

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance



**Testimony of
Wayne Turnage
Director
Department of Health Care Finance**

Before the

Council of the District of Columbia

Committee on Health

Yvette Alexander, Chairwoman

Fiscal Year 2014 Budget Hearing

Thursday, April 11, 2013

10:00 AM

**John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, DC 20004**

Good morning Madam Chairwoman and members of the Committee. It is my pleasure to provide testimony on the Mayor's FY 2014 Budget and confidently share that the proposal fully addresses the needs of the Department of Health Care Finance (DHCF). To support the continued growth of the District of Columbia, Mayor Gray's FY 2014 Budget submission focuses on three priorities: (1) growing and diversifying the economy; (2) educating our children and preparing our workforce for a new economy; and (3) improving the quality of life for all residents.

The mission of DHCF is to improve patient health outcomes by providing access to a comprehensive range of services funded through the Medicaid and Alliance insurance programs. Historically, the District of Columbia has been one of the nation's leaders in providing health care coverage to its low-income residents, effectively insuring nearly a third of all District citizens.

I am pleased to report that the budget proposed by Mayor Gray for FY2014 embraces this history by maintaining the District's high coverage levels without any reductions in the nature or scope of the benefits provided in either the Medicaid or Alliance programs. This is especially important as the country moves closer to the threshold goal of universal coverage in 2014 as embodied in the Affordable Care Act. While many States have been hesitant to expand their Medicaid programs in a way that ensures a seamless link with commercial

insurance programs under health care reform, Mayor Gray's budget guarantees that this important nexus will be pursued in the District for FY2014.

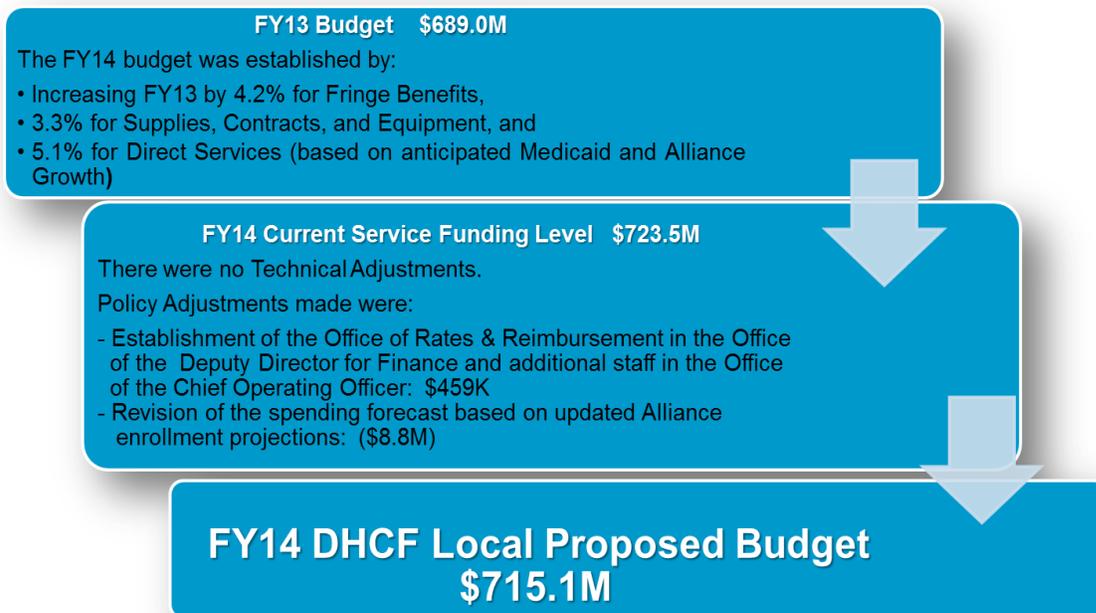
The Mayor's budget proposal for DHCF also includes the necessary funding to support increases in provider payment rates that are necessary to keep pace with the rising cost of health care. As with most Medicaid programs across the United States, provider payments are significant cost components in the program accounting for 96 percent of total spending in the District. Because of growing health care costs, Medicaid and Alliance provider payments cannot be allowed to remain static. Accordingly, when the underlying reimbursement rates are adjusted, these changes create significant spending pressures which must be accommodated in the budget development process.

My remarks today will describe how the agency's budget was formulated while outlining the key enhancements and supporting rationale for these proposed funding increases. In addition, I will discuss some of the spending trends for program areas that create significant cost in the Medicaid program and outline a few of the most important programmatic and fiscal challenges that we must address in FY2014.

Building DHCF's Proposed Agency Budget

Madam Chairwoman, the graphic on page 4 of my testimony illustrates the budget development process for DHCF. Under current practice, the Mayor relies

DHCF'S Budget Development Process



upon the present year's local fund budget of \$689 million to set the base funding level for FY2014. Next, this FY2013 budgeted amount was inflated for several factors to reflect the Current Services Funding Level (CSFL) for FY2014 of \$723.5 million. In essence, the CSFL reflects the cost of providing the same services in FY2014 that were funded in FY2013 before any policy enhancements or reductions are made.

The most significant increase from the FY2013 base budget was a 5.1 percent adjustment to fund direct health care services. In effect, this represents the combined effect of the anticipated growth in patient enrollment, utilization, and health care inflation. Adjustments for supplies, contracts, and equipment (3.3

percent) as well as increases for fringe benefits (4.2 percent) were also factored in the new CSFL.

Once the agency's CSFL was established, the Mayor made several important policy adjustments. First, he allocated \$459,000 to create an Office of Rates and Reimbursements. This office, operating under the auspices of the Deputy Director of Finance, will be fully responsible for designing, modifying and monitoring the agency's reimbursement methodologies for all providers, including our sister agencies.

Issues of payment design and provider reimbursement are some of the most critical policy decisions facing any Medicaid program. However, when the agency was created in 2008, the Office of Rates and Reimbursements was never fully developed under the Director's scope of authority and subsequently the policy attention dedicated to rate setting by DHCF program staff was inconsistent at best.

As a result, when Mayor Gray took office in 2011, his Administration inherited rate models that were, in some cases, outdated, poorly designed, and unnecessarily costly. This proposed Office will fund staff who will dedicate 100 percent of their time to designing, monitoring, and managing the multiple reimbursement systems in place for the Medicaid program.

The second adjustment was a revision to the spending forecast for the Alliance program. As the face-to-face eligibility certification process was

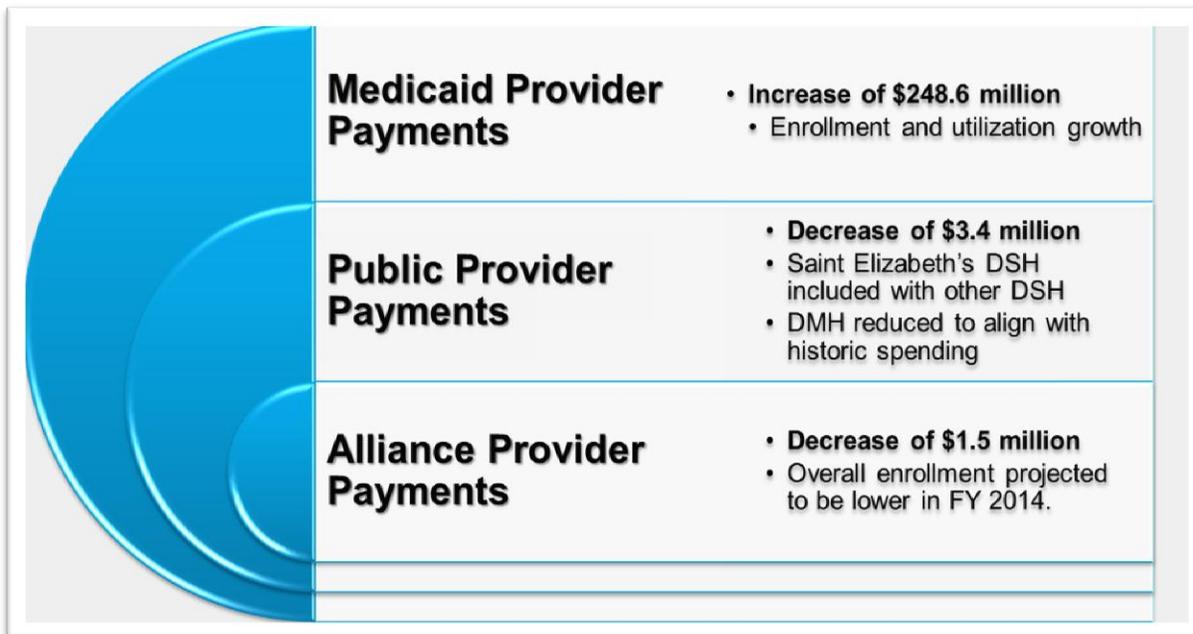
implemented, the enrollment projections for the Alliance program dropped precipitously. As later forecasts captured the continued declines, the enrollment projections along with the associated cost estimates for the program were appropriately revised downward.

When the combination of CSFL increases and program policy adjustments were fully accounted for, the local budget for DHCF was established at \$715.1 million. Once the federal share of Medicaid funds are considered with these local dollars, the total budget amount for DHCF in FY2014 exceeds \$2.7 billion.

As stated earlier, 96 percent of this \$2.7 billion budget is dedicated to provider payments. These payments are made to private, non-profit, and public providers for Medicaid and the Alliance programs. While proposed payments for FY2014 were reduced for Medicaid public providers (\$3.4 million) and the Alliance program (\$1.5 million), the anticipated growth in utilization and inflation for the Medicaid program required a proposed spending increase of nearly \$250 million for other non-public providers (see details on page 7).

The proposed increase in Medicaid payments of \$248.6 million warrant mention. Approximately 48 percent of this amount (\$121.1 million) represents payments from the federal government to cover 100 percent of the cost for persons who established eligibility for Medicaid through the program expansion that covered childless adults up to 133 percent of the federal poverty level. The federal

Provider Payments FY13 to FY14 Budget Comparison



government will pay 100 percent of the cost for some of this population for a three-year period beginning after January 1, 2014. Afterwards, the federal payments are ultimately reduced to cover 90 percent of the cost.

Just over 35 percent of the \$248.6 million reflects the budgeted amount to pay for provider rate increases, inflation, Medicaid enrollment, and the utilization of benefits. This is aptly described as the cost of doing business in the Medicaid program.

Finally, \$29.6 million of this amount (12 percent) is due to an increase in hospital outpatient supplemental payments funded through a provider tax. Hospital provider taxes are in use by virtually every State Medicaid agency in the country to help pay for the rising cost of health care services funded through the program.

The general concept is to fund a portion of Medicaid costs through a tax on health care provider revenue which is returned to the industry in the form of higher Medicaid payments. The Mayor submitted language to authorize a \$12.8 million provider tax which provides hospitals with over \$42 million in gross revenue - \$26 million net of the tax.

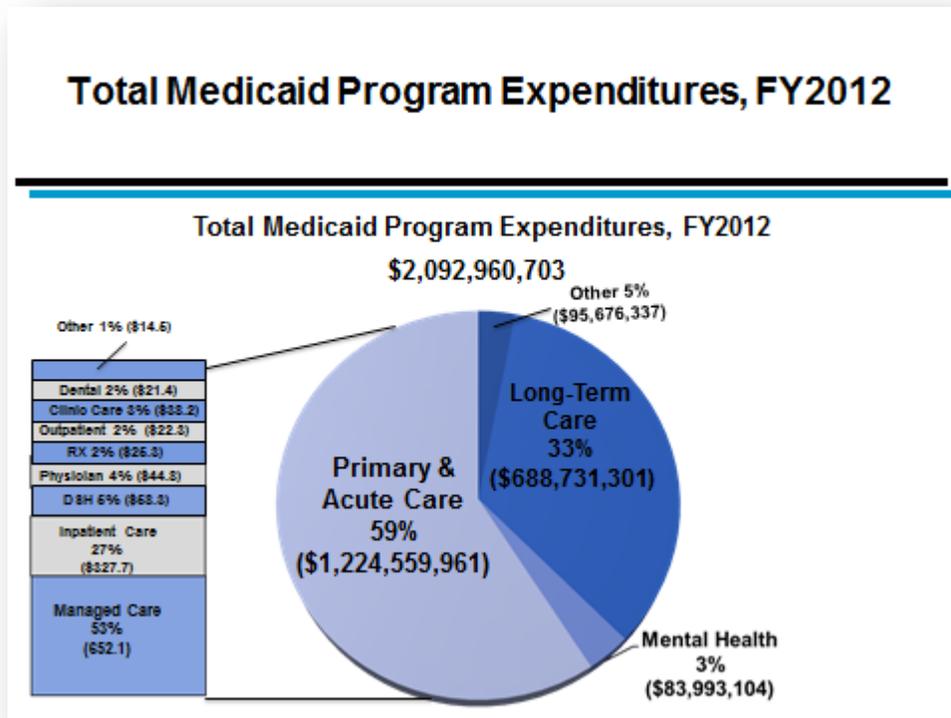
This strategy was pursued to mitigate the impact of the District's low payment rate for outpatient care. While the District's Medicaid program pays one of the highest inpatient reimbursement rates in the United States, for outpatient care, we pay hospitals, on average, about 47 percent of cost. The Mayor's proposed hospital provider tax meets federal requirements as to design and is beneath the taxable limit required to allow the District to return the revenue from the tax to the hospitals in the form of higher reimbursement rates.

The last item that I would like to discuss is actually an allocation to DHCF's Capital budget. The Mayor has proposed spending \$20 million in FY2014 for planning and site development work to ultimately reposition the United Medical Center on the parcel which it currently sits in Ward 8. This proposal builds on the two-year hospital turnaround project recently funded by the Mayor in FY2013 as a part of a larger effort to modernize the operations and management of the United Medical Center. Through the hospital turnaround project, Huron will conduct an analysis of the capital outflow that will likely be needed to construct a new facility

and present the Mayor with several options for both the development and financing of the project.

Key Medicaid Spending Trends and Budget Challenges

At this time Madam Chairwoman, I would like to discuss a few of the spending trends in the Medicaid program. As shown below, spending in the Medicaid program is organized across two major types of care: (1) primary and acute care services (\$1.2 billion); and (2) long term care (\$688.7 million). On the primary and acute care side, essentially 80 percent of all payments are made to the District’s managed care plans (53 percent) or directly to the hospitals for inpatient care provided to beneficiaries who are not enrolled in managed care (27 percent).



Medicaid funding for long-term care is allocated to providers who deliver services in either institutions or through community-based State Plan and waiver programs. The purpose of the waiver programs is to allow individuals who would normally require institutionalization due to their mental or physical disabilities, to receive care in the community. An important caveat to the use of community-based care is the federal requirement that the cost of these services, in the aggregate, must be less expensive than institutional care.

The table below presents details on the scope and cost of the District’s long-term care programs. As shown, while the waiver programs have high average per-participant cost, they are considerably less expensive than their institutional counterparts.

Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
DD Waiver*	1,591	\$148,853,889	\$93,560
ICF/DD	395	\$69,778,061	\$176,653
EPD Waiver	3,679	\$84,544,759	\$22,980
Nursing Facilities	3,724	\$216,988,015	\$58,268

Nevertheless, from a budget standpoint, because the base cost for key components of the District’s acute and long-term care services programs are so

large, we must carefully monitor the spending trends for the associated provider payments. Factors that drive even small percentage cost increases over these large funding bases can create significant budget challenges for the agency. The Table below compares the FY2013 budget amounts to the proposed budget in FY2014 for a few of Medicaid’s major provider groups. In many ways these numbers speak to both the value and challenge of the Medicaid program for DHCF and the District of Columbia.

Provider Type	FY 2013 Budget	FY 2014 Budget	% Growth
Managed Care	\$701.5	\$851.9	21.44%
Inpatient Hospital*	\$349.9	\$338.8	-3.17%
Nursing Facilities	\$251.2	\$274.3	9.20%
EPD Waiver	\$123.6	\$51.8	-58.09%
ICF/DD	\$78.8	\$96.9	22.97%
DD Waiver	\$156.9	\$180.3	14.91%
Personal Care	\$100.7	\$182.3	81.03%

Note: FY 2013 budget includes funding for emergency hospital care for Alliance beneficiaries. In FY14, the cost for this service is shown as a separate line item.

Due in no small part to the District’s aggressive approach to Medicaid eligibility and the comprehensive benefit package funded through our State Plan, a larger share of residents enjoy high levels of coverage with access to the various types of care required to address a broad range of illnesses or needs. At the same time however, this laudable approach to publicly financed health care can and does drive spending to levels which challenge budget development.

As the aforementioned Table shows, the proposed amount budgeted for the largest line item in the Medicaid budget -- managed care -- is over 20 percent higher than the amount we budgeted for this program in FY2013. Federal requirements that we pay actuarially sound rates, higher provider network costs faced by the managed care plans, and the growing health care expenses of the previously mentioned Medicaid expansion population -- typically referred to as childless adults -- are the primary reasons for this growth. As noted earlier, the federal government will help dampen the local fund impact for the majority of the expansion population by paying 100 percent of their Medicaid cost for three years, beginning in January 2014.

The Mayor has budgeted \$338 million to cover the inpatient hospital cost of Medicaid beneficiaries who are not in managed care – the so called fee-for-service population. Although the Table shows a small reduction in the budget for inpatient hospital services in FY2014, it should be noted that the FY 2013 budget for this item includes funding for emergency hospital care for Alliance beneficiaries. The FY2014 budget reports this as a separate \$6.8 million line item.

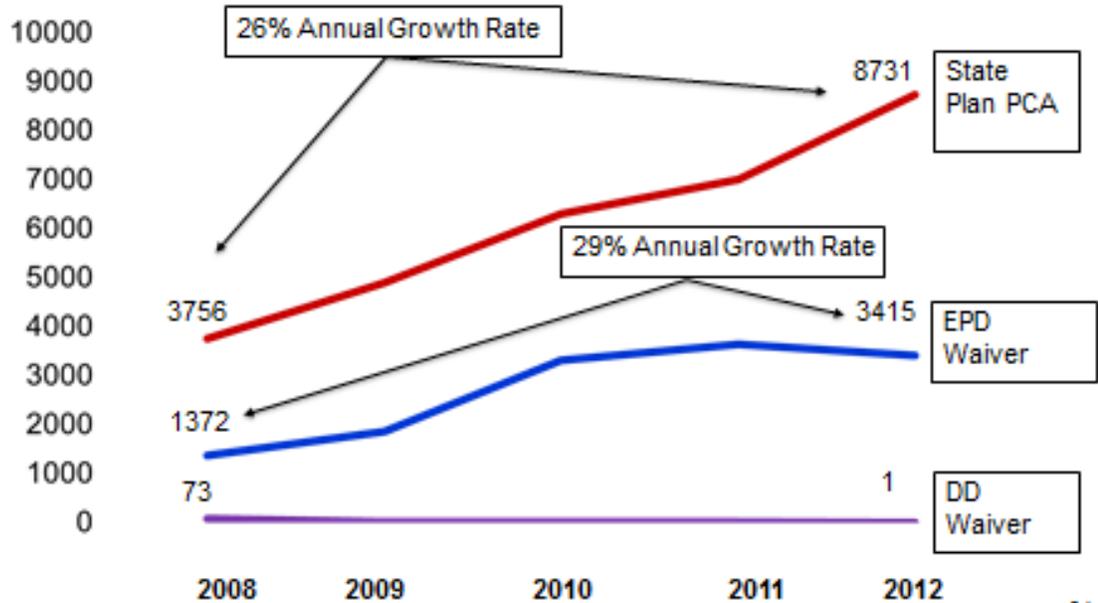
Still, we know from previous study that there is a “high cost” group of Medicaid beneficiaries who comprise about 11 percent of the fee-for-service population. Compared to their “lower cost” counterparts, beneficiaries in this group are nearly five times more likely to visit an emergency room; are admitted

for inpatient care at five times the rate of the “low cost” group; have hospital stays that are twice as long; average 10 more prescriptions, and are more likely to suffer from multiple chronic conditions. We expect this population to exert continued upward pressure on inpatient hospital costs in FY2014.

Finally, over the next two years, we will pay special attention to the services provided through DHCF’s State Plan Option Personal Care program. The previously shown Table reveals projected growth of over 80 percent from the FY 2013 to the FY 2014 budgets. A large portion of this amount, however, can be attributed to an agency policy change which now requires that the first eight hours of personal care for individuals in the Elderly and Persons with Disabilities (EPD) waiver be charged to the State Plan Option program. This was not reflected in the development of the FY 2013 budget.

Notwithstanding this change, a significant portion of the rapidly growing size of this program can be traced to increased utilization of this service as an optional benefit for persons who are not in the EPD waiver. As the graphic on the next page reveals, the number of Medicaid beneficiaries who are not in the EPD waiver but use personal care services has grown at an annual rate of 26 percent over the past five years. In 2012, DHCF spent more than \$18,595 per participant on these members. Although the annual rate of growth for persons in the EPD waiver who use this benefit is comparable (29 percent to 26 percent for State Plan

Growth In The Number Of Beneficiaries Who Are Using State Plan Personal Care Services



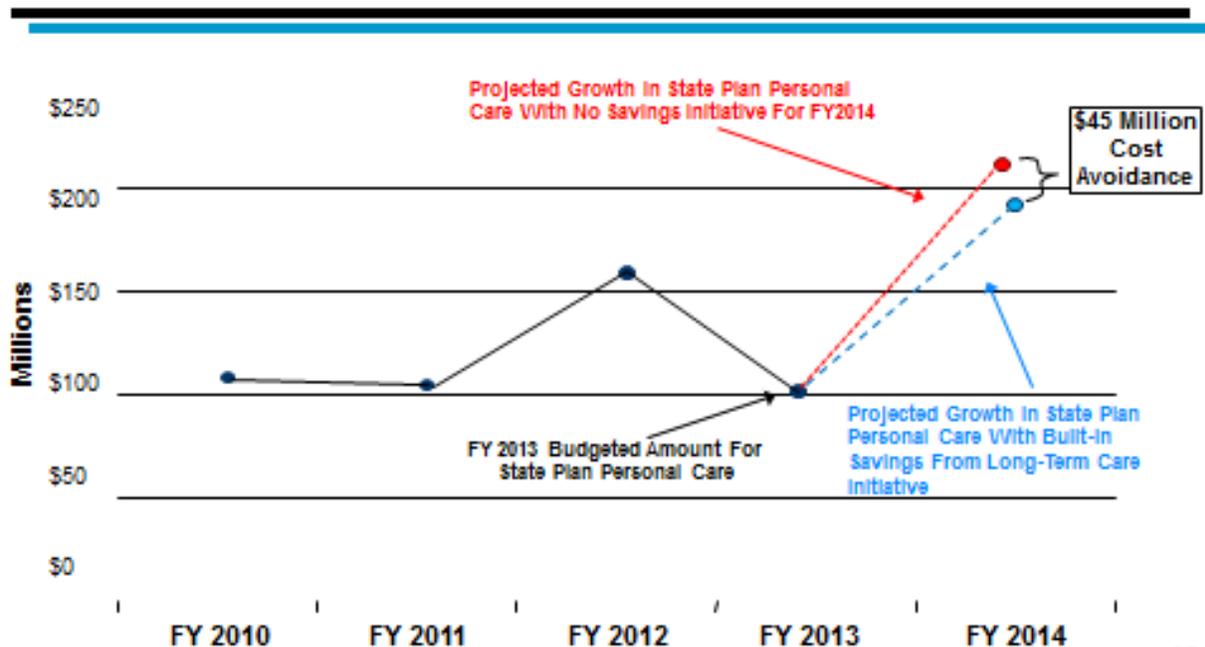
Option Personal Care), the waiver enrollment level is much lower (3,145 to 8,731) and constrained by a federally imposed cap.

The growth in the State Plan Personal Care Program is not easily explained, and we have sufficient anecdotal evidence that points to provider and beneficiary fraud, waste, and abuse as contributing factors. As a result we are currently making a number of rule changes to the program. One of the new rules will incorporate conflict free assessment, meaning that the provider agencies will no longer determine the amount of care needed for the beneficiaries they serve.

Instead, the agency will procure the services of a vendor to determine the level of care needed for beneficiaries and the home health care agency will only be responsible for ensuring the delivery of services. The Mayor has provided funding to support this procurement which will hopefully produce significant savings in FY2014.

As illustrated below, the proposed budget for this benefit in FY2014 is \$182 million, reflecting cost avoidance savings of \$45 million. We are working on a daily basis with Director Staton and the staff at the Office of Contracts and Procurement to finalize this important procurement.

Significant Savings Have Been Built Into The FY2014 Budget For State Plan Personal Care



Madam Chairman, these are just a few of the activities planned which we hope will increase the efficiency of the programs DHCF operates and slow health care cost growth. While we work on these strategies, staff will be asked to simultaneously consider options to extend managed care services to the presently unmanaged fee-for-service population. We will also explore the efficacy of creating medical homes for persons who are suffering with mental illness in the hopes of ensuring a more cost-effective delivery of care to this population. And, we will initiate a number of strategies with the health plans in our newly configured managed care program to drive increased patient access, greater care coordination, and hopefully improved patient outcomes through a more cost-effective delivery of services.

Conclusion

In closing Madam Chairwoman, allow me to reiterate the good news of the Mayor's FY2014 budget proposal for DHCF. Eligibility levels and access to care are preserved. Neither Medicaid nor and Alliance members face reductions in the scope of benefits. Considerable funding has been provided to reimburse the health care providers who care for some of the District's most fragile and vulnerable citizens. And, constructive efforts to find a solution to the problems at United Medical Center will continue.

As we approach FY2014, my staff and I look forward to working with the Committee on Health to ensure that we properly shepherd the resources that the Mayor has entrusted to DHCF and that we work to guarantee District residents have continued access to quality health care services funded through both the Medicaid and Alliance programs.

Madam Chairwoman, this concludes my presentation and I welcome questions from you and the Committee.