DC VALUES IN ACTION - A ROADMAP TO INCLUSIVE PROSPERITY

DHCF Annual Budget Presentation For FY2018

Presentation for:

Medical Care Advisory Committee (MCAC)

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April 26, 2017

Washington DC

Department of Health Care Finance

Presentation Outline

- ☑ **Overview Of District's Budget For FY2018**
- ☐ Budget Development For DHCF
- ☐ Medicaid And Alliance Enrollment Trends
- ☐ Status Of Automated Medicaid Eligibility System
- ☐ Medicaid Managed Care Program Trends
- ☐ Medicaid Fee-For-Service Access And Expenditure Patterns
- ☐ Medicaid Long-Term Care Expenditure Patterns
- ☐ Next Steps With United Medical Center
- ☐ Conclusion

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Our Approach

- **Engage with the public** and solicit their input about community priorities
- Invest in making the District **more affordable**
- Invest in **public safety**, including attracting and retaining police officers
- Enact the **middle class tax reductions**

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Budget Process

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Mayor's Proposed Budget For DHCF

FY17 Budget $705,605,632

FY18 Current Service Funding Level $722,470,828

The CSFL increased by 2.4% from FY17

- Fringe benefit rate reduction of ($8,741)
- $708,379 increase in Consumer Price Index
- ($88,093) decrease in Fixed Cost Inflation
- $15,323,651 increase in Medicaid provider payments
- $930,000 increase in Operating Impact of Capital

FY18 Budget Adjustments -$8,401,128

The net effect of several changes

- ($25,423,341) reduction for provider payment savings (breakout on slide 7)
- $1,874,645 PS costs in excess of CSFL adjustments
- $1,614,064 Fixed Cost and Contract estimates in excess of CSFL adjustments
- $13,533,505 for a forecast revision for the Fee for Service (FFS) provider types – this was a Technical Adjustment

FY18 DHCF Local Proposed Budget
$ 714,069,700

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DHCF's FY2018 Proposed Strategies And Savings

$14.4 mil	• **DSH Payments:** Lowered estimate of Hospitals' allowable DSH costs
$6.9 mil	**Nursing Facilities:** Savings from starting a new methodology for calculating rates at the start of CY2018
$1.6 mil	**Fund Shift:** Shift of eligible operating costs to the Healthy DC Fund
$1.6 mil	• **Enrollment:** Public Assistance Reporting Information System (PARIS) match savings. Removal of Medicaid beneficiaries who are no longer residents of the District
$0.9 mil	• **Capture Living Wage Savings:** Lowered estimate of PCA living wage adjustment impact
$25.4 million	

Budget Request For Medicaid Mandatory Services

(in Millions) Medicaid Mandatory Service	FY16 Expenditures	FY17 Budgeted Amount	FY18 Budget Request
Inpatient Hospital	247.79	250.78	210.29
Nursing Facilities	233.91	280.89	275.48
Physician Services	39.25	39.46	39.79
Outpatient Hospital, Supplemental & Emergency	60.87	65.12	43.74
Durable Medical Equip (including prosthetics, orthotics, and supplies)	26.36	31.36	24.77
Non-Emergency Transportation	22.36	26.16	30.07
Federally Qualified Health Centers	44.03	55.71	54.13
Lab & X-Ray	22.32	13.18	26.24

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Budget Request For Medicaid Optional Services

(in Millions) Medicaid Optional Services	FY16 Expenditures	FY17 Budgeted Amount	FY18 Budget Request
Managed Care Services	1,105.90	1,215.96	1,283.23
DD Waiver (all FY 2016-18includes intra-district funds)	203.09	207.46	208.31
Personal Care Aide	190.92	195.60	196.53
EPD Waiver	42.82	75.18	48.78
Pharmacy (net of rebates)	44.84	28.77	62.43
Mental Health (includes DBH intra-district for MHRS)	100.82	89.60	85.46
Day Treatment / Adult Day Health	4.69	13.27	5.95
Home Health	8.07	18.39	16.01

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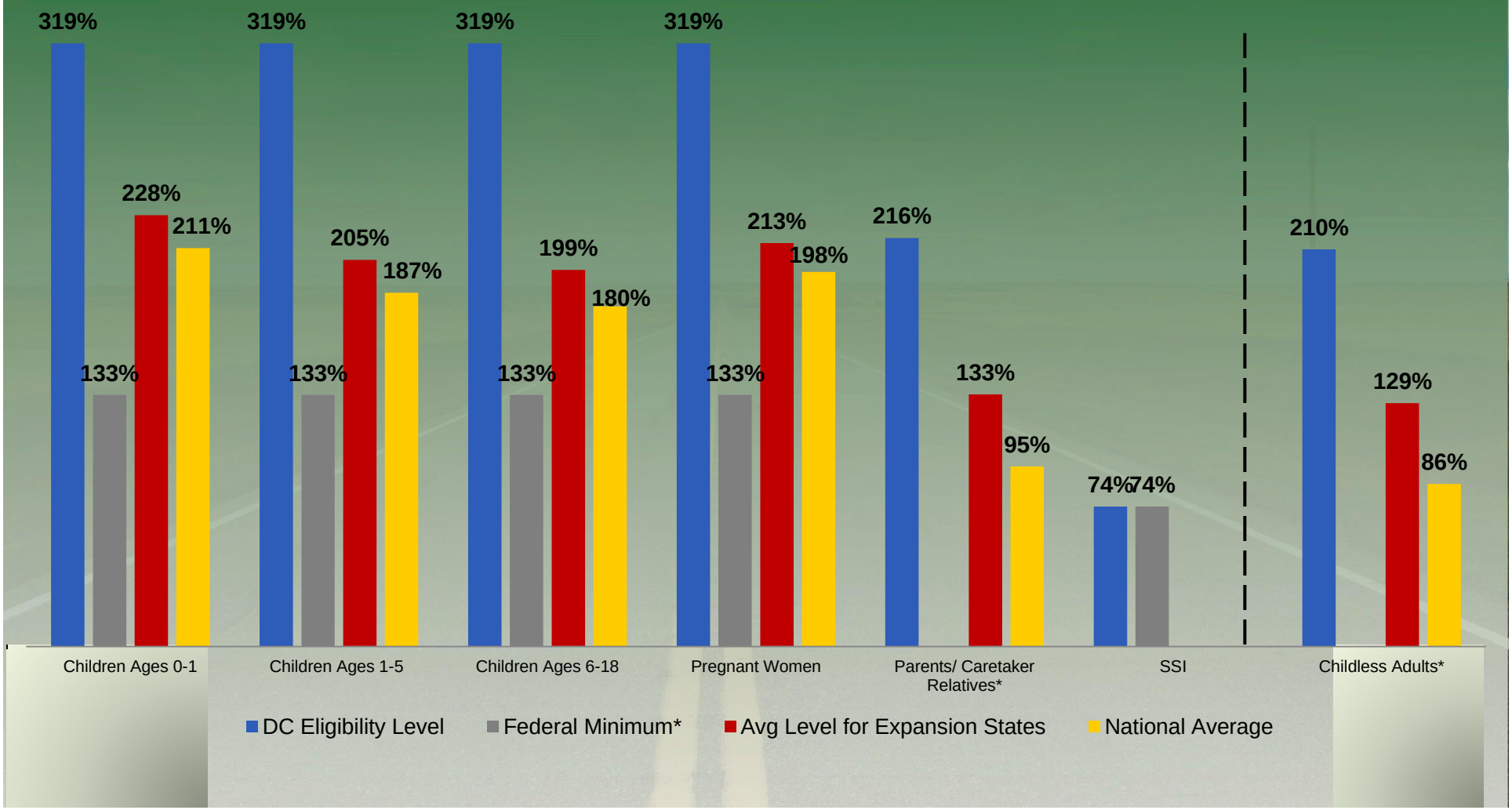
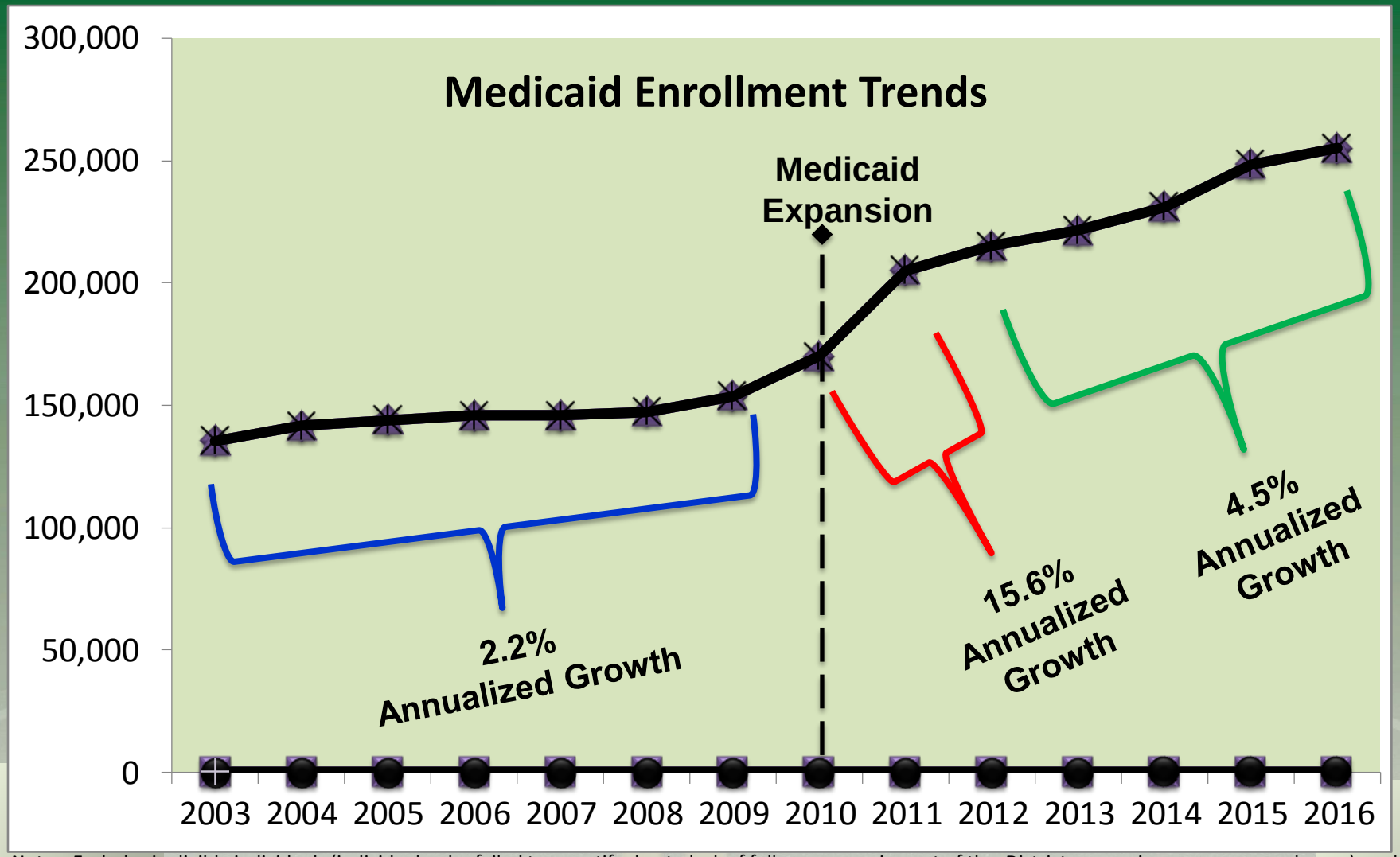
The District's Eligibility Levels Exceed Federal Requirements And Statewide Averages



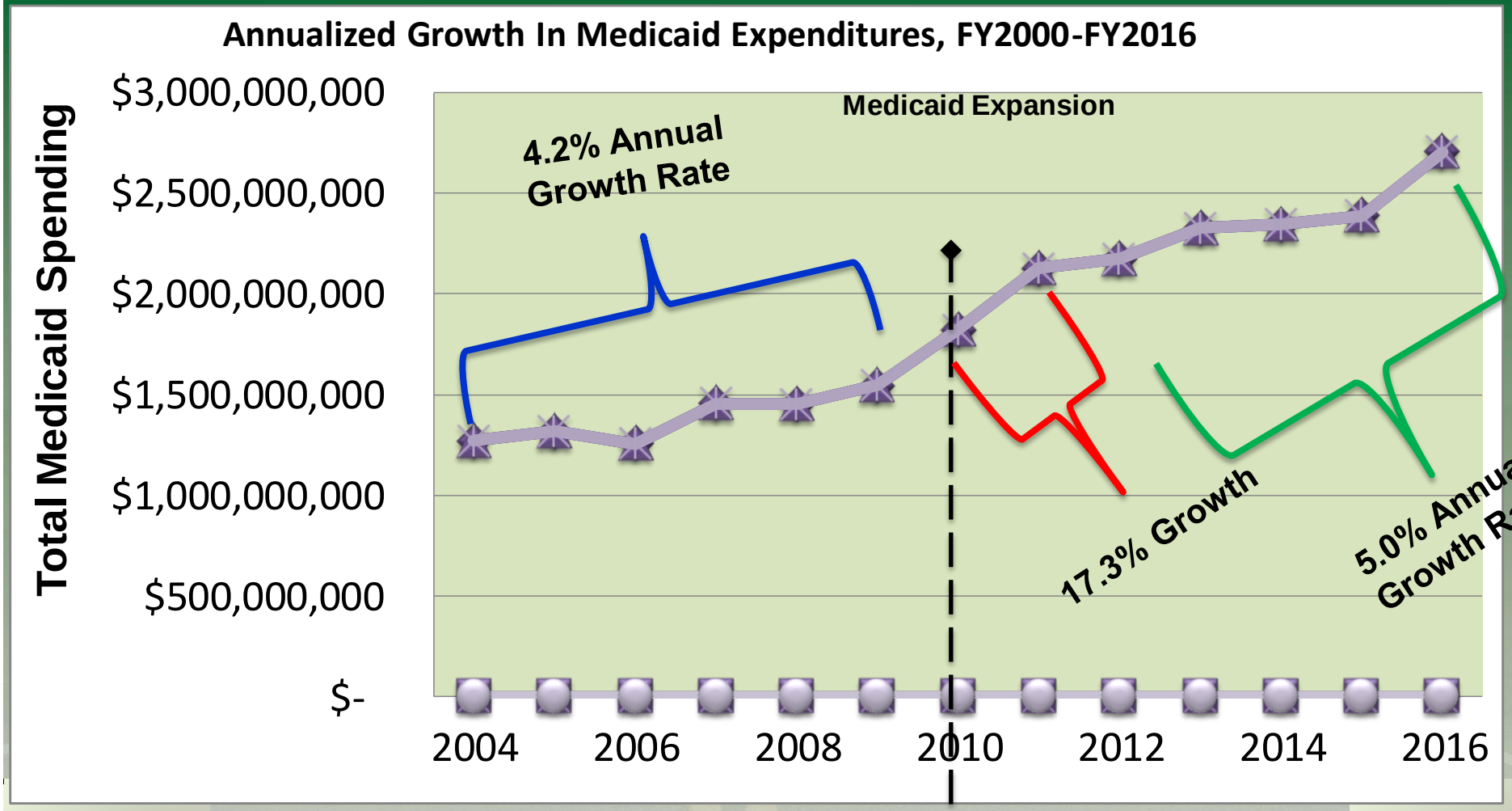
Six Years Since ACA Was Medicaid Enrollment Growth Is More Than Double Pre-ACA Levels



Notes: Excludes ineligible individuals (individuals who failed to recertify due to lack of follow-up, moving out of the District, excess income, or passed away), and those in the Alliance and Immigrant Children programs.

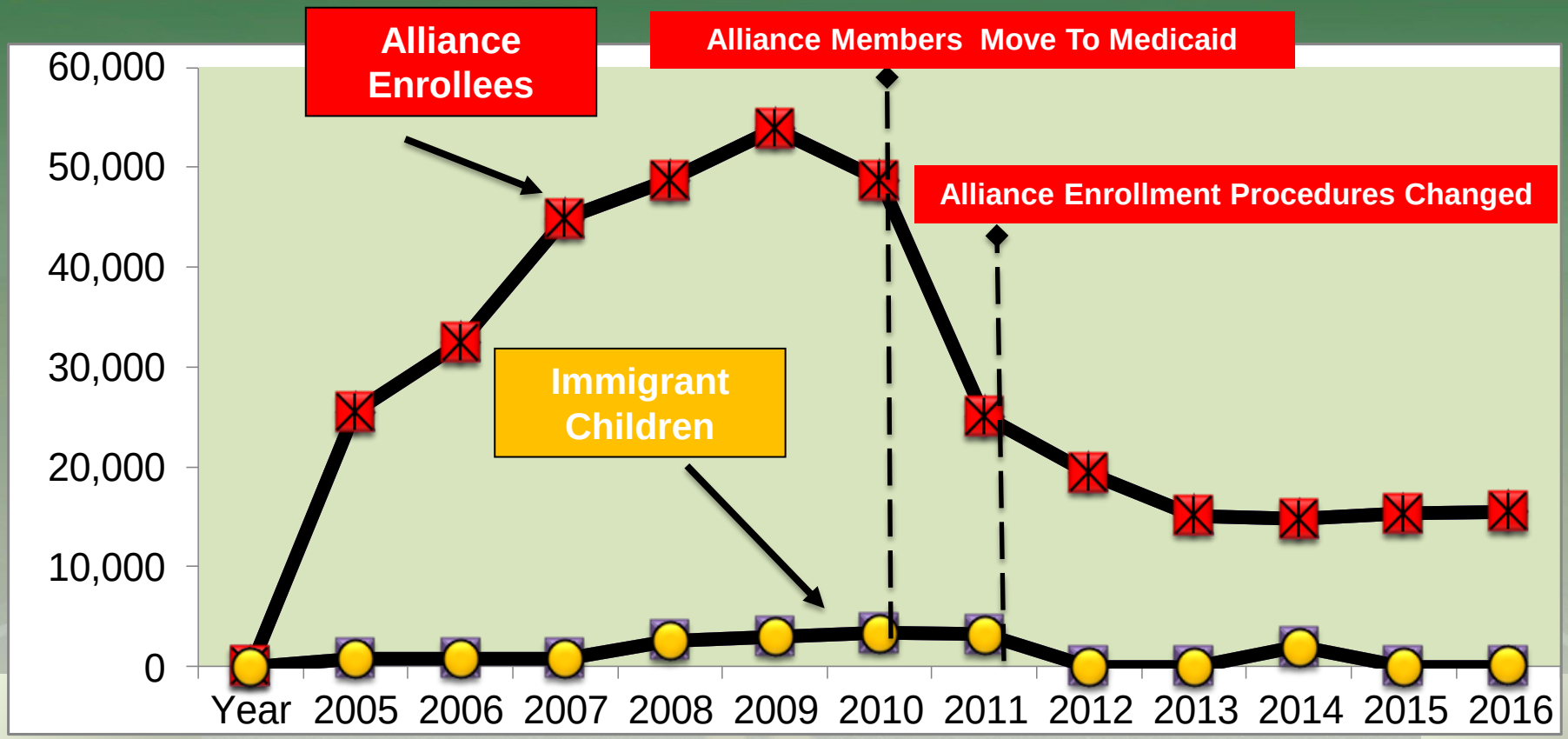
Source: Data for 2000-2009 data was extracted by Xerox from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports.

Medicaid Cost Trends Track Enrollment Growth Trends



Source: FY08-FY11 totals extracted from Cognos by fiscal year (October, 1 through September, 30), using variable Clm Hdr Tot Pd Amt (total provider reimbursement for claim). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance Line of Business or Immigrant Children's group program code. Only includes claims adjudicated through MMIS; excludes expenditures paid outside of MMIS (e.g. pharmacy rebates, Medicare Premiums).

Enrollment Trends For Alliance Adult Population Continue To Moderate



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The Development of DCAS Is Organized In Three Separate Releases

Release 1

***BENEFIT PROGRAMS**:

Assisted Insurance:

MAGI Medicaid

QHP (Premium Tax Credits)

Unassisted Insurance:

SHOP

Individual Market

SOFTWARE PRODUCT:

HCR Caseworker Portal

HCR Citizen Portal

Release 2

***BENEFIT PROGRAMS**:

Food Benefits:

SNAP; ESNAP; TSNAP; DSNAP

Energy Assistance:

LIHEAP

Cash Benefits:

TANF; POWER; GC; IDA; RCA; Burial Assistance.

SOFTWARE PRODUCT:

CGISS Caseworker Portal

Release 3

***BENEFIT PROGRAMS**:

Medical:

Non-MAGI Medicaid

Alliance

Immigrant Children's Program

Family Services Programs:

Homeless Services Program Management, and other human service benefits

Economic Services Programs:

SNAP & TANF Enhancements

SOFTWARE PRODUCT:

CGISS Caseworker Portal

CGISS Citizen Portal

HCR Caseworker Portal

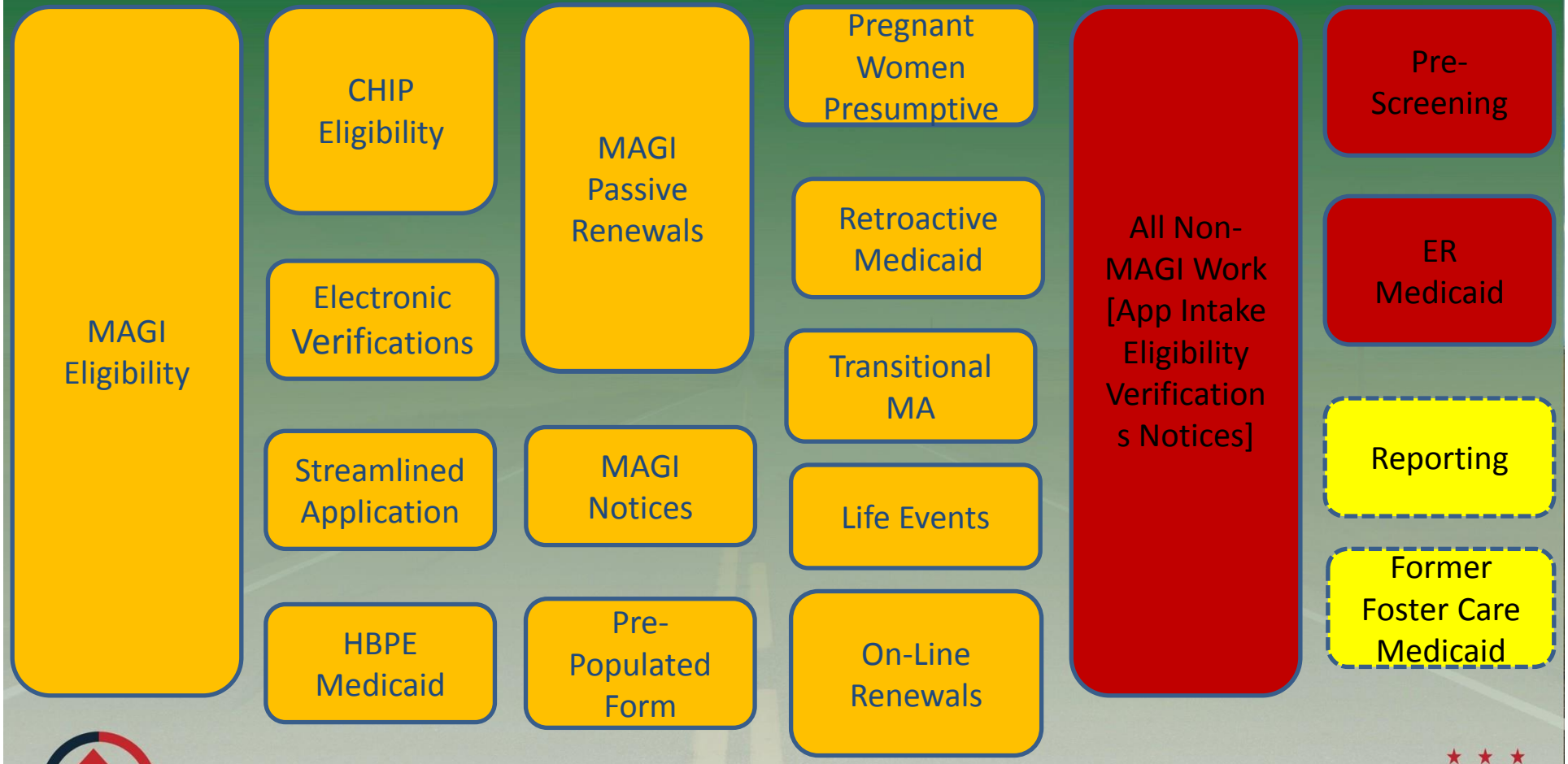
HCR Citizen Portal

DCAS currently implements two "Modules" of the IBM/Cúram product:

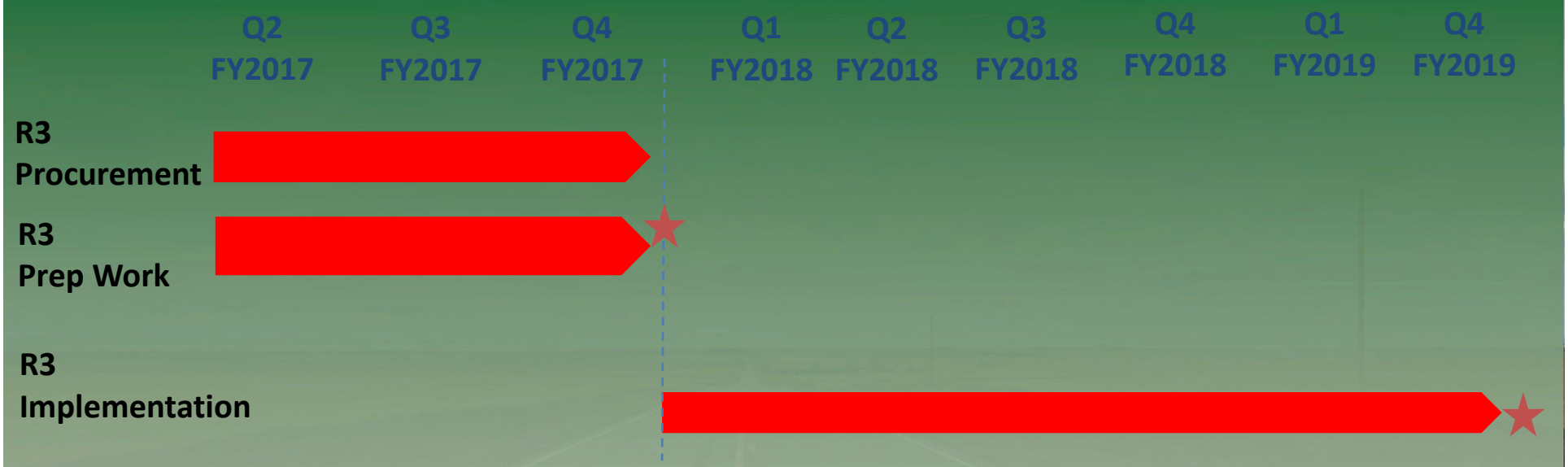
1. Health Care Reform (HCR) Module – including HCR Case Worker and HCR Citizen Portal.
2. Cúram Global Income Support Suite (CGISS) Module - Case Worker Portal

R3 will be implemented in CGISS Case Worker Portal, and launch the CGISS Citizen Portal.

Most Of The Phase 1 Defects For Medicaid Eligibility Processing Have Been Addressed But More Work Is Needed In Releases 3



R3 Timelines & Budget



R3 Projected Budget			
FY17 Total Cost	FY18 Total Cost	FY19 Total Cost	Total
$41,049,590	$71,419,390	$31,283,103	$143,752,083

Release 3 scope is defined by the critical system capabilities and organizational change required to fully operationalize applications, infrastructure, and operations needed to retire ACEDS and other legacy systems to consolidate R3 programs in-scope into DCAS. These system integration projects, business and technical requirements were included in the R3 Request for Proposals (RFP). Programs in scope for R3 are: Non-MAGI Medicaid and Human Services programs.

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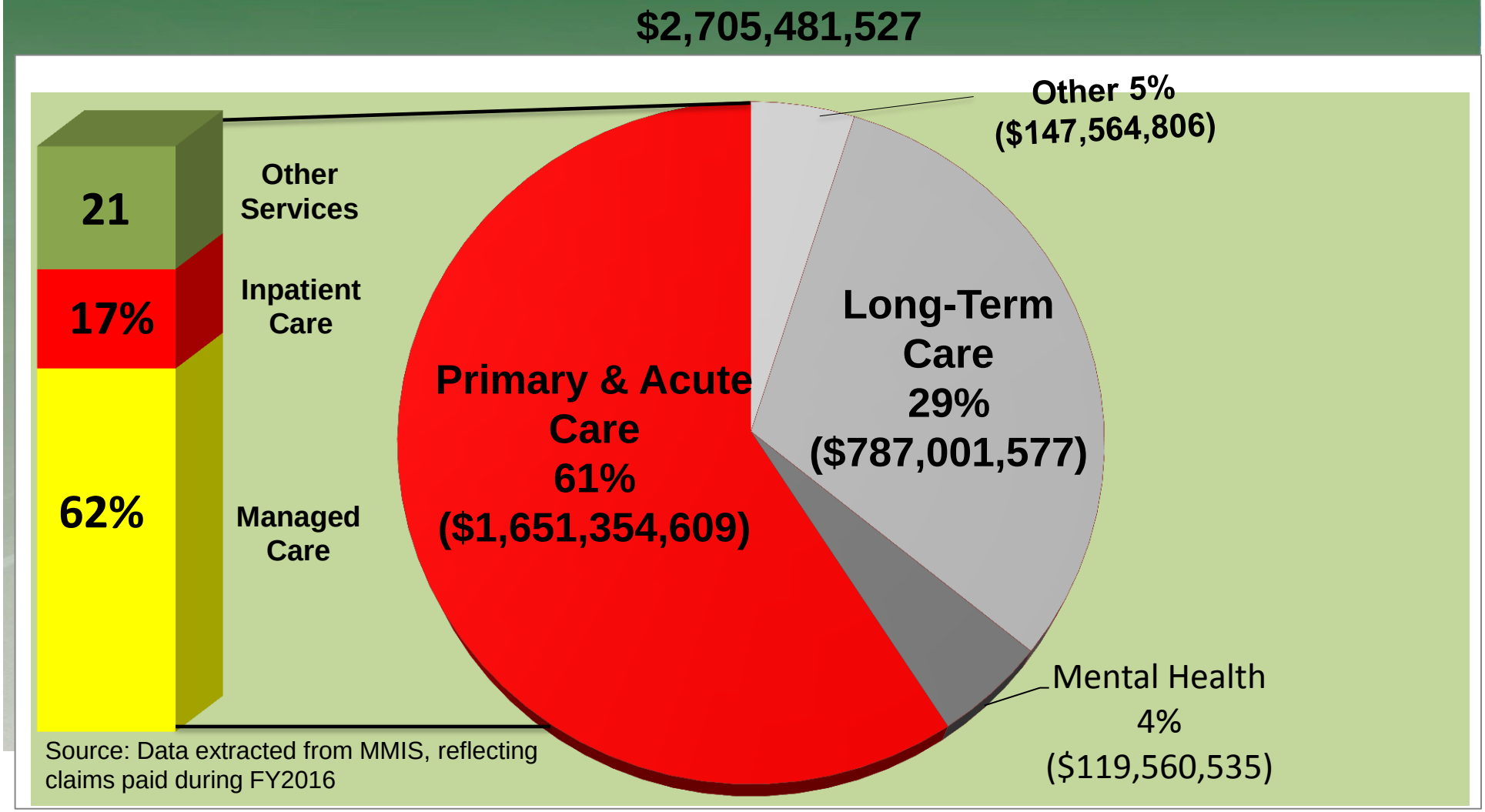
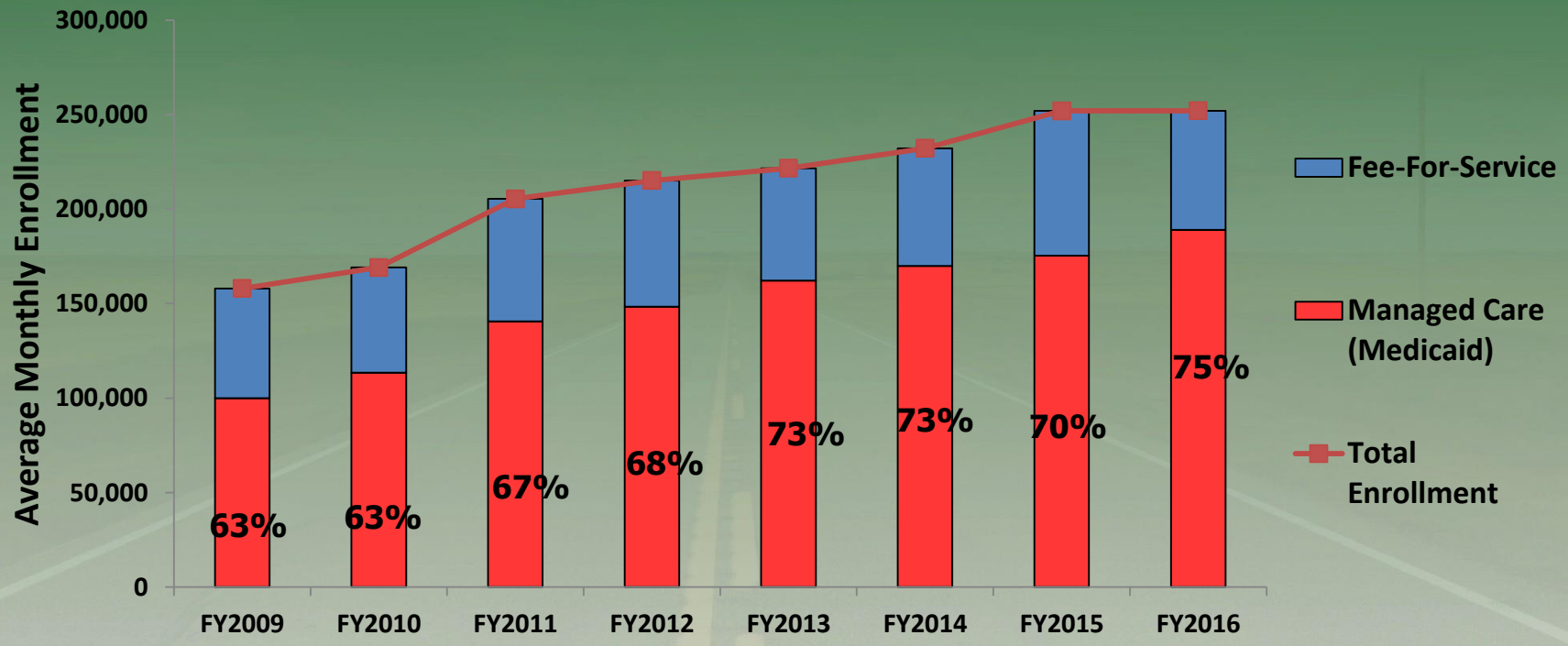
Acute Care Cost Drive Overall Medicaid Spending



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

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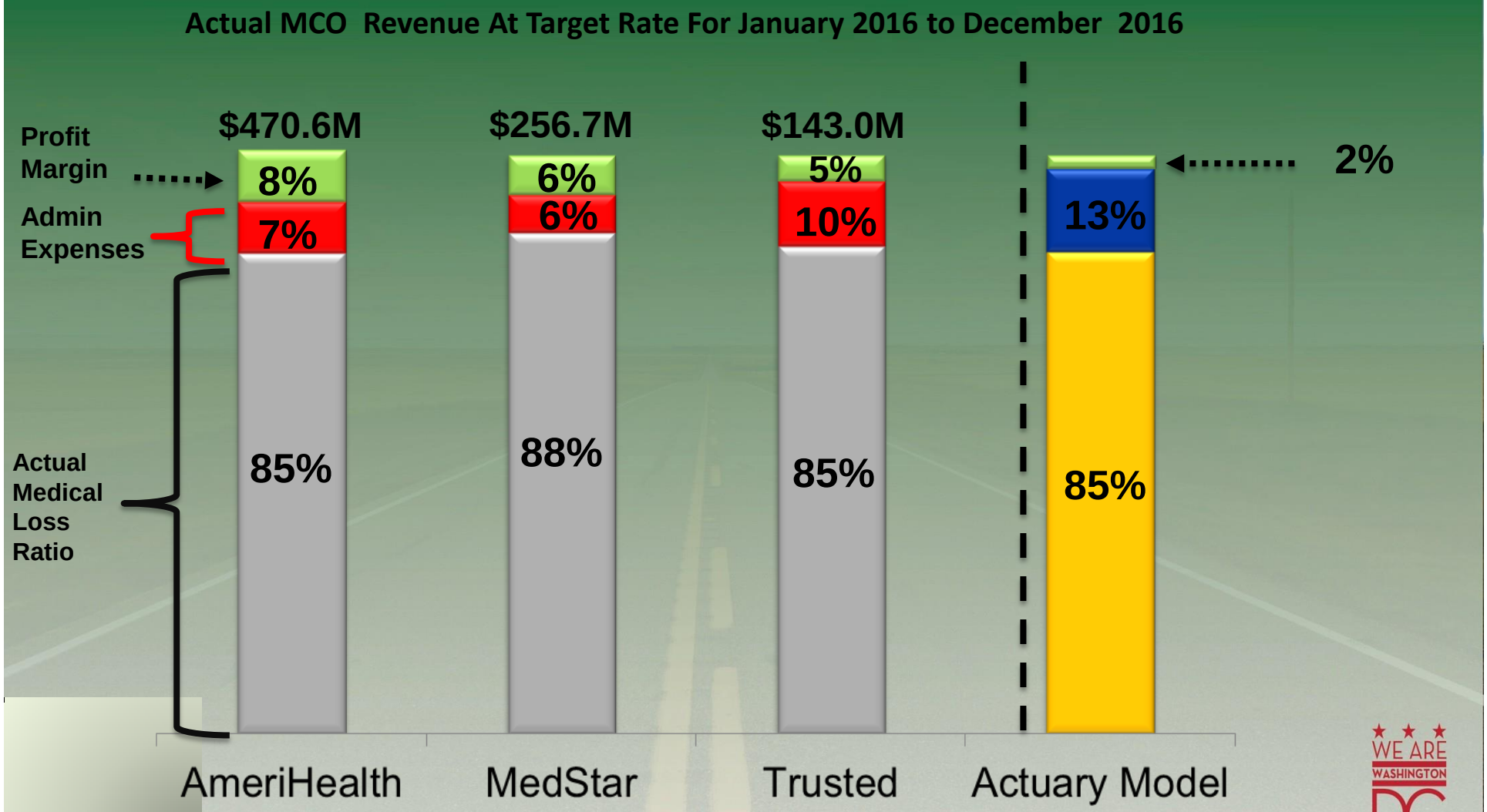
Each Of The Full Risk Plans Spend A Least 85 Percent Of Revenue On Member Medical Expenses With All Three Plans Posted An End-of-Year Profit



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

Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Quarterly statements for shared risk plan, HSCSN

DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The Health Plans To Coordinate Enrollee Care

- Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program.
- The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management.
- After reviewing several years worth of data, DHCF can now more closely examine the following performance indicators for each of the District's three health plans:
  - Emergency room utilization for non-emergency conditions
  - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
  - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days -- hospitalization

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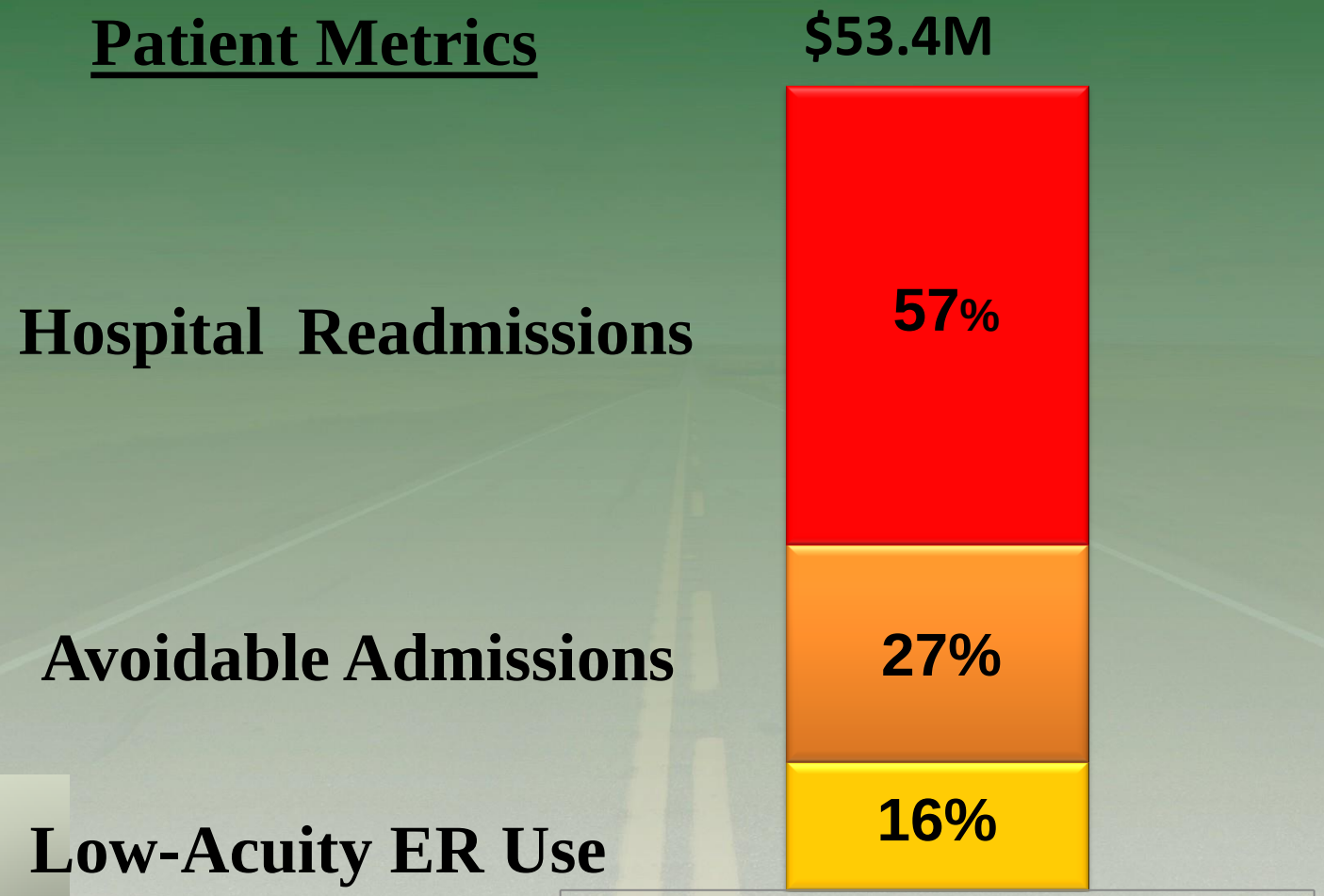
More Than $53 Million In Managed Care Expenses -- 6% of Plan Revenue -- in 2016 Were Potentially Avoidable

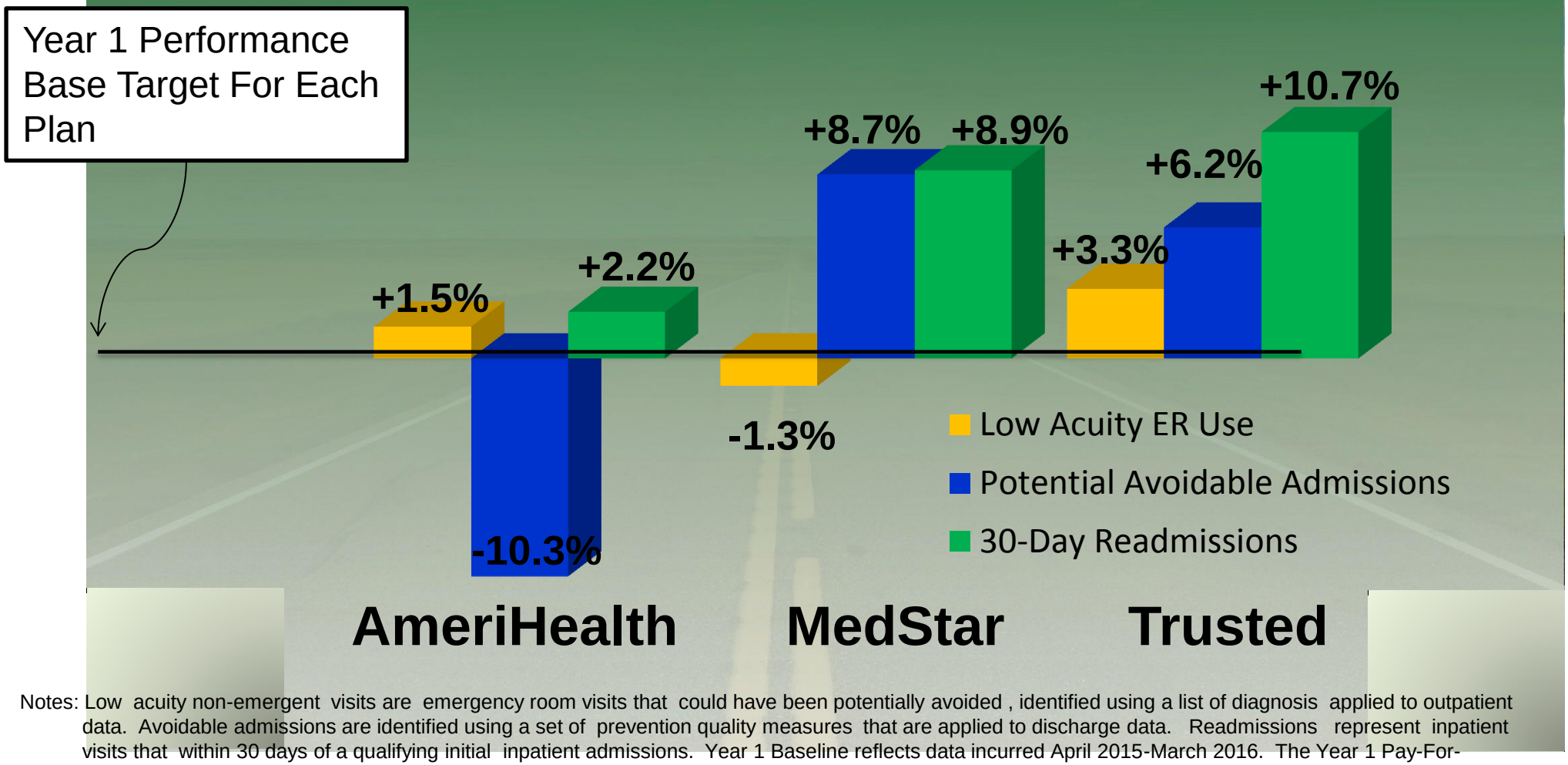


Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided , identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that within 30 days of a qualifying initial inpatient admissions.

Source: Mercer analysis of MCO Encounter data reported by the health plans to DHCF.

Had The MCO Pay-For-Performance Program Been In Place In FY2016, Only Trusted Would Have Shown Improvement From Its Baseline Targets On All Three Measures

Comparison of FY2016 Results To Year One Baseline Performance Metrics



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Source: Mercer analysis of MCO Encounter data reported by the health plans to DHCF.

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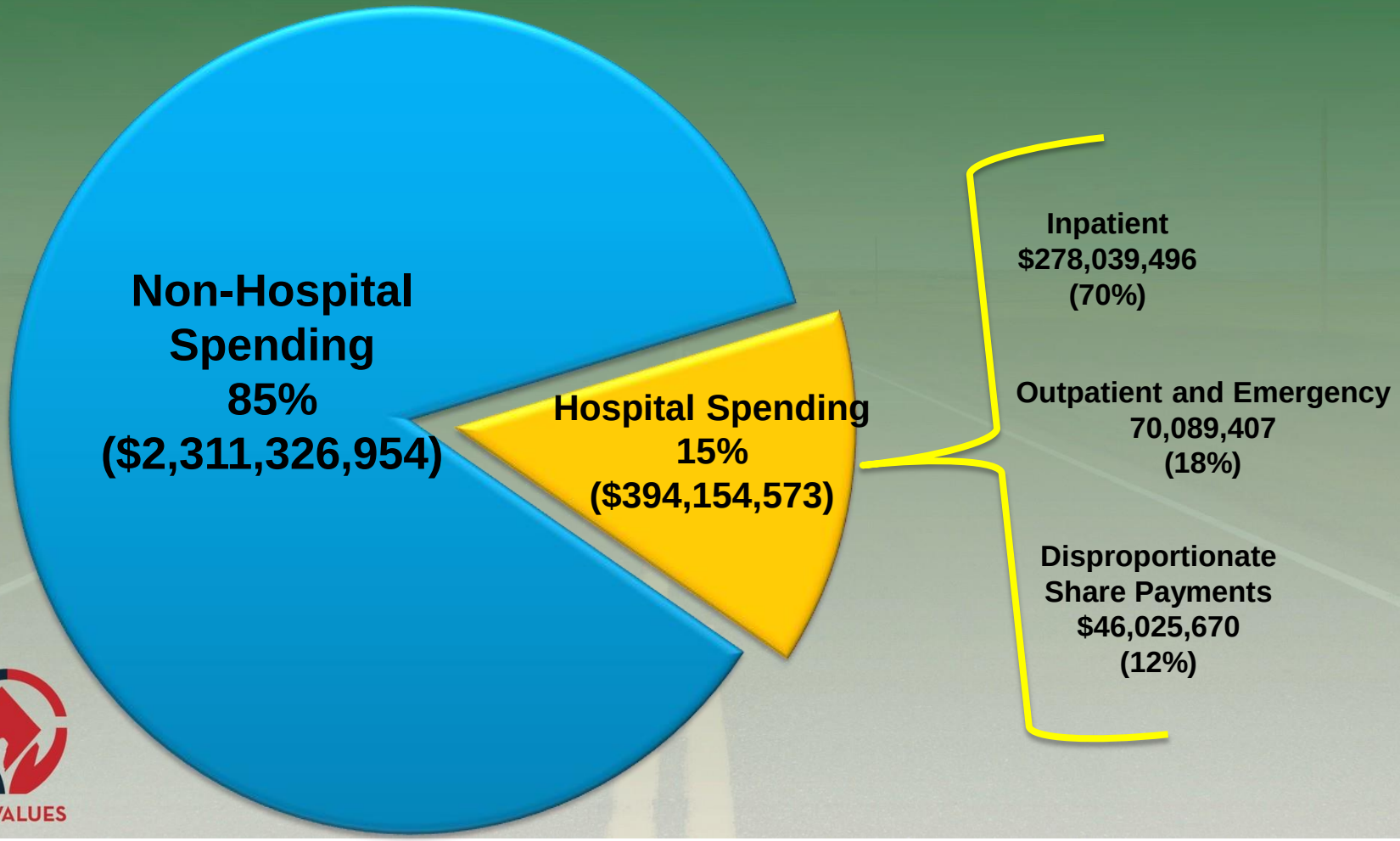
Fee-For-Service Medicaid Hospital Spending Is 15 Percent Of Total Medicaid Expenditures

A Comparison Of Hospital To Non-Hospital Medicaid Spending

$2,705,481,527



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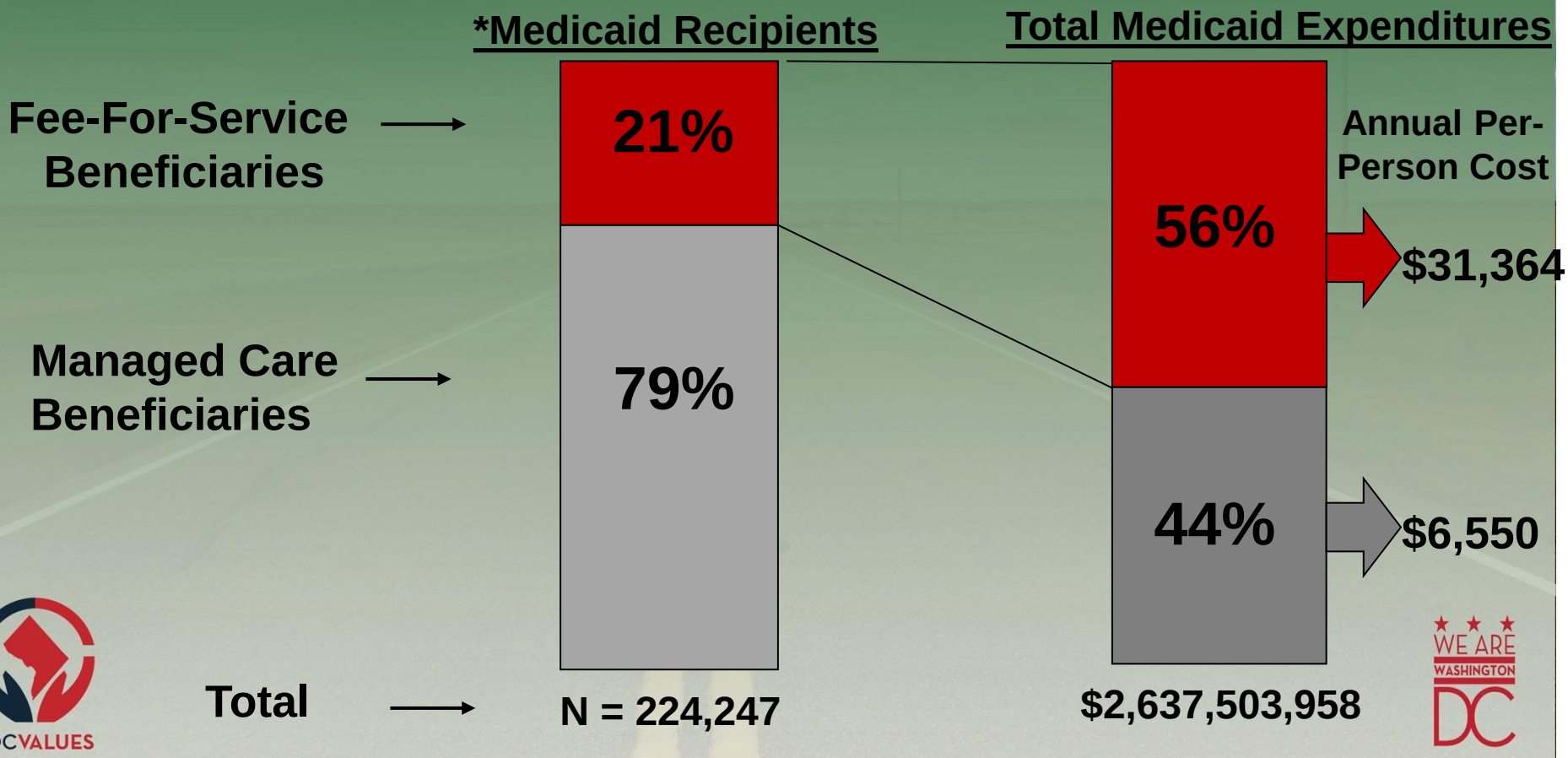
Source: Data extracted from MMIS reflect final claims, including adjustments, and DSH payments made during FY16

Fee-For-Service Recipients Are Responsible For A Disproportionate Share of Medicaid Expenditures

A Comparison Of Medicaid Spending For Fee-For-Service And Managed Care Beneficiaries



Source: Data from DHCF MMIS system. *Only persons with 12 months of continuous eligibility in 2016 are included in this analysis

My Health GPS Program Will Help High-Need Beneficiaries Navigate the Health System

- Intervention:
  - Robust care coordination for beneficiaries with 3+ chronic conditions
  - Monthly payment to integrate and coordinate *all* health-related services
  - As of FY19, pay for performance holds providers accountable to meet program goals
- Program Goals:
  - Increase health quality and outcomes
  - Reduce preventable utilization of 911/FEMS
  - Reduce avoidable hospital admissions
  - Reduce emergency department services
- Design: Interdisciplinary teams in primary care settings
- Target Population: ~25,000 beneficiaries by FY2020
- Start Date: July 1, 2017

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

Characteristic	"My Health GPS Eligible Population	All Other Non-Waiver And Non-Institutional 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.

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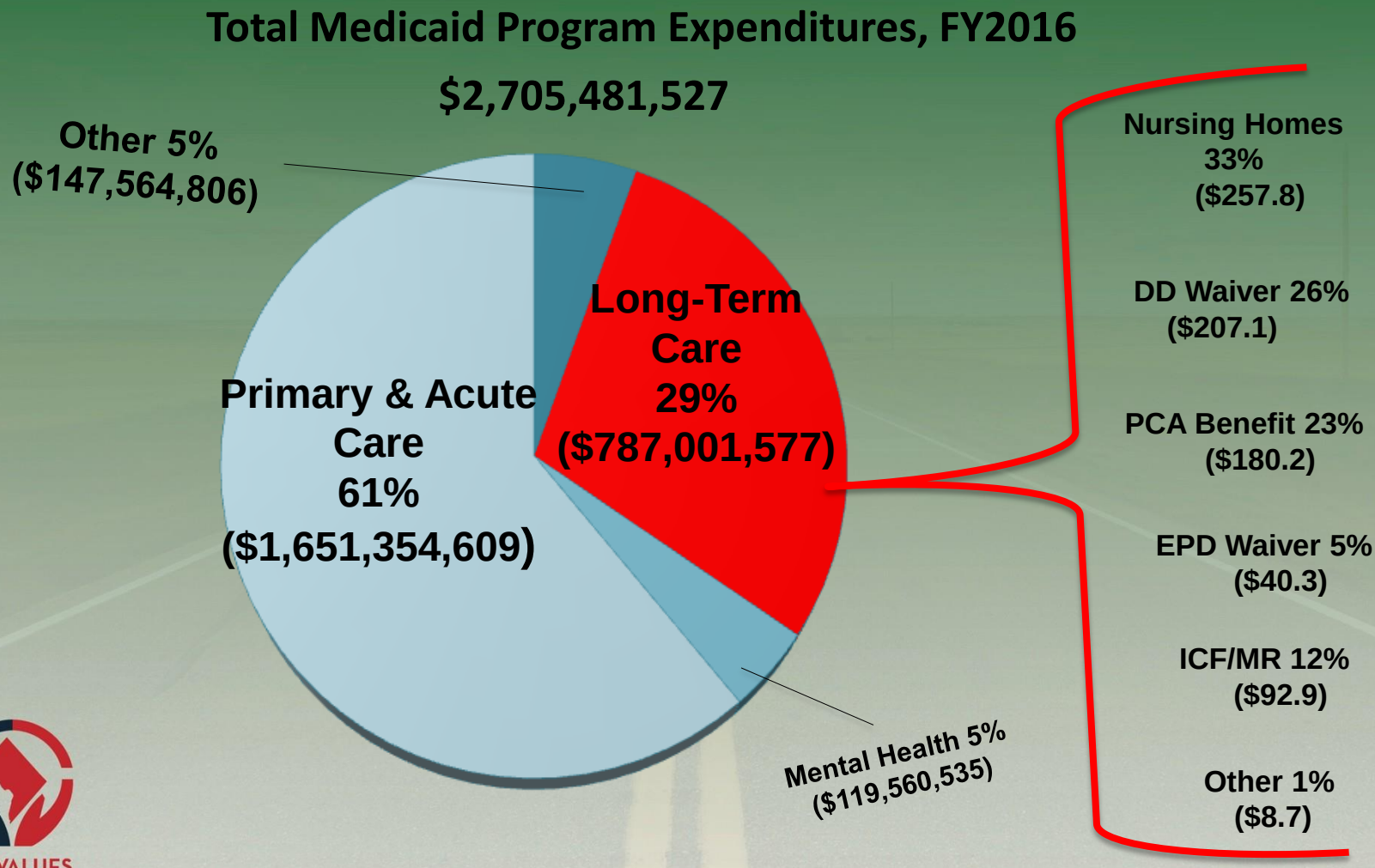
Almost Three In Every 10 Medicaid Dollars Is Spent On Long-Term Care Services



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Source: Data extracted from MMIS, reflecting claims paid during FY2016

Though High, Waiver Program Costs Compare Favorably To Institutional Spending FY2016 Numbers

Medicaid Institutional And Waiver Spending

Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
DD Waiver*	1,753	$207,144,674	$118,166
ICF/DD	337	$92,906,449	$275,687
EPD Waiver	2,788	$40,308,308	$14,458
State Plan Personal Care	5,372	$180,209,292	$33,546
Nursing Facilities	3,698	$257,771,222	$69,706

Source: Data extracted from MMIS, reflecting claims paid during FY2016

Elderly and Persons with Disabilities Waiver Improvements

- Effective April 4, 2017, the EPD Waiver was renewed for an additional five years.
- Improvements include:
  - A streamlined recertification process that will make it easier for enrollees to stay connected to services
  - Community Transition Services to pay set up expenses for individuals transitioning from nursing facilities to the community
  - Strengthened training requirements and alternative sanctions for providers
  - Increased payment rate for Assisted Living

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Key Facts About United Medical Center (UMC)

- UMC is a Level II hospital:
  - Was purchased at an auction by the District in 2010 through the forgiving of Specialty Hospital's $20 million debt to the District – loan was in default
  - Contains 254 acute care beds and 120 skilled nursing beds in a 50-year old building that has high maintenance needs
  - Primary Service Areas are Ward 7 and Ward 8 with secondary market in Maryland – competes mostly with MedStar for its patients
  - Is a stand alone hospital with no link to ambulatory care centers in the Primary Service Area

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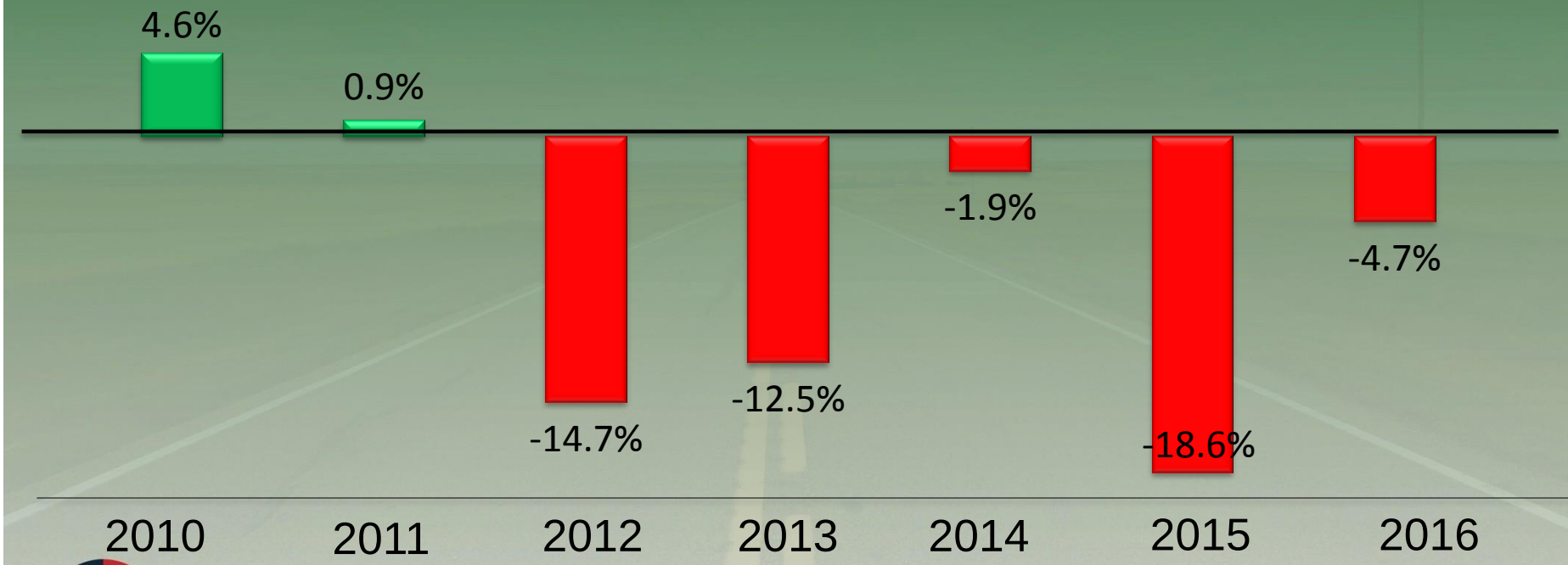
The Operational And Fiscal Challenges Are Reflected In The Worsening Operating Margins For United Medical Center

United Medical Center Operating Margins, 2010-2016



Note: Operating margin is a measure of profitability calculated by dividing net operating income by operating revenue. Thus, this measure indicates how much each dollar of operating revenue remains after operating expenses are considered. A negative operating margin for UMC of 18 percent in 2015 for example, means that for every dollar of revenue the hospital collected that year, it lost 18 cents.

Source: United Medical Center Not-For-Profit Hospital Corporation Audited Financial Statements, 2010-2016.

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As A Result Most Medicaid Spending On Secondary And Tertiary Care For Residents In Wards 7 & 8 Escapes UMC

80.2% To Providers In Other Wards ($484.4M)

$604 Million Medicaid & Alliance Health Care Revenue Stream

19.8% To UMC Hospital ($119.9M)

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Note: Medicaid and Alliance spending are included in these totals and they reflects payments made to providers in FY2016 for managed care and fee-for-service members for inpatient, outpatient, and non-primary care physician services.

Source: Medicaid Management Information System (MMIS) United Medical Center Not-For-Profit Hospital Corporation Audited Financial Statements, 2010-2016.

Bowser Administration Goals For UMC

- The Bowser Administration has four broad goals for UMC

1. Stabilize operations and end annual financial losses
2. Limit non-portable capital investments to those required to ensure public safety and meet code requirements
3. Pursue a partnership model that offers the promise that UMC will operate without District government intervention and free from public subsidy
4. Explore potential sites for a replacement hospital for UMC and initiate a multi-million capital funding request towards the construction of a new hospital

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DHCF Released A RFP in February To Procure The Services Of A Health Care Consultant To Inform Planning For A Replacement Hospital – Bids Are In

- Focus of project to include –
  - Analysis of changes in healthcare policy -- reimbursement, technology, new approaches to health care delivery -- and how these changes are likely to impact future inpatient admission rates, average lengths of stay, use of outpatient care, and emergency room visits in the District of Columbia;
  - A market analysis on inpatient and outpatient trends for other health care systems in the District of Columbia to inform recommendations regarding the most appropriate hospital design for a replacement hospital in Wards 7 and 8;
  - The range of financing options available to the District of Columbia; and
  - An assessment of the possibility of viable partnership arrangements for the District, along with an analysis of the various management archetypes for a new hospital which ultimately removes the District from its current role of hospital operator.
  - Report should be completed by September of 2017

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Conclusion

- Due to the aggressive eligibility levels funded in Mayor Bower's proposed budget for Medicaid and the Alliance program, DHCF provides health coverage to 4 in 10 District residents, with persistent growth in Medicaid enrollment, especially among childless adults with incomes between 133% and 210% of federal poverty levels

- However, concern remains that these eligibility gains could be threatened by possible shifts in health care policy at the national level. Although ACA repeal legislation appears less likely at this time, Medicaid is still at risk for reforms and funding cuts, including threats to children's health insurance

- Programmatically, the Mayor's budget supports fully funded contracts for the District's Medicaid managed care plans – health plans that are now required to meet specific performance metrics on three key indicators designed to measure improvement in patient outcomes

Conclusions (continued)

- Similarly, the Mayor's budget adequately funds DHCF's fee-for-service program which serves Medicaid's most fragile and highest cost beneficiaries
- In FY2018, DHCF will offer a new program -- My Health GPS -- that is designed to empower providers to implement strategies that improve care and patient outcomes for beneficiaries who are chronically ill
- This program will be implemented concomitant with DHCF efforts to improve long term care services and supports through the EPD Waiver renewal
- Finally, Mayor Bowser's capital budget makes a down payment on her plans to construct a new hospital as a part of strategy to establish a first rate integrated health care system for the residents of Wards 7 and 8.