facilities	248.71	291.60	292.44	Maintains rates but eliminates Quality Incentive payment for FY20 quality measures to be paid in FY21. NH will still receive FY19 quality Incentive in FY20
Physician Services	40.08	30.72	49.11	FY19 anticipated expenditures are $43.3
Outpatient Hospital, Supplemental, ER & Emergency Medicaid	32.27	35.11	40.53	Increased utilization due to shifting allowable Immigrant Children's services to Emergency Medicaid
Durable Medical Equip (including prosthetics, orthotics, and supplies)	24.63	27.29	27.67	
Non-Emergency Transportation	29.25	29.33	29.92	
Federally Qualified Health Centers	43.11	55.91	63.73	FY20 represents the impact of the new rate methodology
Lab & X-Ray	17.24	17.96	17.99	
Home Health	11.76	16.21	13.14	

FY 2020 PROPOSED BUDGET AND FINANCIAL PLAN DC MURIEL BOWSER, MAYOR

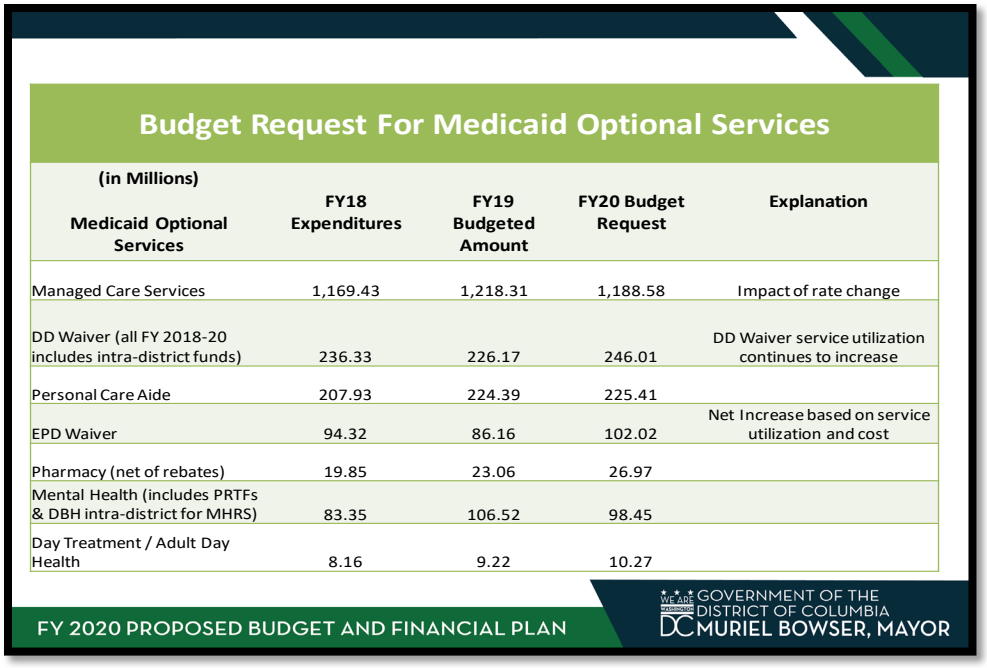
The Mayor's budget fully funds the anticipated need for primary, mental health, and dental clinic services that are delivered by Federally Qualified Health Centers (FQHC), as well as hospital outpatient, emergency care, and primary physician care services provided outside of the FQHC environment.

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 FY19. 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 that are less than the reported expenditure levels in FY18 and the budgeted figures for FY19. It is important to note, however, that these are not funding reductions.

The proposed funding for FY20 does not include the higher payment levels 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 FY20 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 such services in the Mayor's proposed budget are significant. When total funds are considered, the Mayor's proposed FY20 budget allocates more than $2 billion to programs and benefits that are not mandated by federal law (see table on page 9). Most significant are the dollars reserved to fund the District's four managed care contracts. The District funds these payments based on actuarially sound rates, and, in FY20, the Mayor is providing over $1.2 billion to support this optional program.

In addition to these payments, the Mayor's budget sets aside nearly $574 million in total funds for various long-term care services, including the waiver for persons with intellectual disabilities, personal care services to support persons who need help performing basic activities of daily living, and DHCF's EPD waiver program for the elderly and persons with physical disabilities.



Budget Request For Medicaid Optional Services

(in Millions) Medicaid Optional Services	FY18 Expenditures	FY19 Budgeted Amount	FY20 Budget Request	Explanation
Managed Care Services	1,169.43	1,218.31	1,188.58	Impact of rate change
DD Waiver (all FY 2018-20 includes intra-district funds)	236.33	226.17	246.01	DD Waiver service utilization continues to increase
Personal Care Aide	207.93	224.39	225.41	
EPD Waiver	94.32	86.16	102.02	Net Increase based on service utilization and cost
Pharmacy (net of rebates)	19.85	23.06	26.97	
Mental Health (includes PRTFs & DBH intra-district for MHRS)	83.35	106.52	98.45	
Day Treatment / Adult Day Health	8.16	9.22	10.27	

These programs comprise a robust mix of services to help Medicaid recipients age in community settings, as opposed to in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) institutional settings.

Key Program Challenge Faced By DHCF

Now, Mr. Chairman, I would like to close the DHCF portion of my testimony by drawing attention to important issues that we face within the Medicaid managed care and Alliance programs. In the case of Medicaid managed care, routine but important, changes are needed in rate setting to offset problems created by adverse selection that impact one plan. With respect to Alliance, we continue to monitor the rapid cost growth in the program and the causal factors. Further, we are constantly vetting potential changes in the program's application process that could ease any questions about beneficiary access, but not at the expense of the six-month recertification requirement process that protects the integrity of the program.

Medicaid Managed Care and Adverse Selection. Mr. Chairman, if you recall, the managed care program was disrupted in 2017 by a protest of DHCF's decision to award contracts to the

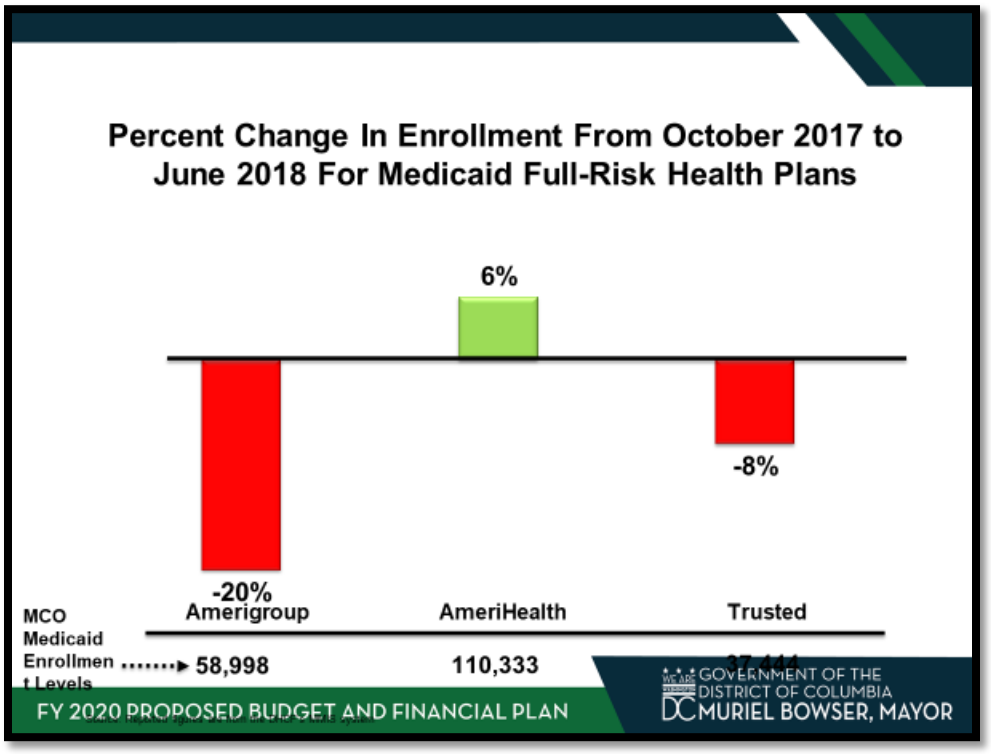
three current vendors – AmeriHealth Caritas District of Columbia, Amerigroup (which replaced MedStar Family Choice), and Trusted Health Plan. Since that time, a substantial number of Medicaid beneficiaries who were previous members of MedStar, and to a lesser degree, Trusted, moved to AmeriHealth in ways that have upended the managed care risk pools.

Why Member Risk Pools Matter. In the managed care environment, health plan solvency is not only linked to the rate that companies are paid for managing and paying for the care of beneficiaries, but is also directly tied to the relative balance of member risk pools. Effective risk pooling requires a diverse membership panel that includes a favorable combination of high-cost and low-cost members in the same plan. A sufficient number of low-cost members is necessary to offset the medical expenses for high-cost beneficiaries in the plan.

As you would expect, larger diverse risk pools tend to be more stable because they usually provide the optimal mix of healthy and unhealthy plan members. The biggest threat to stable risk pools is the phenomenon of adverse selection. In Medicaid, this occurs when a disproportionate share of unhealthy individuals gravitates to a given health plan, usually to secure access to a panel of physicians unavailable to members of other plans. We try to protect against this problem in the Medicaid and Alliance programs by randomly assigning beneficiaries to avoid disproportionate pooling. However, members have federally-mandated freedom of choice and can thus request a change to another plan at any time during the year – even after initial enrollment closes.

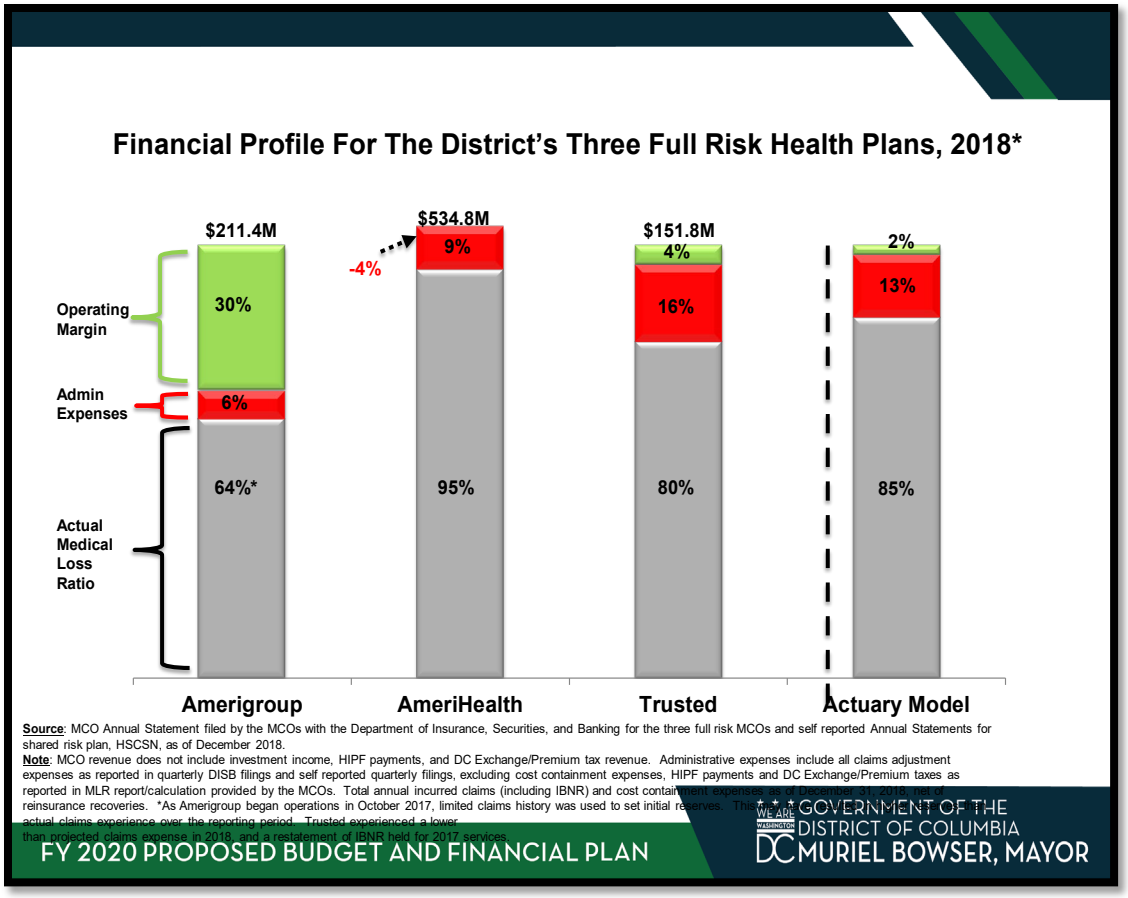
When new MCO contracts began in 2017, a reshuffling of members occurred as substantial numbers of beneficiaries for both Trusted Health Plan and Amerigroup requested and received transfers to AmeriHealth, the only managed care plan in the District's Medicaid program with which MedStar Health System has elected to contract. The sharpest enrollment reductions

occurred for Amerigroup (20 percent) but Trusted experienced an eight percent decline as well (see graph below).



When the medical costs of the recipients who transferred to AmeriHealth from the other two plans are examined, the data shows that these beneficiaries had much higher medical risk and expense profiles than AmeriHealth's legacy population. Thus, the impact of the transfers was to dramatically increase the health care expenses for AmeriHealth, while substantially reducing the health care costs for the other plans.

As would be expected, this markedly changed the financial profile of all three health plans. AmeriHealth was forced to spend significantly more on health care expenses than anticipated by the actuary's payment model, wiping out the company's historical margins of six percent, dropping to negative four percent in 2018 (see graph on page 12). This represents a near $50 million swing. Conversely, with a disproportionate number of the healthiest members in Medicaid, neither

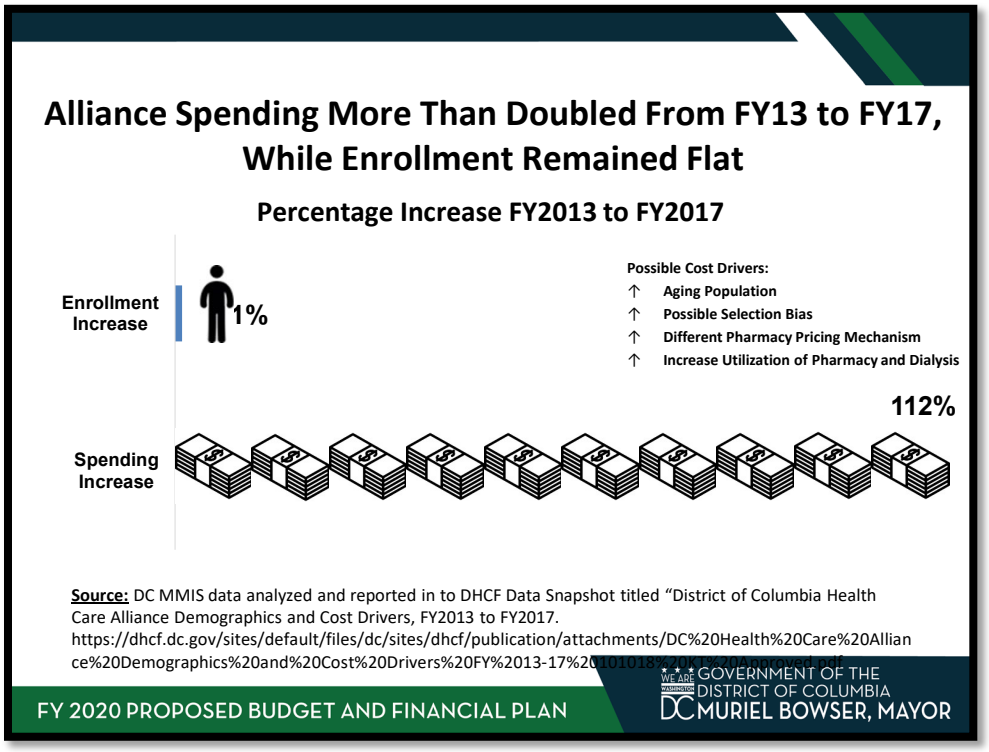


Amerigroup nor Trusted were able to meet the required 85 percent medical spending levels in 2018, and Amerigroup experienced a profit level heretofore unseen in the District's managed care program.

If this problem is not corrected, the District's largest health plan will be insolvent before 2020 concludes, while the other health plans will be unjustly enriched. To avoid this problem, DHCF will be required to work with its actuary and reinstate risk adjustment strategies that raise the rates for the plan with the more medically expensive members, while imposing corresponding decreases for the other plans. This modification will be budget neutral.

As we approach FY20, DHCF staff will continue to investigate ways to improve the Alliance program, while pursuing efforts to slow down an unsustainable cost growth rate. In

perhaps the most revealing statistic for the program, DHCF data shows that since 2013, enrollment levels in the program have increased by just one percent, while cost has more than doubled by an increase of 112 percent (see below).

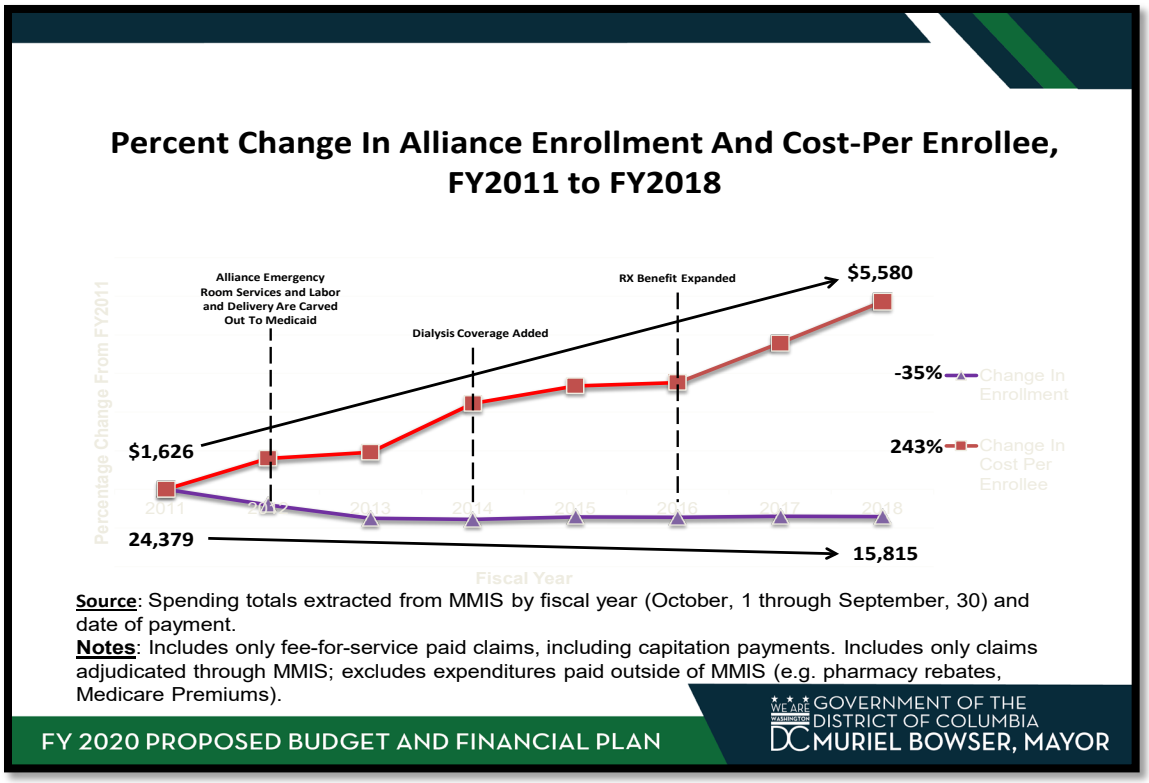


DHCF staff analysis suggests that older Alliance members, likely with more complex health problems than the rest of the population, are growing at a faster rate. Evidence of this can be seen in their increased utilization of hospital-based services and pharmaceutical benefits, in sharp contrast to younger members in the program. Moreover, policy changes, which have expanded the benefit over time to include dialysis (2014) and more generous pharmacy coverage (2016), are underlying factors.

As an example of greater utilization by more senior Alliance members, since 2013, beneficiaries who are 65 years of age or more increased their use of hospital-based services by 348 percent. This is more than twice the growth rate of the younger members in the program. With

respect to pharmacy utilization, the growth rate from 2013 is 206 percent, compared to 106 percent for Alliance members who are less than 65.

These cost drivers have generated the trends shown in the graph below that reveal a benefit increase by a factor of nearly 3.5 times since 2013 (from $1,626 to $5,580). This reflects a 243 percent increase, compared to a 35 percent decrease in enrollment.



There remains concern, however, that the face-to-face recertifications established in 2012 to help curtail documented fraud in the Alliance program is now discouraging healthy members from immediately recertifying though they are eligible. This is believed to be a factor in the rising per-enrollee cost as those with more severe and costly health problems are disproportionately choosing to re-enroll. Previous analysis indicates that Alliance members who do not have acute illnesses are 30 percent less likely to re-enroll in the program. While the reasons are not clear, DHCF is working with ESA to implement exemptions from the face-to-face interview requirement

to include applicants/enrollees who are either hospitalized, disabled, pregnant, elderly (65 or older), or caring for a household member meeting these categories. Additionally, DHCF is planning to implement the Medicaid MAGI methodology for Alliance eligibility to streamline and simplify eligibility and enrollment once the DCAS eligibility system is operational for Alliance coverage. We expect this to occur in March 2020. DHCF is also planning to implement suspension of benefits, rather than termination, for incarcerated Alliance members. This will make it easier to restart Alliance coverage upon their release from incarceration.

Finally, DHCF is working with ESA to implement a modified process at all service centers and outstation eligibility sites so that individuals who cannot wait for a face-to-face interview can satisfy the interview portion of the face-to-face requirement in an expedited manner, separate and apart from the remainder of the application process. Hopefully, these changes will continue to reduce wait times for recertification, while protecting an administrative practice that has value in slowing the rate of fraud in the program.

Conclusion

Mr. Chairman, this concludes the portion of my testimony covering Mayor Bowser's budget for DHCF. While there is much to consider in a $3.3 billion budget, there are several key take aways: both Medicaid and Alliance eligibility levels and access to care are preserved; there has been no retrenchment in benefit plans; historical funding for community-based providers has been maintained; and resources to return the managed care rates to the target or mid-point level have been allocated. In the context of this impressive budget, DHCF staff look forward to working with your capable team to ensure that District residents have continued access to quality health care services.

Budget Testimony for Office of the Deputy Mayor

Mr. Chairman, at this time, I would like to turn your attention to the FY20 budget for the Office of the Deputy Mayor for Health and Human Services (DMHHS). As noted earlier, the health and human services cluster occupies a central place in the Mayor's budget, playing a vital role in Mayor Bowser's vision to ensure that all District residents, regardless of address or income, receive a "fair shot" at benefiting from the economic prosperity of this city. Thus, while DMHHS has a comparatively small budget, its mission of coordinating a comprehensive system of benefits, goods, and services across seven Executive Branch agencies touches every corner of the Mayor's agenda for human services.

In terms of office funding and structure, the Mayor's FY20 proposed budget provides $2.1 million to support the work of DMHHS. This budget funds nearly 14 full-time staff who provide oversight to the following District agencies in the cluster:

- Department of Health Care Finance (DHCF);
- Department of Health (DOH);
- Department of Human Services (DHS);
- Department of Aging and Community Living (DACL);
- Child and Family Services Agency (CFSA);
- Department of Behavioral Health (DBH); and
- Department on Disability Services (DDS).

DMHHS staff serve a number of critical functions, including coordinating interagency teams, working closely with two of our external independent agencies (the Health Benefit Exchange Authority and the United Medical Center), and working with the Interagency Council on Homelessness (ICH) and the Thrive by Five Coordinating Council. DMHHS is also directly responsible for two internally-directed programs: the Encampment Protocol Engagements and Age-Friendly DC.

Key Targeted Investments for DMHHS

In her FY20 budget, the Mayor identified expanding the reach of health and human services as one of the top priorities of her Administration. While the scope of the programs funded in the Mayor's budget have a broad reach, they are succinctly organized under three key guiding principles:

1. Addressing the very challenging problem of homelessness in the city;
2. Improving the quality of life for our seniors; and,
3. Investing in and supporting children and families with a special focus on ensuring access to health care services.

Addressing Homelessness. Shaped by the ICH and Solid Foundations DC-led plans, Mayor Bower's budget allocates $37 million in new investments for Homeward DC. We know that approximately 7,000 people experience homelessness in the District on any given night, some of whom have been homeless on the streets of the District for decades. Using the Homeward DC plan to guide the way, we are working to transform our homeless services system into an effective crisis-response system focused on preventing homelessness whenever possible and otherwise stabilizing and returning individuals and families back to permanent housing as quickly as possible.

Through a $26 million enhancement, the District will continue its transformation of the homeless services system by continuing to scale permanent housing programs that are critical in helping people transition from shelters and the streets back into permanent housing. This includes providing an increase of over $15 million into the local rent supplement program to help people stay in homes. The housing resources allocated to Homeward DC are, of course, in addition to the Mayor's investments in affordable housing across the District through the Department of Housing and Community Development.

In addition, this enhancement allows us to continue our work to transform the District's emergency shelter stock to provide facilities and programs that are responsive to the needs of individuals and families in crisis. In addition to the $11.2 million for operating expenses at the new Short-term Family Housing sites, the FY20 budget also includes resources to continue our shelter redevelopment work for single adults. For instance, we will move forward to begin redevelopment of the 801 East Men's Shelter on the St. Elizabeths East campus, while this year's budget allocates new resources to replace the Harriet Tubman Shelter for women.

Improving the Quality of Life for Seniors. The Mayor made several investments in our seniors by funding programs that combat social isolation and engage seniors in activities that keep them active members in the community. The centerpiece of her plan is the recurring investments made in Safe at Home, which provides in-home adaptations for seniors, including chairlifts, grab bars, accessibility ramps, and the installation of security cameras. The investment in this year's budget will allow for the completion of more than 1,000 home adaptations for new clients, as well as the installation of security cameras to allow even more seniors to age safely in place. Supplementing this program, the Mayor funded a $500,000 grant to support senior dental health; expedited construction plans to move completion date of the City-Wide Senior Wellness Center in Ward 8 up two years; and expanded the "Keep Housing Affordable Tax Credit," a $5.2 million value designed to allow more seniors to keep their homes.

Investing in Children and Families. In her second Inaugural Address, Mayor Bowser emphasized her commitment to those in our city who, despite being surrounded by prosperity and visible economic growth, remain mired in poverty and suffer from lagging wages that fuel the growing income disparity these residents face when compared to others across the city. Families First DC is a $4.7 million commitment by Mayor Bowser in support of her belief that our success

is defined by the accomplishments of those who have historically been left behind. This program of promise is designed to disrupt the way services are delivered in 10 communities where barriers to opportunity, achievement, and well-being are most acute. It represents a whole community, whole family approach designed to give all District residents a fair shot. As part of the District's evolution in how we interact with our customers, Families First DC will be a neighborhood-based, neighborhood-driven, neighborhood-led approach aimed at reducing disparities and creating stronger, more resilient families through meaningful access to District services. The 10 focus communities in Wards 7 and 8 — which were selected based on social determinant of health indicators and Safer, Stronger DC target areas — will each have a neighborhood-centric, place-based Family Success Center that will integrate government initiatives and programs to build on family and community strengths and meet families' complex, interconnected needs. Led by community advisory committees, residents will determine the services offered at their center, as well as how to spend a community-based grant designed to fill critical gaps and fund a range of services designed to improve the human capital of the residents. By empowering communities to customize solutions based on community assessed strengths and needs, this initiative will ensure that families are safe, healthy, and able to thrive.

Lastly, the District has lacked a city-wide comprehensive and integrated service delivery model that leverages the city's resources within a school mental health structure to provide students with broad and equitable access to school-based mental health services. Embracing recommendations from the Task Force on School Mental Health and the current Coordinating Council on School Mental Health, Mayor Bowser's budget invests an additional $6 million to continue the expansion of a coordinated and responsive behavioral health system to all children in all DC Public and Public Charter Schools. Key system elements include:

- Expansion to an additional 67 schools in year two, based on highest need;
- A multi-tiered behavioral health model that provides access to prevention, early intervention, and treatment;
- Support for school and community-based provider partnerships; and
- Enhanced senior-level oversight and project management of the Expansion.

Status of the New Hospital

Mr. Chairman, I will close my testimony today with a brief update on the status of the new hospital on the St. Elizabeths campus. Over the last two years, the Office of the City Administrator, in coordination with DHCF, DC Health, and the Deputy Mayors for Planning and Economic Development and Health and Human Services, has lead a transparent and deliberative process to lay the groundwork for establishing a comprehensive healthcare system east of the Anacostia River that is anchored by a new, acute care community hospital. In support of this planning, Mayor Bowser's FY19 budget included a detailed five-year plan to fund, construct, and deliver a new, centrally located, state-of-the-art, medical center in Ward 8 by 2023. Our comprehensive plan calls for a new hospital, ambulatory care center, retail services, parking, medical office space, and community partnerships that will establish a system of care and continue the progress we have made redeveloping the Saint Elizabeth's campus.

In support of this plan, we successfully identified a regional partner -- not a standalone hospital -- who is willing to take on the risk of running a hospital in a historically underserved area with patients who rely mostly on public health insurance. This was a significant achievement, and the Mayor's commitment remains clear. The premise of this project is that government should not be in the business of operating a hospital. This is not one of our core competencies, and the

operation of a hospital can be more expertly managed through a partnership with those proficient in hospital management, like our current partner, George Washington University (GWU) Hospital.

We are, of course, aware that the changes made to your *East End Health Equity Act*, have slowed ongoing negotiations. To that end, the City Administrator is working toward a path forward with both GWU Hospital and Howard to determine if there is a reasonable path to success under the conditions put forward in the legislation. If there is not, we will determine whether we can successfully move forward with an individual party, or if we need another plan altogether. Our goal is to move forward with a contract that we can present to the Council later this year, allowing this critically important project to break ground.

Mr. Chairman, this concludes my testimony for today. Thank you for the opportunity to testify before you today. I am happy to answer any questions and the Committee may have.