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 2015 Budget Hearing

Tuesday, April 29, 2014

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 Mayor Vincent Gray's FY 2015 Budget for the Department of Health Care Finance (DHCF). Allow me to state at the outset

that this is a strategic budget proposal that fully addresses the needs of DHCF and smartly takes advantage of nearly $30 million in agency cost avoidance efforts in FY2014. In general, the Mayor's proposal accomplishes two major objectives. First, it continues the funding necessary to maintain health care access based on the District's aggressive eligibility levels. The refusal to retrench on existing eligibility policy ensures that the District's Medicaid program will be an effective complement to the goal of universal health insurance coverage articulated in the Affordable Care Act.

With Medicaid expansion safely in place for FY2015, there is no coverage gap between the District's Medicaid and private insurance programs. 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 policy, which was established in 2010, will remain in place for FY2015. Thus all persons who do not earn enough income to qualify for a federal subsidy under the Affordable Care Act will continue to be eligible for publicly-funded health care insurance under the Medicaid program.

Second, the proposed budget adequately funds expected increases in provider payments brought about by increased beneficiary utilization while also insulating FY2015 managed care capitated rates from externally imposed taxes and

fees. This attention to provider reimbursement rates is an important and necessary feature to adequately fund the Medicaid program. Provider payments represent the most significant cost component in our budget, accounting for 96 cents of every dollar we spend. As both rate enhancements and utilization growth have the potential to create significant spending pressures, the Mayor's proposed budget for DHCF carefully addresses both of these issues.

Considered together, I am pleased to report that the Mayor's cumulative funding proposals for DHCF clearly embrace the agency's mission to improve patient health outcomes by providing access to a comprehensive range of services funded through the Medicaid and Alliance insurance programs.

My remarks today will first describe how the agency's budget was formulated with a specific focus on the Mayor's key proposed enhancements, the underlying rationale supporting these decisions, and the associated funding requests. I will close my comments by briefly highlighting the agency's focus on key activities in FY2015 that could have significant implications for DHCF's budget over time.

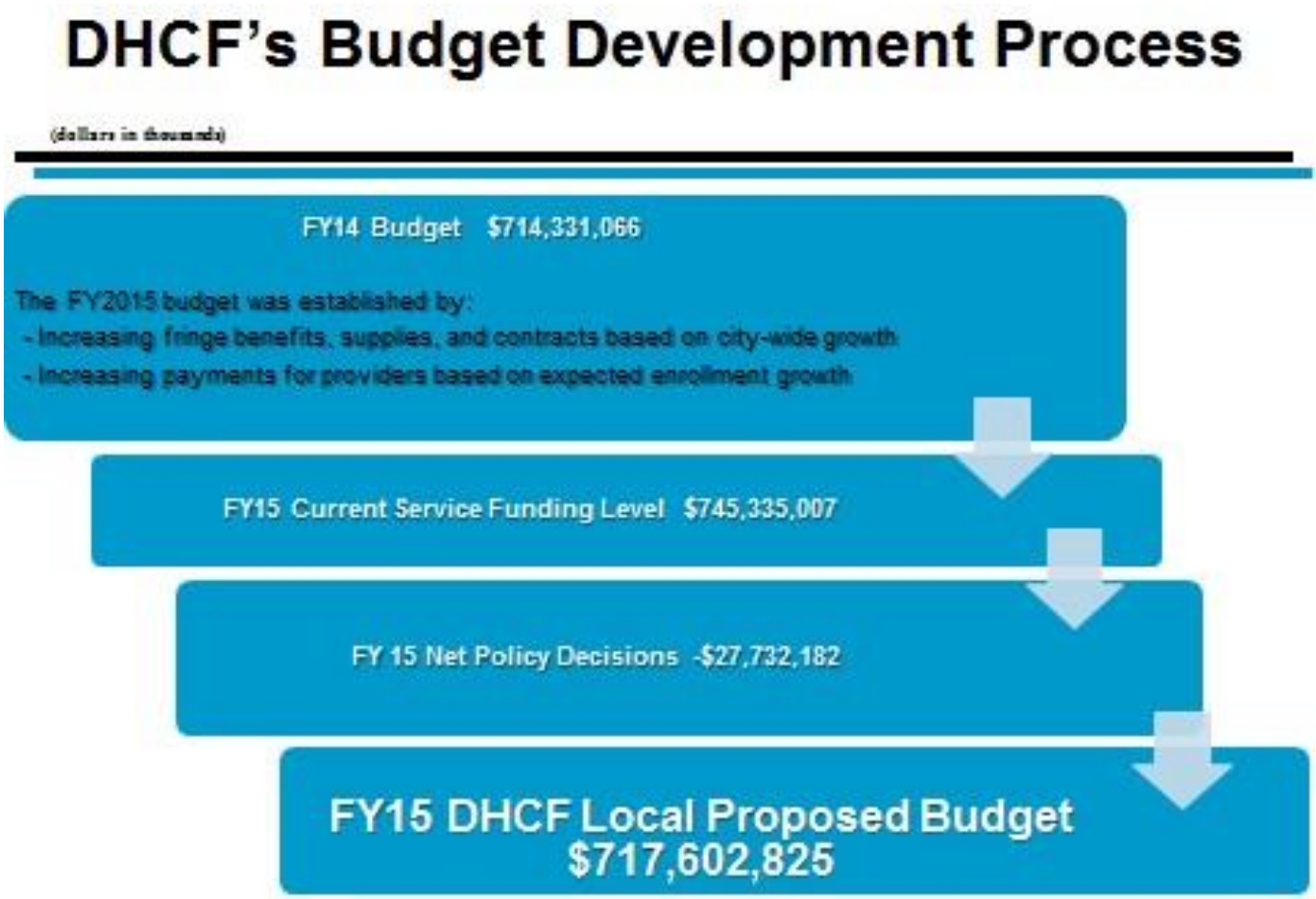
Building DHCF's Proposed Agency Budget

Madam Chairwoman, the District's Current Services Funding Level (CSFL) budget is created annually by the Office of the Chief Financial Officer (OCFO).

Through the CSFL process, the OCFO calculates the local cost of providing the same services from the previous year into the next fiscal year by adjusting agency budgets for inflation and other growth factors. The adjusted budgets serve as the baseline from which the Mayor makes his funding proposals.

The graphic on page 5 of my testimony illustrates the budget development process for DHCF. As shown, the Mayor set the funding level for the FY2015 budget by first using the FY2014 local fund budget of $714.3 million. Next, this budgeted amount was inflated for several factors to reflect the Current Services Funding Level (CSFL) for FY2015 of $745.3 million. Perhaps the most significant adjustment is the 4.4 percent overall increase made for direct service payments under the Medicaid program.

Finally, each of the Mayor's policy proposals were analyzed and assigned a dollar amount reflecting the local cost of the policy change. This includes policy decisions that both increase and decrease local fund needs thereby allowing the calculation of the net spending change required to establish DHCF's final proposed budget for FY2015.



The CSFL for DHCF ($745.3 million) represents a growth rate of 4.3 percent or $31 million in local funds. As noted earlier, this amount does not reflect any new initiatives or program savings but mostly indicates the impact of the anticipated enrollment growth, increased utilization, and the annual adjustment to the capitated payment rates for the District's three health plans. Once the CSFL was established, the Mayor made a series of adjustments that resulted in a net

reduction of $27.7 million in local funds to set DHCF's FY2015 budget at the proposed level of $717.6 million.

The budget actions that were implemented included program enhancements, funding reductions, technical adjustments, and one agency transfer. The Table below lists each of the proposed enhancements which totaled just over $28 million in local funds. A few of these enhancements warrant some discussion.

DHCF Local Fund Enhancements To The FY2015 CSFL Budget

Budget Enhancement	**Total Local Funds**
Eliminate Bed Tax and Maintain Hospital Inpatient Rate	$15,080,000
Raise Hospital Outpatient Payment-to-Cost ratio to 77%	$6,000,000
Health Benefits Exchange Fee	$2,728,950
Expand Transplant Coverage	$2,506,440
UMC Sustainability	$1,143,494
Well Child / EPSDT Enhancement	$866,609
Total	$28,325,493

As shown, the first two of these adjustments added $21 million in local funds to the budget. Just over $15 million of this amount was allocated to replace the revenue the District will lose with the sunset of the $3,788 per bed hospital tax at the end of FY2014. As this bed tax was used to partially fund the Medicaid inpatient hospital reimbursement rate during the economic crisis, the District

needed to either replace the revenue due to be eliminated by the sunset provisions in the enabling legislation or, reduce the rate commensurate with the decline in revenue. With this proposal, the District fulfills its promise to eliminate the tax while allowing hospitals to retain the rates they were paid for inpatient care in FY2014.

The remaining $6 million in local funds were allocated to support an increase in the hospital outpatient rate. In FY2013, DHCF reimbursed hospitals only 47 percent of the cost incurred for services delivered to Medicaid patients. The hospitals agreed to an industry wide tax of more than $12 million in FY2014 to draw down federal dollars and raise the Medicaid outpatient rate to cover 98 percent of the cost incurred. However, like the bed tax, this provider tax also sunsets at the conclusion of FY2014. With this proposal, DHCF will be able to raise the Medicaid outpatient rate to cover 77 percent of hospital cost in FY2015 despite the elimination of the outpatient provider tax.

The Mayor also allocated more than $2.7 million to cover the cost of the health insurance provider fee that the quasi-independent Health Benefits Exchange (HBX) is planning to assess against all health carriers in the District. Since this fee is broad-based – meaning it covers all health carriers – uniformly applied, and less than six percent, the federal government will pay 70 percent of the assessment for

the Medicaid plans. The proposed $2.7 million represents the District's local share.

Also, included among the enhancements are the necessary funds to update the District's transplant program. Specifically, more than $2.5 million is allocated to include autologous bone marrow transplants (BMT) and lung transplants. Autologous BMT and lung transplants are established evidence-based best practice treatments for many conditions and will significantly expand treatment options for persons suffering with various hematologic illnesses or end-stage lung diseases.

Finally, the Mayor has proposed over $866,000 in local funds as an incentive program for primary care physicians to encourage better documentation of the already required well child visits under EPSDT (Early Periodic Screening Diagnostic and Treatment). This proposal will require primary care providers to document the child screenings which they regular conduct for oral health, behavioral health, and developmental testing as a part of their primary care visit. Physicians will then be required to share the results with the appropriate health plans to promote better care coordination. The initiative funded by this action will prove helpful as the District works to meet the requirements imposed under the Salazar Consent Order.

In addition to these enhancements, the Mayor's budget for DHCF includes two technical adjustments -- items which must be funded in response to externally

imposed requirements -- which add another $10.9 million to DHCF's budget. One of these adjustments is for slightly more than $3.6 million to cover the impact of the Affordable Care Act health insurance provider fee. This fee is assessed on the so-called "risk revenue" for all health insurance companies including Medicaid. Because this tax will increase cost for the Medicaid health plans, the District must supplement the rates it pays the plans to protect the actuarial soundness of the rates established for the three companies in the face of this fee.

The second technical adjustment of $7.3 million is included to pay for the increase in the Medicaid personal care services rate due to the District's living wage requirement. The most recent living wage increase was announced in March 2014. However, District law requires another increase to be announced in March 2015. Although most Medicaid providers are exempt from the living wage, home health agencies that provide personal care services are not and this technical adjustment covers the local share of this cost.

Although these actions along with other policy enhancements added nearly $40 million to the DHCF's budget for FY2015, the net adjustment for the agency was, as noted earlier, a negative $27.7 million. A portion of the reduction reflected $10.3 million in projected program savings from the payment suspensions we imposed on numerous home health care agencies due to allegations of fraud.

However, it is important to note that most of the offset that produced the

$27.7 million net reduction does not reflect an actual decline in spending for the Medicaid program or DHCF. Rather, it represents the impact of shifting $51 million in local funds for the Developmental Disabilities waiver program from DHCF's budget to the Department of Disability Services (DDS). This change was made to ensure that the responsibility for policymaking and program budgeting would exist in the same agency – DDS – rather than be divided across two entities as is currently the case.

Capital Funding To Build a New Hospital

The final major proposal in the Mayor's budget for DHCF concerned the United Medical Center Hospital (UMC). In 2012, DHCF awarded a two-year contract to Huron Healthcare to turnaround the operations and finances of UMC while also developing a plan to improve the long-term fortunes of the hospital. The goal was to improve the hospital's financial performance through both expense reduction and revenue enhancement while assisting in the implementation of a strategic plan that would provide a roadmap for the long-term sustainability of UMC.

At the completion of the first year of the project Huron successfully fulfilled a number of tasks including the following:

- Hired an interim CEO and CIO, to stabilize the operations of the hospital.

- Conducted an opportunity assessment on all key operational segments of the hospital. The improvements are projected to yield between $8 million to $14.9 million. To date, these improvements have produced over $6.5 million in savings and hospital officials report that the balance sheet is no longer in the red.

- Completed a comprehensive strategic plan with financial projections that was approved by the UMC Board on August 2, 2013; and,

- Made significant progress in identifying potential partners to align with UMC to operate the hospital on a long-term basis.

In light of the age of the existing hospital, its outdated building design, and looming future infrastructure needs, Mayor Gray is proposing that a new hospital be constructed to replace the current facility which would be operated by a partner through agreement with the District. The capital funds to support the new hospital total more than $344 million and would be allocated over the next six years as shown in the Table below.

Proposed Capital Funding For New United Medical Center

Year	Funding Amount
2015	$41.6M
2016	$92.9M
2017	$90.0M
2018	---

2019	$120.0M
Total	$344.50M

As Huron approaches the last phase of this project, work continues on UMC performance improvements and expense reductions with the goal of increasing hospital operating revenue. At the same time, Huron is increasingly focused on carrying out those tasks that must be successfully completed to sustain UMC in the future. This includes aggressively implementing a physician development plan, finalizing a Master Plan to support a new campus and community programs, and most importantly, formally aligning UMC with a strong health care system and business partner.

Key Budget Challenges for FY2015

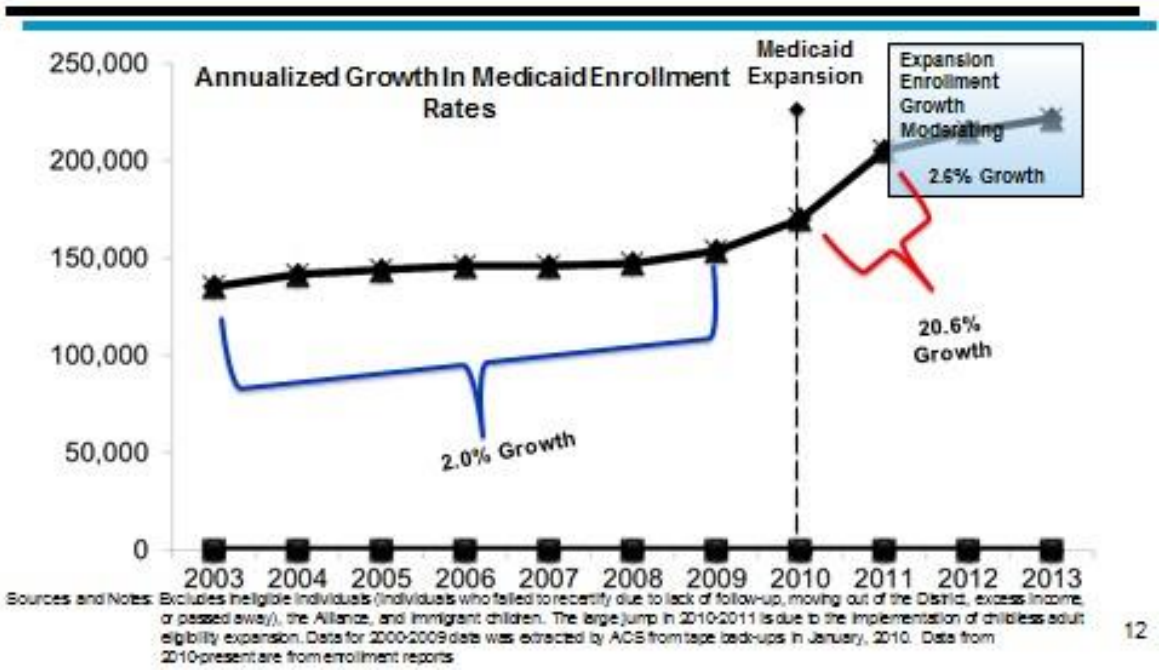
Madam Chairwoman as we move into FY2015, DHCF will continue efforts to improve access to quality health care while managing expenditure growth. With Medicaid, cost pressures can surface through spikes in enrollment, significant changes to provider reimbursement methodologies, or unexpected, inefficient, or fraudulent utilization of benefits.

Notwithstanding the push for universal coverage through the Affordable Care Act, we do not anticipate significant enrollment growth for the Medicaid program in the near future. The District's 2010 eligibility expansion activities did

produce a considerable jump in the number of persons who signed up for the program but that growth has moderated in recent years.

As shown in the Figure below, Medicaid enrollment growth in the two years following expansion averaged 20.6 percent as coverage levels reached record highs in the District. However, since 2011, enrollment levels have stabilized with growth rates averaging less than three percent. There is no reason to anticipate a major change in this trend even as enrollment activities for the Affordable Care Act continue.

Medicaid Enrollment Trends, 2003-2013



It is equally unlikely that there will be a sharp rate of growth in Medicaid or

Alliance payments due to changes in provider reimbursement methodologies. While we are making plans to revamp the payment models for clinics and the few hospitals that are currently paid on a per diem basis, the associated cost increases at the margin should be modest.

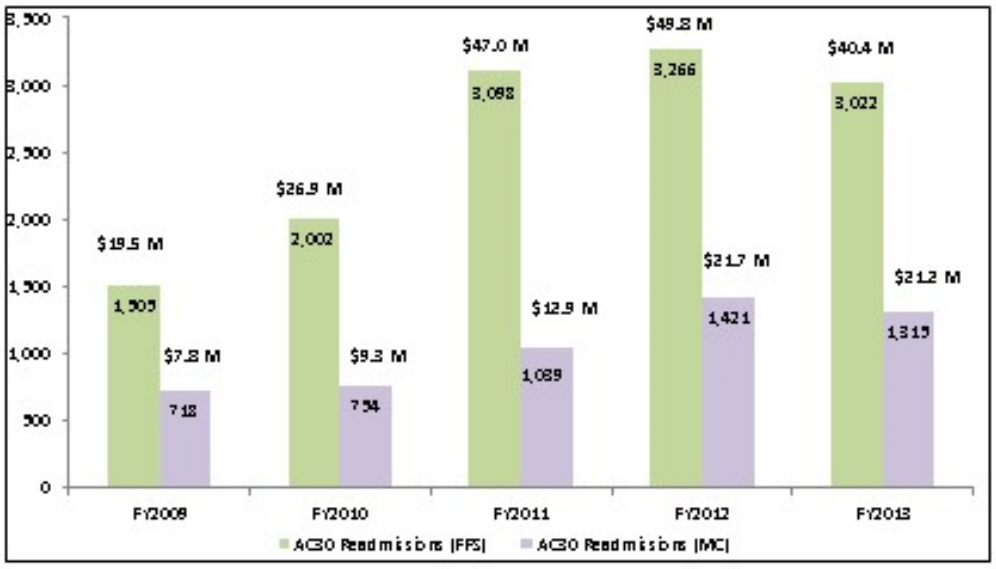
More significant are the challenges we face in FY2015 to address the inefficient use of benefits by beneficiaries while simultaneously arresting the fraud in the program which has greatly increased spending. With respect to the inefficient utilization of health care benefits, we know from previous DHCF research that roughly 28 percent of the beneficiaries in the Medicaid program -- who are not in managed care plans -- are responsible for more than 55 percent of the program's cost. We also know that there is a high-cost segment of individuals within this unmanaged population that have a higher incidence of chronic illnesses, is more likely to be hospitalized, and will stay in hospitals twice as long as their lower cost counterparts.

More significantly, when members of this unmanaged population leave the hospital, many return -- in greater numbers than is witnessed for manage care members -- within 30 days for the same illness (see Figure on page 15).

Due to the press of other duties, we have not focused the required attention on this group to adequately address the frequent and often inappropriate ways that these beneficiaries access and utilize health care. That will change in FY2015 as

we ramp up care coordination program efforts which hold the promise of improved health outcomes and lower spending. Our focus will include the implementation of

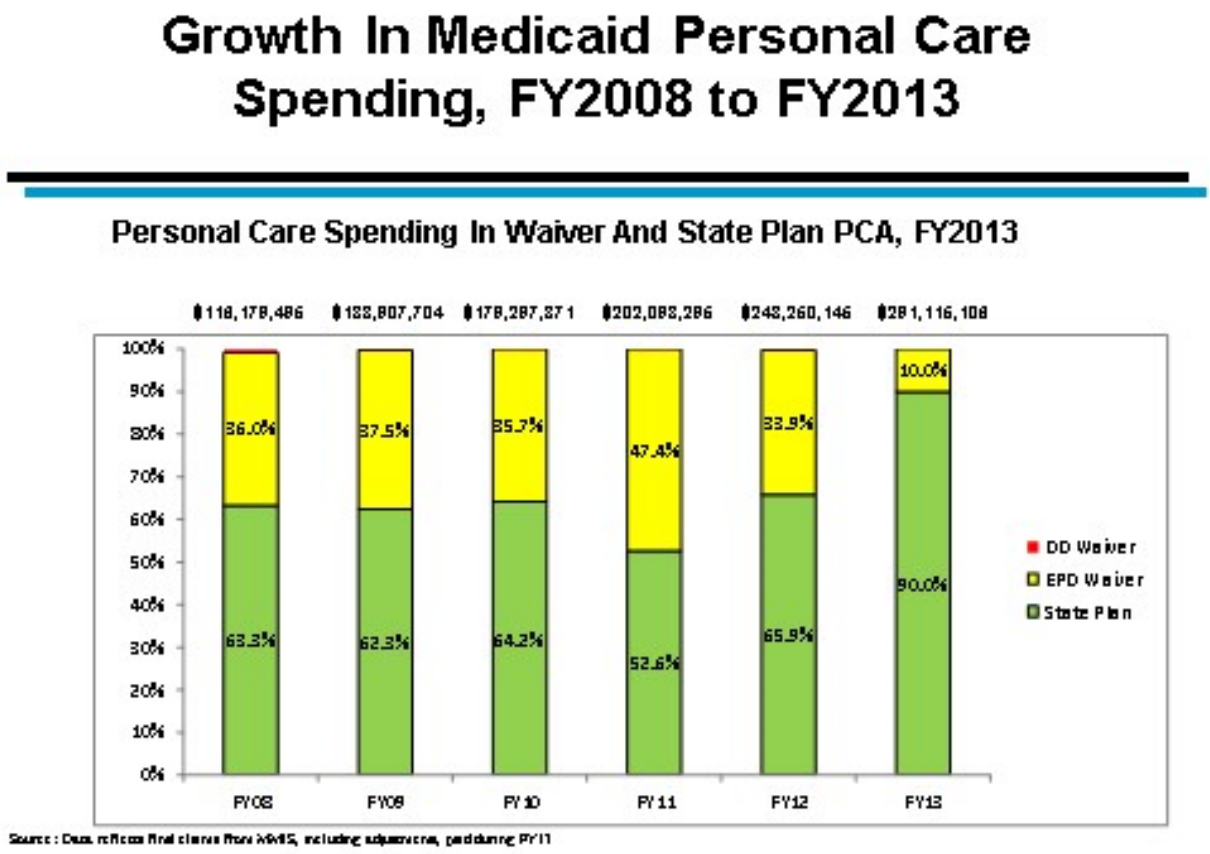
Trend In 30-Day Hospital Readmissions
For Fee-For-Service and Managed Care Populations



a health homes model for persons who are suffering with mental illness, improved discharged planning, and enhanced care coordination with community stakeholders. While we anticipate launching the Health Homes project at the beginning of FY2015, I have asked staff to move immediately forward with other care coordination plans for the fee-for-service Medicaid population.

In terms of combating program fraud, FY2015 will be a critical year in our efforts to reform long-term care and, most especially, the Medicaid personal care

program. As we have previously discussed, Medicaid spending on personal care services has soared in recent years, reaching levels in FY2013 that were unexplainably high. Personal care expenditures have become the fastest growing line item in the Medicaid budget with total spending on this service falling just short of $300 million (see Figure below).



The recent law enforcement action by the United States Attorney's office and DHCF's related decision to suspend payments for 13 home health care agencies are the first steps in what will be a long process to restore integrity to the program and, by extension, reduce the future cost of this benefit.

The FY2015 budget DHCF submitted included nearly $30 million in local fund savings as compared to the spending trend based on historical expenditure data for personal care. These savings were based on the overhaul of the personal care program that we implemented in FY2014 and payment suspension actions which are required by federal regulation.

For the balance of this year and FY2015, DHCF staff will take a number of steps aimed at removing fraudulent providers from the Medicaid program and ensuring that only eligible beneficiaries receive personal care benefits in the appropriate amounts as prescribed through patient assessments performed by trained nurses. We believe these actions will go a long way towards right sizing this program and produce greater savings for the District Medicaid program in the out years.

As we approach FY2015, my staff and I look forward to working with the Committee on Health as professional stewards of the budgets for the Medicaid and Alliance programs. Through skillful management and prudent decision making we will work to guarantee District residents have continued access to high quality, publicly financed, health care services.

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