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# **DHCF Budget Presentation For FY2015**

*Presentation for:*  
**Medical Care Advisory Committee**

# Presentation Outline

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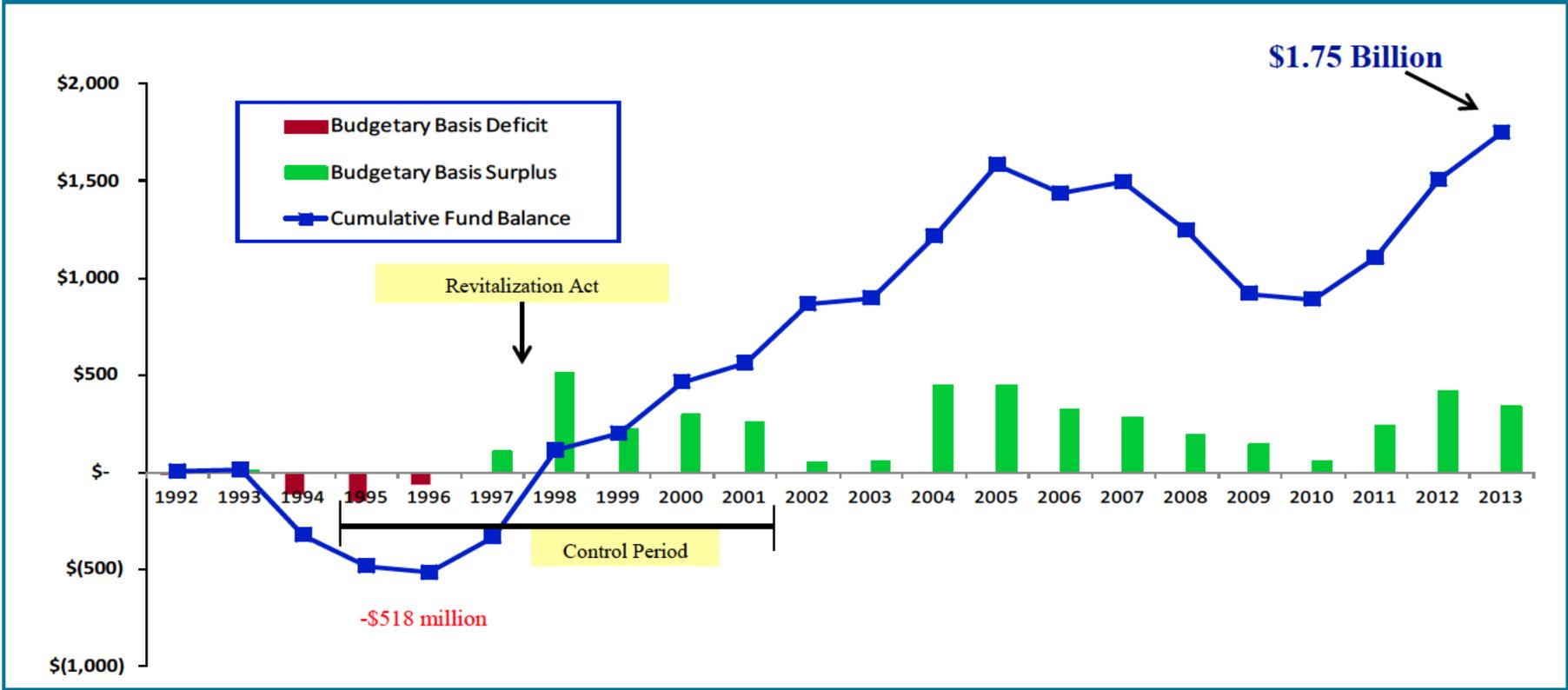
- Overview Of District's Budget For FY2015**
- Budget Development For DHCF
- DHCF Budget Initiatives For FY2015
- Medicaid Cost Drivers, Policy Issues, And Challenges
- Alliance Spending Trends and Enrollment Issues

# Continuing Fiscal Responsibility

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- ❑ A structurally sound budget and financial plan that does not use locally mandated reserves
  
- ❑ Preservation of 12% debt cap and funding of dedicated Pay-As-You-Go Capital fund
  - To continue upward trajectory of District bond ratings
  
- ❑ No tax or fee increases to balance the budget

# Fund Balance Continues To Grow



### General Obligation Bond Ratings

S&P:	A-	A-	A-	B	B	B	BB	BBB	BBB	BBB+	BBB+	A-	A-	A	A+	A+	A+	A+	A+	A+	A+	AA-	
Moody's:	Baa	Baa	Baa	Ba	Ba	Ba2	Ba1	Baa3	Baa3	Baa1	Baa1	Baa1	A2	A2	A2	A1	A1	A1	A1	Aa2	Aa2	Aa2	Aa2
Fitch:	A-	A-	A-	BB	BB	BB	BB+	BBB	BBB	BBB+	BBB+	A-	A-	A	A	A+	A+	A+	A+	AA-	AA-	AA-	AA-

Income Tax Secured Revenue Bonds: S&P: AAA Moody's: Aa1 Fitch: AA+

# Local Fund Budget Summary

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- FY 2014 approved budget - \$6.35B

Total baseline expenses - \$6.64B

- CSFL for Local funds- \$6.48B
- Technical adjustments to CSFL - \$157.7M
- 4.5% increase over FY 2014 approved budget

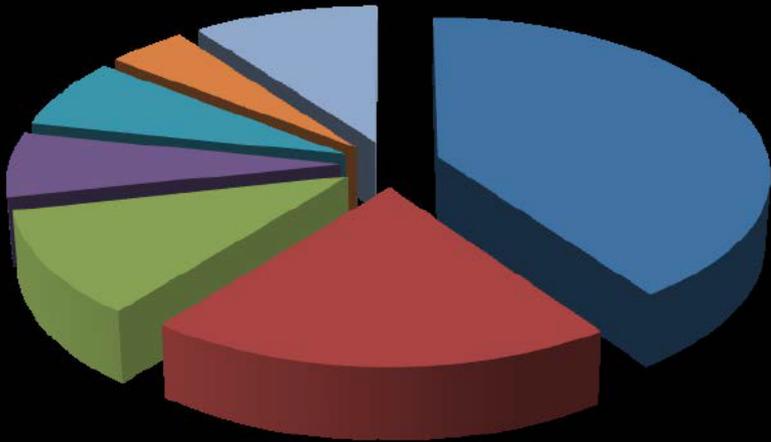
FY 2015 proposed budget - \$6.79B

- Total new policy decisions - \$139M
- 2.3% of total FY 2015 proposed budget
- By comparison, the District's population grew by 2.1%



# FY 2015 At A Glance

**Total Gross Funds Budget : \$10.7B**



- ❑ Human Support Services:  
\$4.34B - 40.3%
- ❑ Public Education:  
\$2.19B - 20.4%
- ❑ Public Safety:  
\$1.19B - 11.0%
- ❑ Government Operations:  
\$0.78B - 7.2%
- ❑ Economic Development:  
\$0.47B - 4.4%
- ❑ Financing and Other:  
\$1.09B - 10.1%

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# Medicaid Is A Key Factor In Growth Of The District's Current Services Funding Level

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- ❑ CSFL budget is created annually by the Office of the Chief Financial Officer
  - Calculates the local cost of providing the same services in the next fiscal year
  - Adjusts agency budgets for inflation and other growth factors
  - Serves as the baseline budget for the Mayor to make his decisions.
  
- ❑ The FY 2015 CSFL budget grew 4.5% or \$157.7 million over the FY 2014 approved budget, excluding one-time costs.
  
- ❑ DHCF CSFL growth was 4.3% or \$31 million
  - Growth outside provider payments based on city-wide growth rates
  - Provider payment growth based on preliminary forecast
    - ❖ Actual enrollment through March 2013
    - ❖ Actual spending through June 2013
    - ❖ Trended per beneficiary per month costs
    - ❖ No new initiatives or savings
  
- ❑ At the time the CSFL was produced in November 2013, the gap between the FY2015 CFSL and projected revenue was \$2.7 million

# FY15 Local Budget Development

(dollars in millions)

FY14 Budget \$714,331,066

FY15 Current Service Funding Level \$745,335,007

FY 15 Net Policy Decisions -\$27,732,182

FY15 DHCF Local Proposed Budget  
\$717,602,825

# FY 2014 Approved versus FY2015 Proposed Explanation by Fund

(in millions)	FY2014 Approved	FY2015 Proposed	% Change	
Local Funds	\$714.3	\$717.6	0.5%	CSFL increase plus \$33M of policy decisions minus MCO rate updates, PCA utilization declines, and DD Waiver transfer.
Dedicated Taxes	\$86.3	\$65.8	-23.8%	Growth in Healthy DC, Nursing Home Quality of Care, and Stevie Sellows offset by the expiration of the Hospital Bed Tax and Hospital Provider Fee.
Special Purpose Revenue	\$3.6	\$3.6	0%	
<b>Total General Funds</b>	<b>\$804.2</b>	<b>\$787.0</b>	<b>-2.1%</b>	<b>No change</b>
Federal Grant Funds	\$28.4	\$2.1	-92.6%	Expiration of the grant to Establish the Health Benefits Exchange and build DCAS. Next phase at HBX.
Federal Medicaid Funds	\$1,891.9	\$2,049.2	8.3%	Match to Local, Dedicated Tax, Special Purpose, and I-D funds. DD Waiver budget did not shift and 4 qtrs of 100% FMAP for childless adults in FY 2015.
<b>Total Federal Funds</b>	<b>\$1,920.3</b>	<b>\$2,051.3</b>	<b>6.8%</b>	
Intra District Funds	\$22.4	\$74.6	233%	Shifting \$51M DD Waiver local budget to DDS requires DDS to send funds DHCF via intra-district for match to DD Waiver spending.
<b>Gross Funds</b>	<b>\$2,746.9</b>	<b>\$2,912.9</b>	<b>6%</b>	

# Personal Services and Support Services for DHCF Operations

(dollars in thousands)

	FY14 Approved Budget	FY15 Proposed Budget	% Change
Personal Services	\$19,513.6	\$22,211.0	13.8%
Fixed Cost	\$935.5	\$937.9	0.3%
Other Non- Personal Services (excludes provider payments)	\$1,689.4	\$1,911.5	13.1%
Contractual Services	\$65,481.8	\$60,668.4	-7.4%

24.4 additional FTEs and step increases.

Central agency projections.

Net effect of normal contract increases and reductions from FY 2014 budget for HIT and LTC.

The federal grants budget is not included in the above comparison

# Budget Request For Select Medicaid Mandatory Services

Medicaid Mandatory Service	FY13 Expenditures	FY14 Budgeted Amount	FY15 Budget Request
Inpatient Hospital	\$278.8	\$338.8	\$348.7
Nursing Facilities	\$227.8	\$274.3	\$261.9
Physician Services	\$42.0	\$47.6	\$61.1
Outpatient Hospital, Supplemental & Emergency	\$26.9	\$70.6	\$59.2
Durable Medical Equip (including prosthetics, orthotics, and supplies)	\$27.9	\$40.6	\$37.2
Non-Emergency Transportation	\$25.1	\$17.2	\$24.1
Federally Qualified Health Centers	\$37.8	\$32.6	\$42.9
Lab & X-Ray	\$14.9	\$17.4	\$25.5

Budget and spending information is based on SOAR which includes all adjustments. Data presented in subsequent slides is based exclusively on MMIS claims and may not include adjustments occurring at the provider level (FTs) or adjustments in SOAR.

# Budget Request For Select Medicaid Optional Services

Medicaid Optional Services	FY13 Expenditures	FY14 Budgeted Amount	FY15 Budget Request
Managed Care Services	\$789.9	\$849.2	\$934.1
DD Waiver (FY 2015 includes intra-district funds from DDS)	\$158.1	\$180.3	\$170.9
Personal Care Aide	\$260.8	\$182.3	\$259.8
EPD Waiver	\$35.1	\$51.8	\$39.2
Pharmacy (net of rebates)	\$33.2	\$71.9	\$78.1
Mental Health (includes DMH intra-district for MHRS)	\$83.3	\$74.9	\$80.6
Day Treatment / Adult Day Health	\$19.6	\$27.4	\$11.4
Home Health	\$11.1	\$10.9	\$16.4

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# DHCF New Initiatives in FY15

Amounts reflect local portion only

\$15,080,000

- Maintain Hospital In-Patient Rates (replaces hospital bed tax)

\$6,000,000

- Raise Hospital Out-Patient Rate from 47% to 77%

\$2,506,440

- Expand Medicaid Transplant Benefit to Include Autologous Bone Marrow Transplants and Lung Transplants

\$866,609

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

# Initiatives in FY15

## Continue Plans For A New Hospital To Replace United Medical Center

### Capital Funding Plan For New Hospital

Fiscal Year	Amount
2015	\$41.6 million
2016	\$92.9 million
2017	\$90 million
2018	--
2019	<u>\$120 million</u>
Total	\$344.6 million

# DHCF Budget Accounts For Federal Fee On Insurers and Proposed Health Insurance Fees

\$3,639,373

- Affordable Care Act health insurance provider fee applies to all health insurance risk revenue including Medicaid and the Children's Health Insurance Program. This will increase MCO cost and thus requires an increase in local funds for the District's three plans.

\$2,728,950

- A one percent fee on all insurers to generate revenue for the operation of the Exchange includes Medicaid plans. This budget request would cover the local cost of the fee for the three health plans.

# Additional DHCF Requests Assigned To Revenue Priority List

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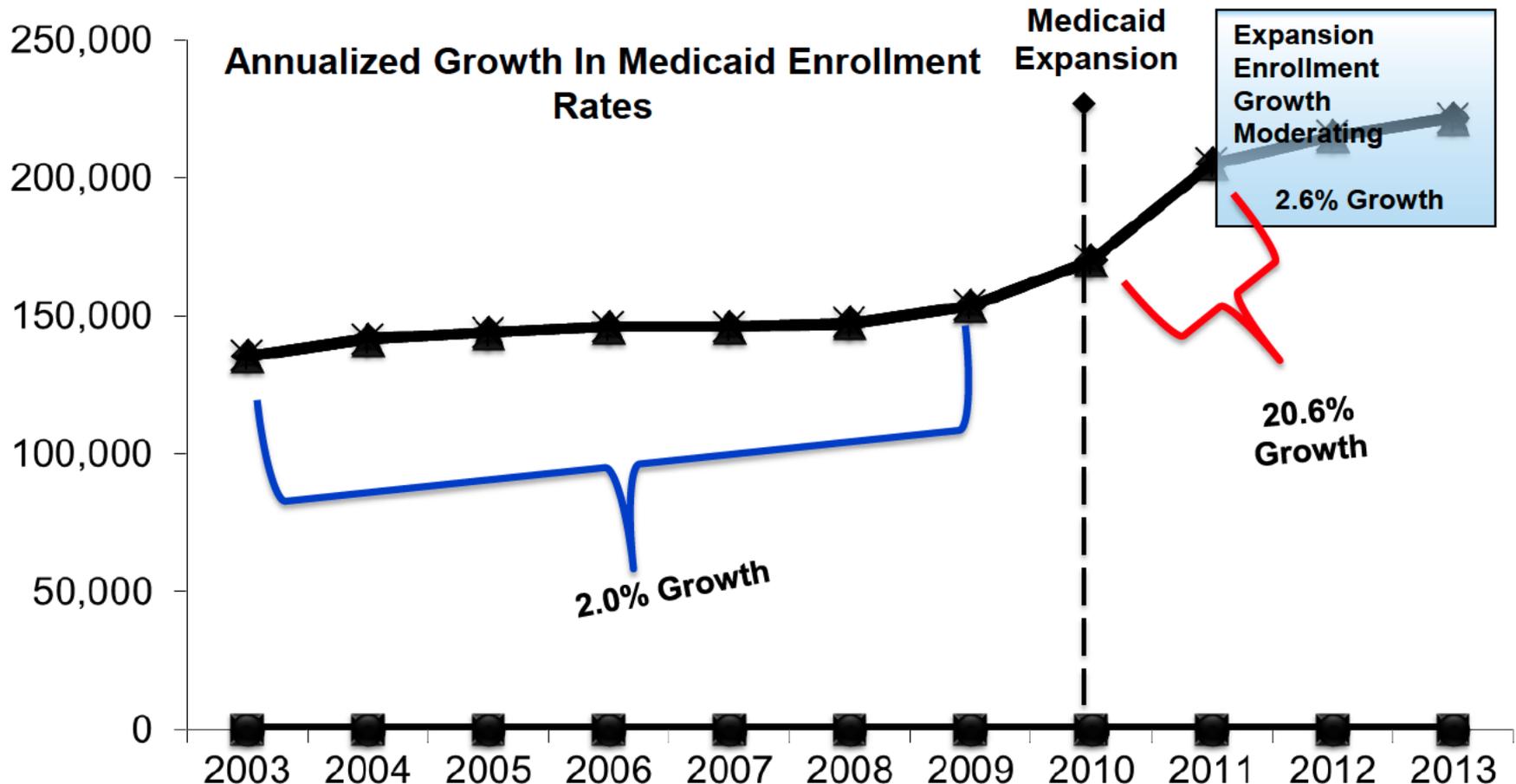
1. \$1.8M Coverage of Ineligible for Health Benefits Exchange Insurance
2. \$1.5M Federally Qualified Health Center (FQHC) Rate Methodology
3. \$1.0M Elderly and Persons with Disability Wavier

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# The Enrollment Spikes That Followed Medicaid Expansion In The District Have Begun To Significantly Moderate

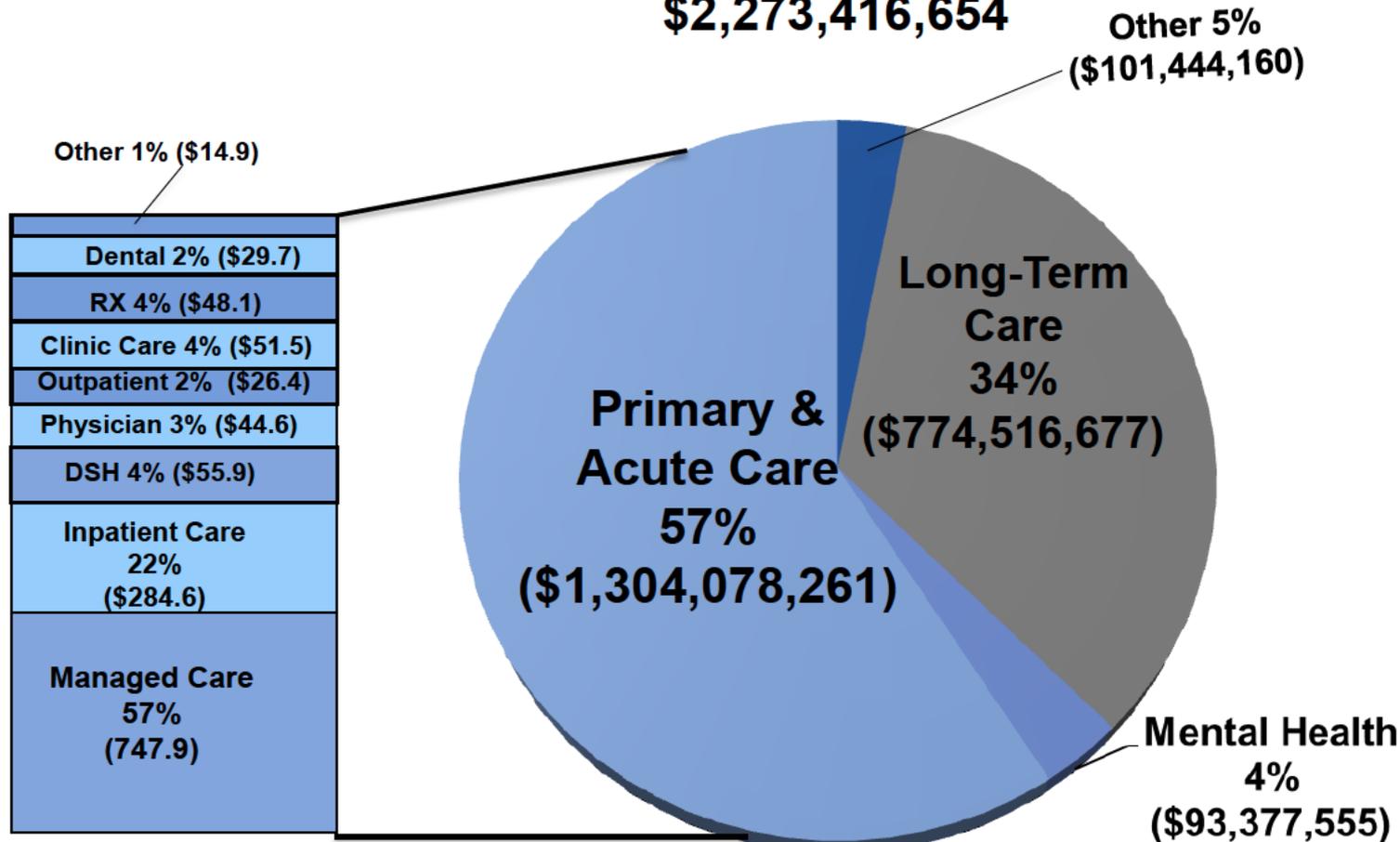


Sources and Notes: Excludes ineligible individuals (individuals who failed to recertify due to lack of follow-up, moving out of the District, excess income, or passed away), the Alliance, and immigrant children. The large jump in 2010-2011 is due to the implementation of childless adult eligibility expansion. Data for 2000-2009 data was extracted by ACS from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports

# Managed Care And Fee-For Service Hospital Spending Are The Major Cost Drivers For Medicaid Acute Care Services

## Total Medicaid Program Expenditures, FY2013

**\$2,273,416,654**



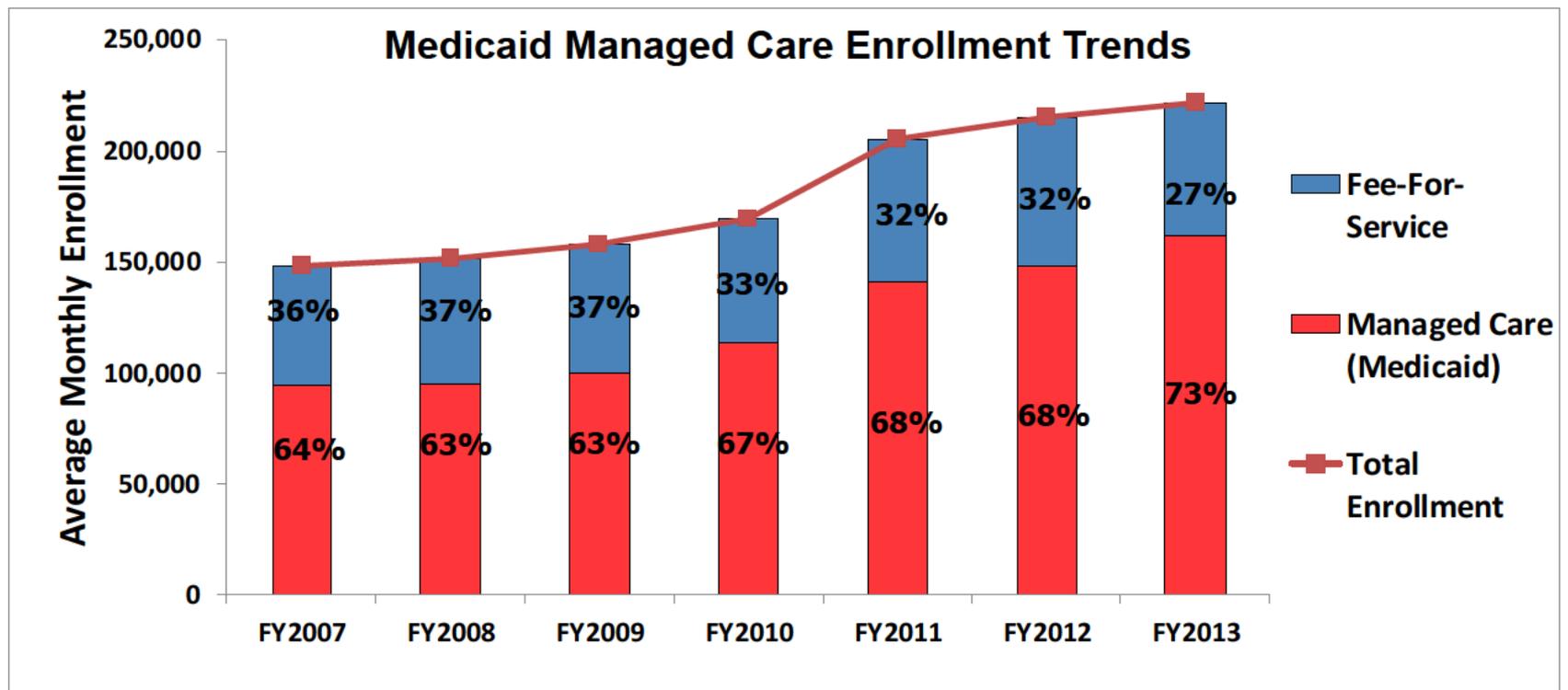
Source: Data extracted from MMIS, reflecting claims paid during FY2013

# While DHCF Is Negotiating With The Health Plans For Rates That Will Take Effect May 1, 2014, As In Past Years, The Actuarial Sound Rate Range Will Guide Agency Decision Making

Year	Low Rate	High Rate	Rate Paid	Separate Rate Cell For Waiver Population		
				Low Rate	High Rate	Rate Paid
2009-10	\$237.43	\$257.23	\$247.90			
2010-11	\$268.86	\$303.21	\$285.02			
2011-12	\$289.26	\$319.27	\$291.45			
2012-13	\$305.26	\$334.38	\$316.53	\$609.05	\$657.13	\$657.23
2013-14	\$311.13	\$344.61	\$311.12 \$316.53 \$336.40	\$561.94	\$614.34	\$561.94 \$606.32 \$564.18
2014-15 Children (1-19) Adults	185.17 396.74	200.20 429.68	\$192.57 \$412.68	542.86	587.36	564.78

Note: For the period from May 1, 2015 through September 30, 2015, DHCF has assumed a 5.6 percent increase in managed care rates. For 2013-2014, the health plans were allowed to select their own rates as a part of the competitive bidding process. Thus the rates paid for this contract year are not uniform

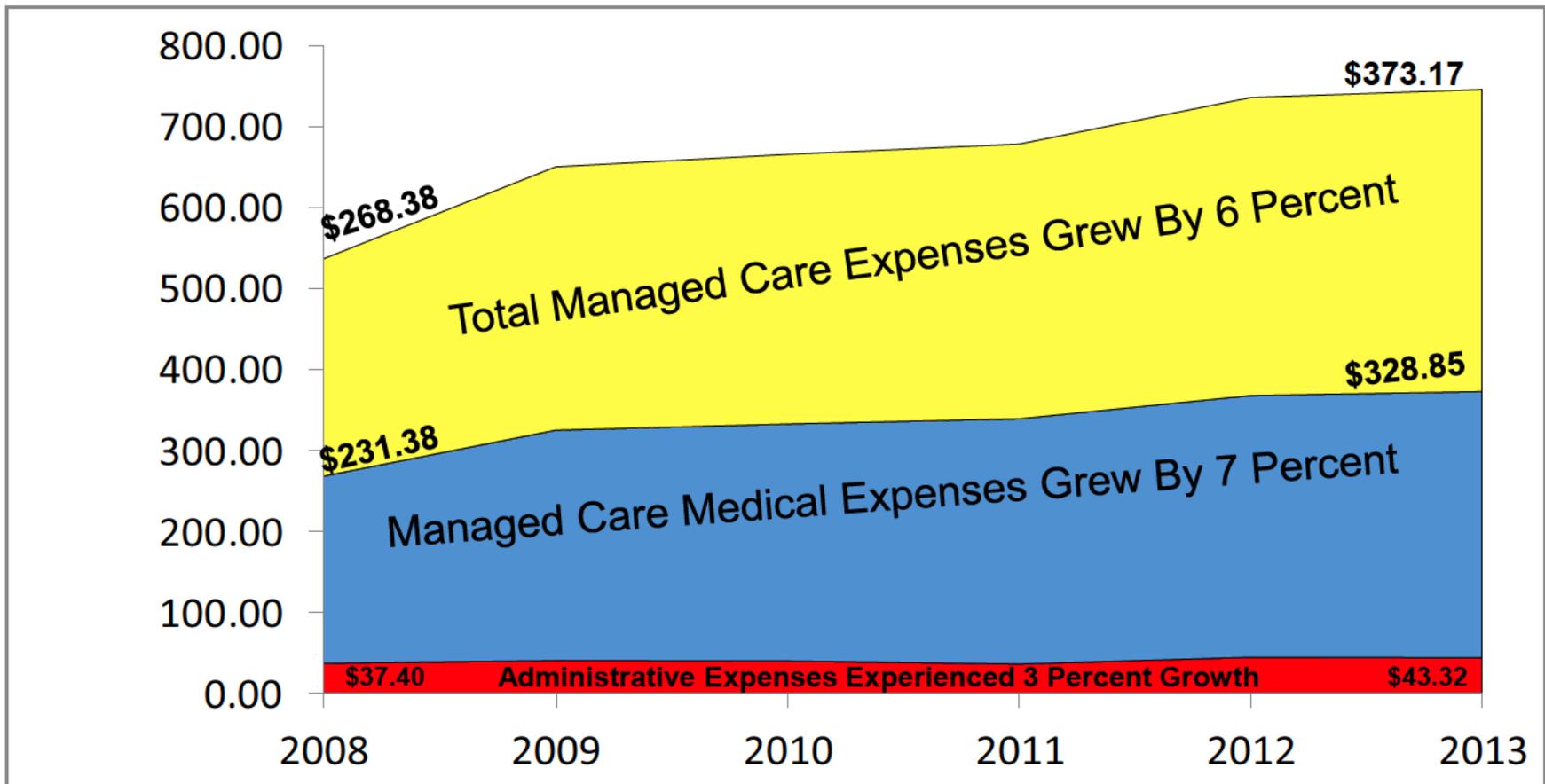
# The Enrollment Growth In The Managed Care Program -- Now At 73 Percent Of The Total Medicaid Population -- Combined With Federal Requirements For Rate Adequacy Drive The Cost Of This Program



Source: DHCF staff analysis of data extracted from the agency's MMIS.

# The Annual Growth In Managed Care Expenses For Medical Services Dropped Slightly To Six Percent

Annualized Growth Rates For Per-Member Per-Month Managed Care Expenses, 2008-2013

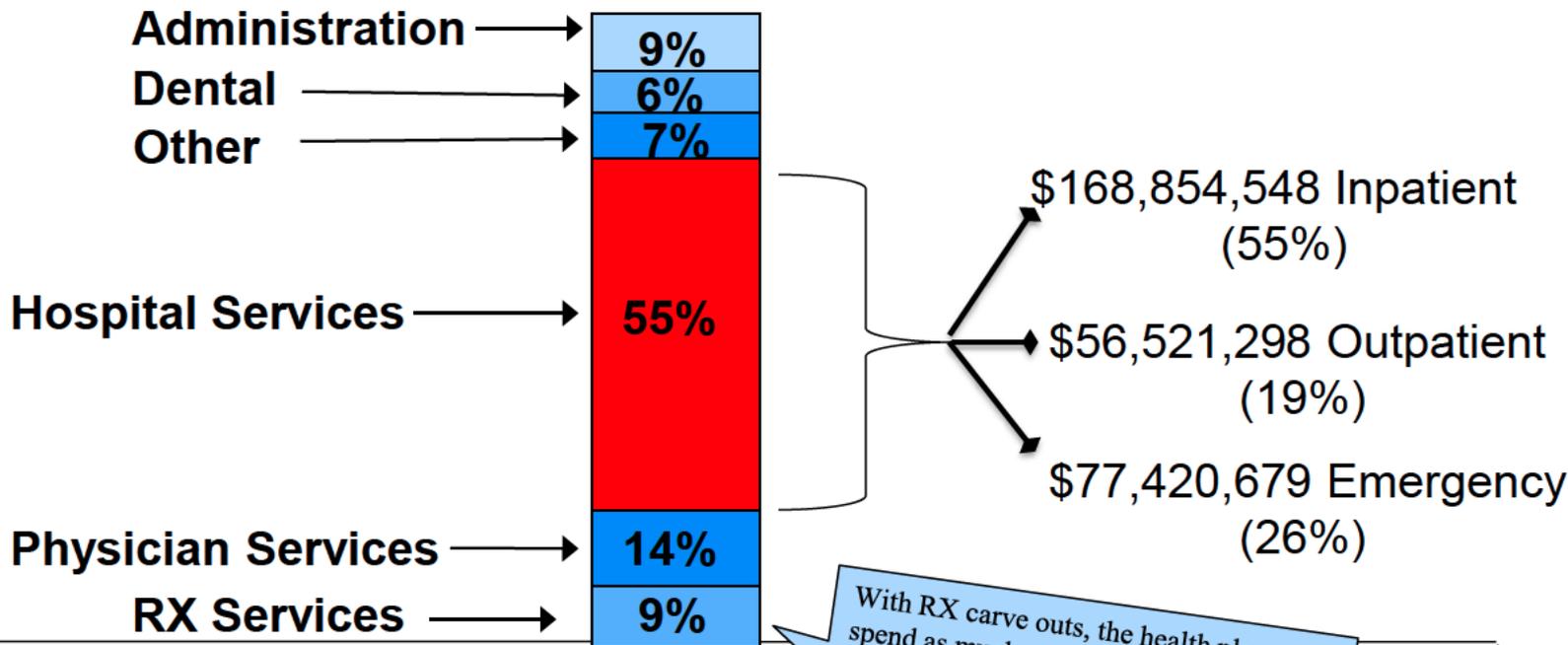


Source: Mercer analysis of MMIS Encounter data and the financial reports of the managed care plans

# More Than Half Of All Managed Care Expenses Incurred By The District's Three Health Plans Are Hospital-Based

## Total FY2013 Managed Care Medicaid Expenses

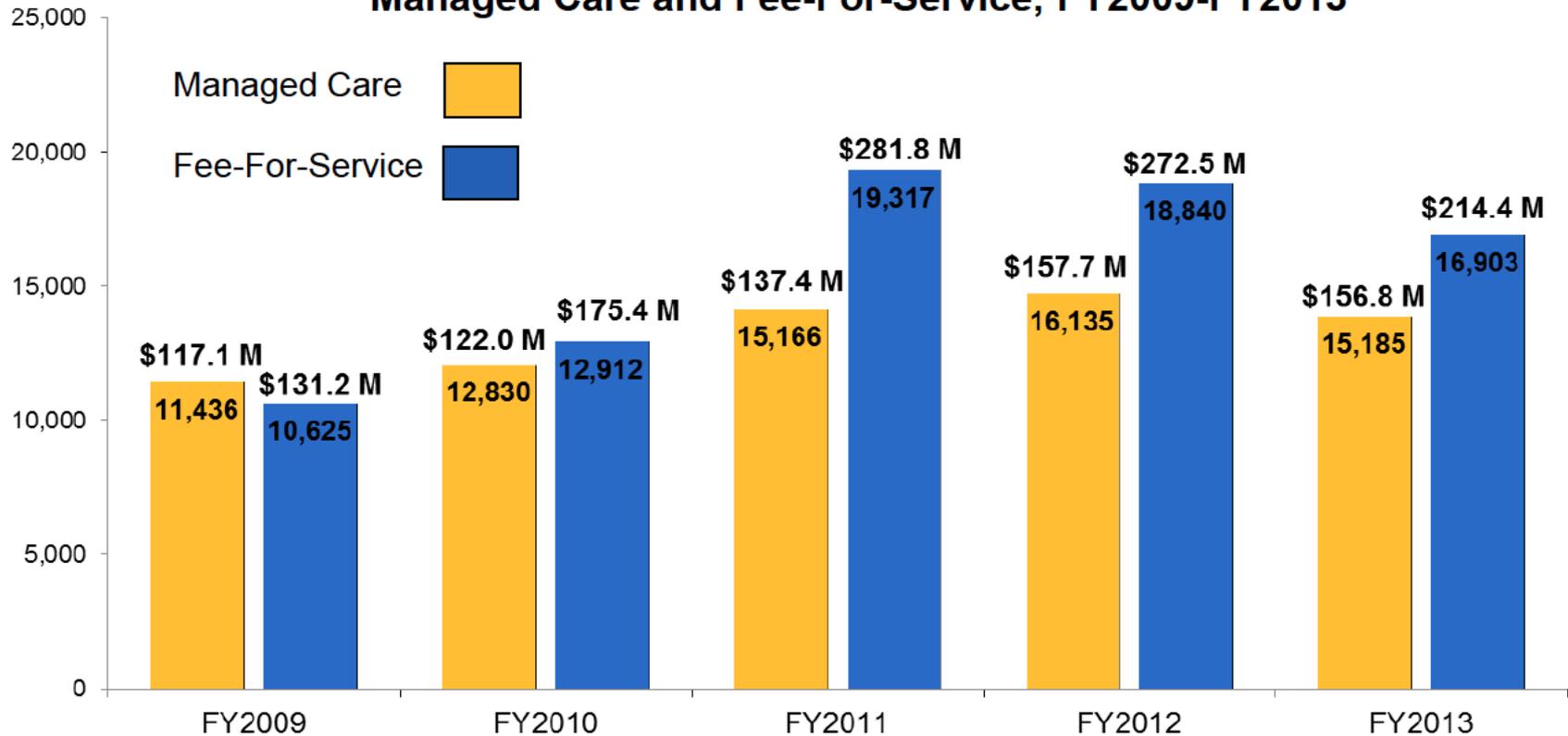
\$544,223,802



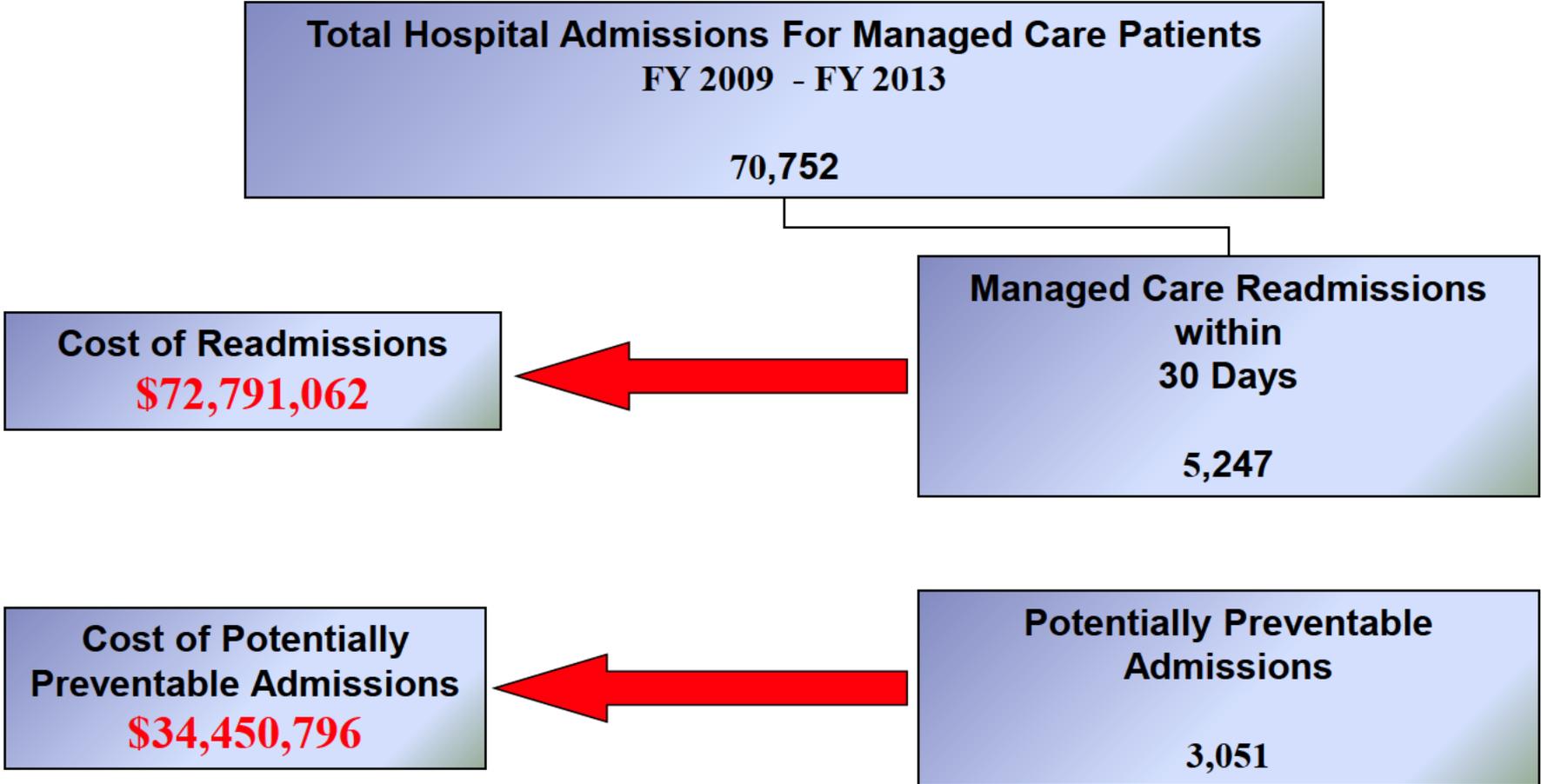
With RX carve outs, the health plans now spend as much on administrative costs as they do on pharmacy.

# Hospital Admissions For Managed Care And Fee-For-Service Have Moderated In The Last Two Years

Comparison Of Trends In Hospital Admissions For Medicaid Managed Care and Fee-For-Service, FY2009-FY2013



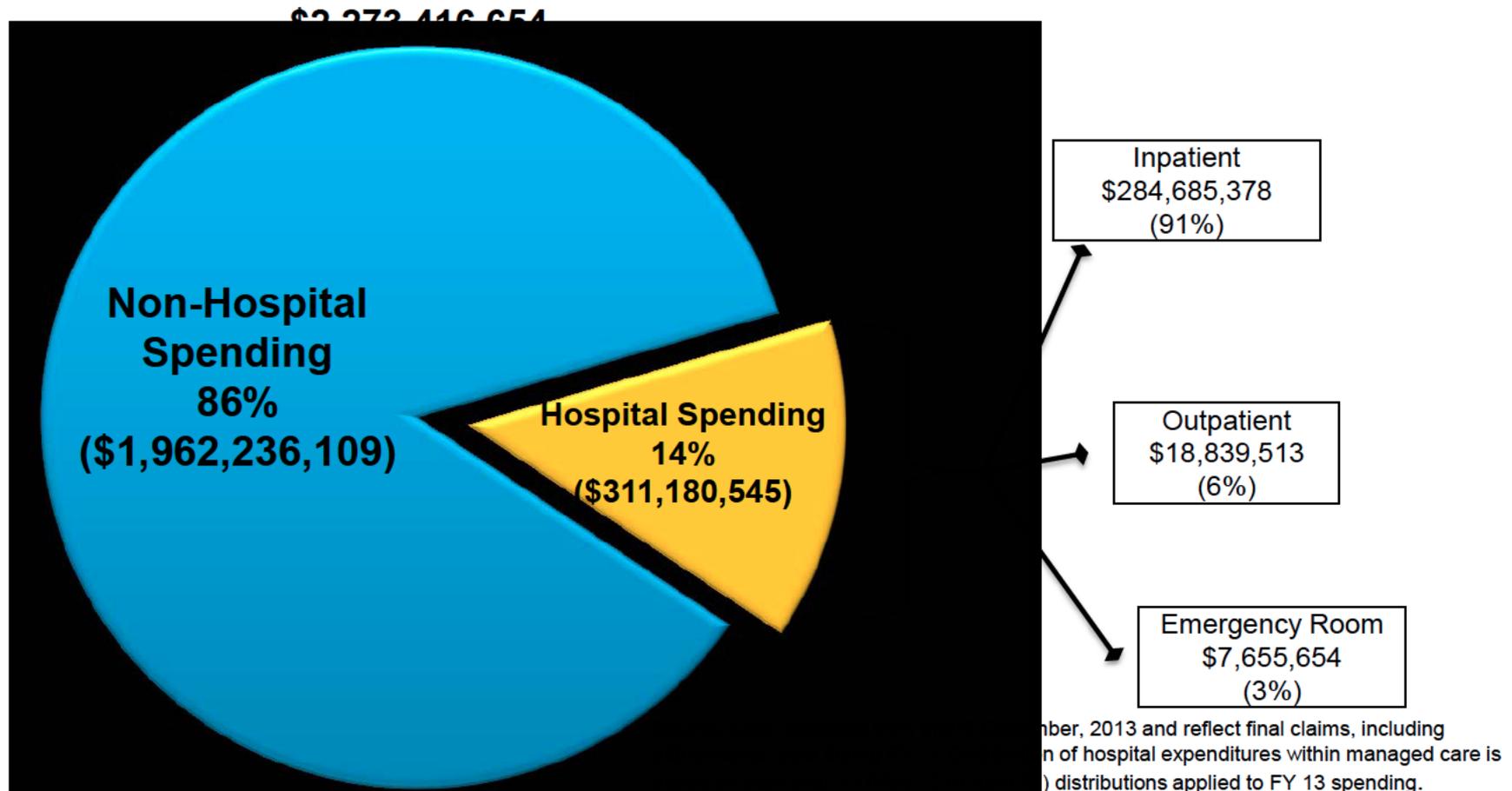
# Nonetheless, Hospital Readmissions And Potentially Avoidable Admissions For The Managed Care Population Remain A Concern



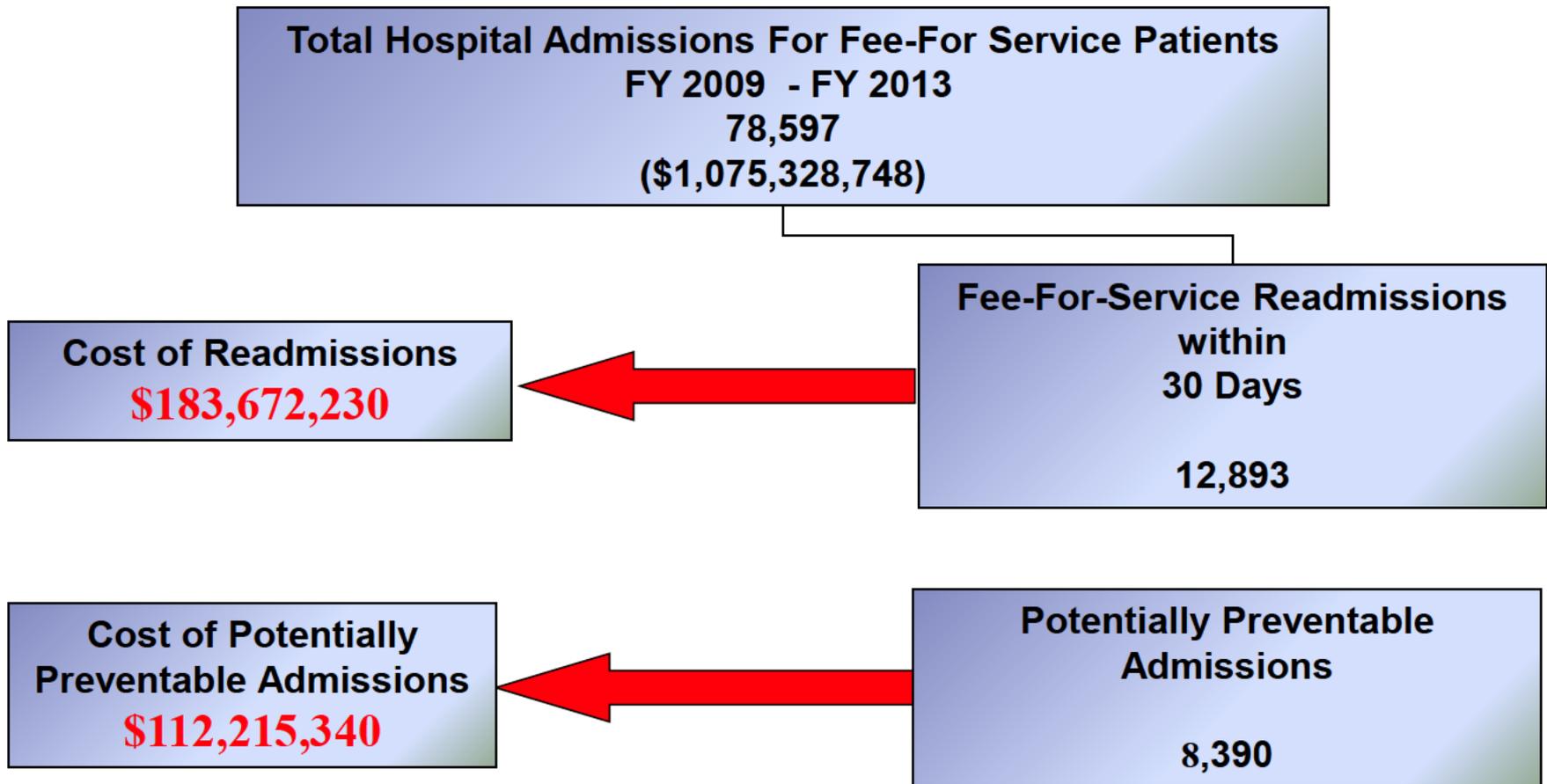
Source: DHCF staff analysis of data extracted from MMIS

# Fee-For-Service (FFS) Hospital Spending Is The Second Largest Expenditure Item In The Medicaid Budget

FFS Medicaid Hospital Spending As A Percent Of Total Medicaid Cost

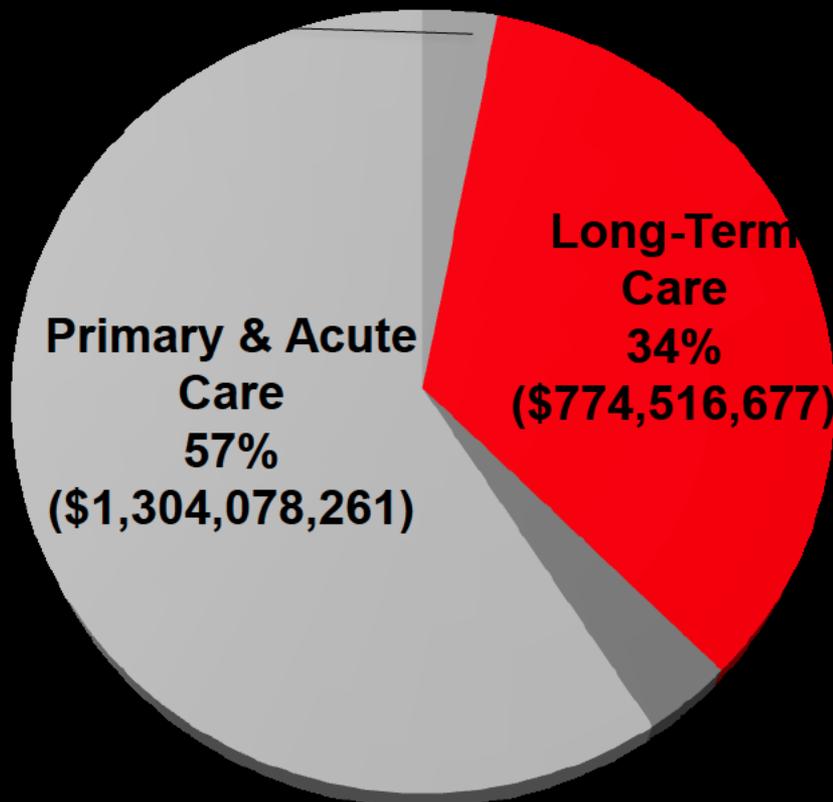


# Fee-For-Service Hospital Readmissions And Potentially Avoidable Admissions Are Costly Problems For The Medicaid Program



# Long-Term Care Spending Accounts For More Than Three Of Every 10 Dollars Spent In Medicaid

Total Medicaid Program Expenditures, FY2013  
**\$2,273,416,654**



Nursing Homes 29%  
(\$227.4)

DD Waiver 20%  
(\$158.1)

PCA Benefit 34%  
(\$262.4)

EPD Waiver 5%  
(\$34.8)

ICF/MR 11%  
(\$85.1)

Other 1%  
(\$6.6)

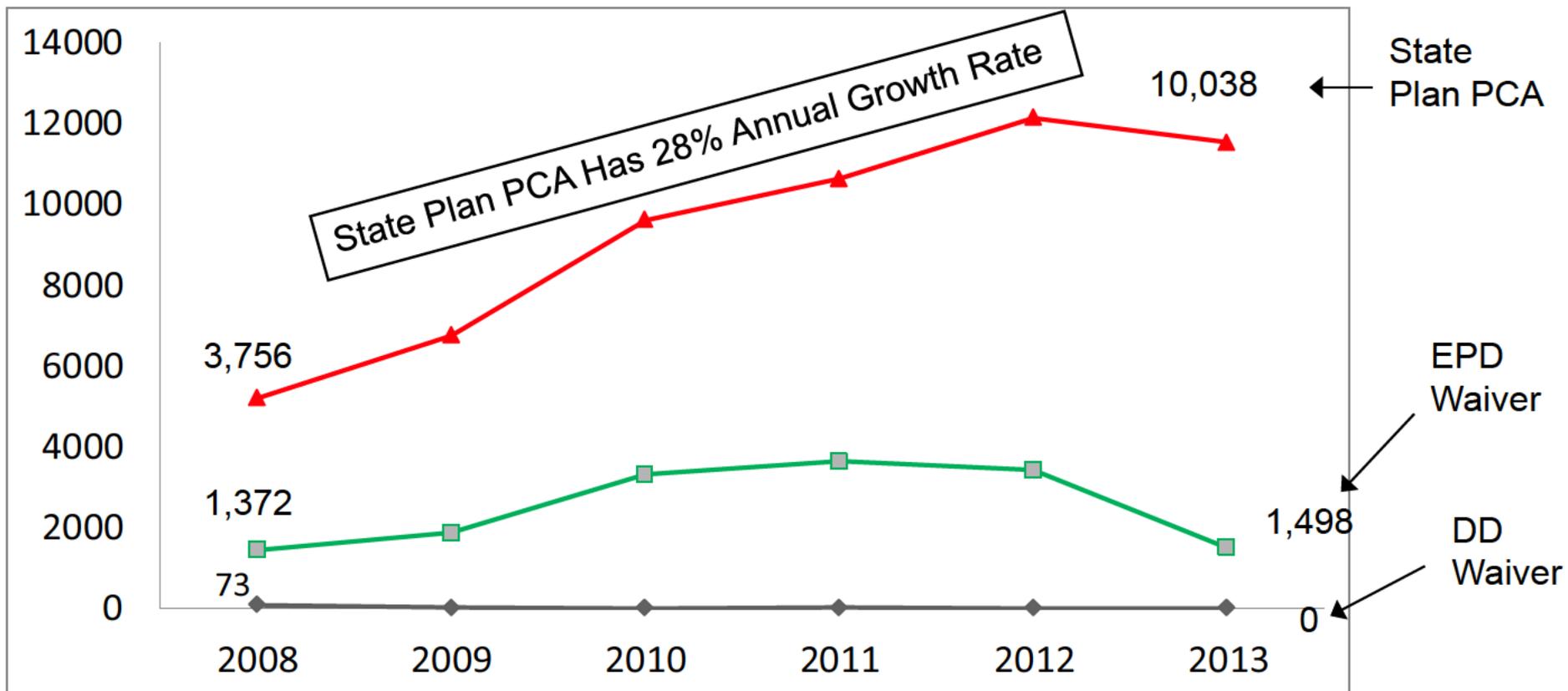
# The FY 2013 Cost of The Waiver Programs And State Plan Personal Care Services Are Especially High But Less Than Institutional Care

Overall And Per Recipient Cost For Waiver, Personal Care And Institutional LTC Programs, FY2013

Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
DD Waiver*	1,593	\$158,111,464	\$99,254
EPD Waiver	3,270	\$34,860,545	\$10,661
ICF/DD	368	\$84,197,479	\$228,797
State Plan Personal Care	10,038	\$261,851,850	\$26,086
Nursing Facilities	4093	\$227,401,814	\$55,559

\*DD Waiver costs do not include DDS local funds for the waiver.

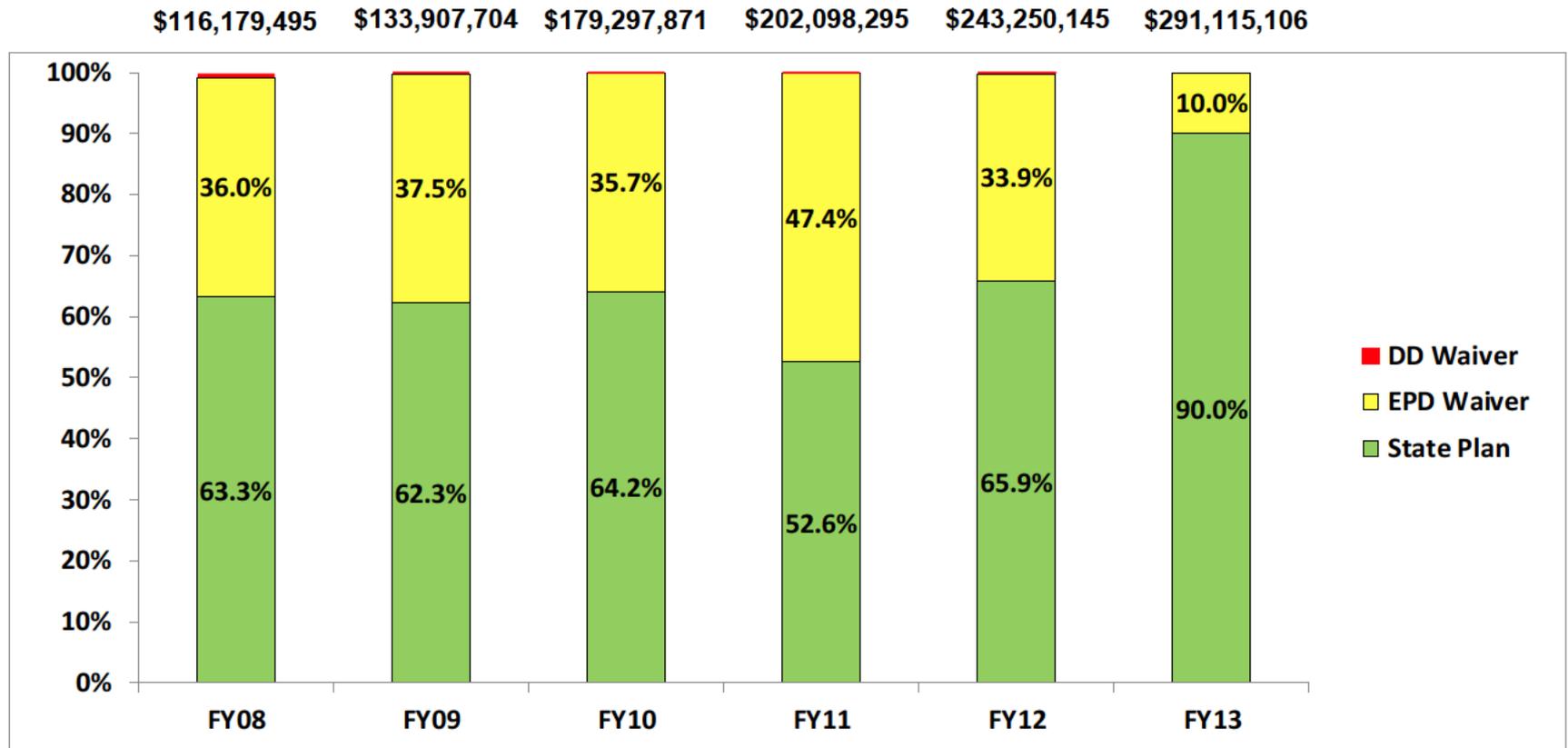
# The Number Of Medicaid Recipients Using Personal Care Benefits In The State Plan Program Continues To Rapidly Increase



Source: Data reflects final claims, including adjustments, paid during FY13. Claims are identified via procedure code and categorized by program according to modifiers. Unique benefit counts indicate total number of individuals with non-zero claims paid during FY13.

# Nine Out Of Every 10 Dollars Spent On Personal Care Is Through The State Plan Program

## Personal Care Spending In Waiver And State Plan PCA, FY2013

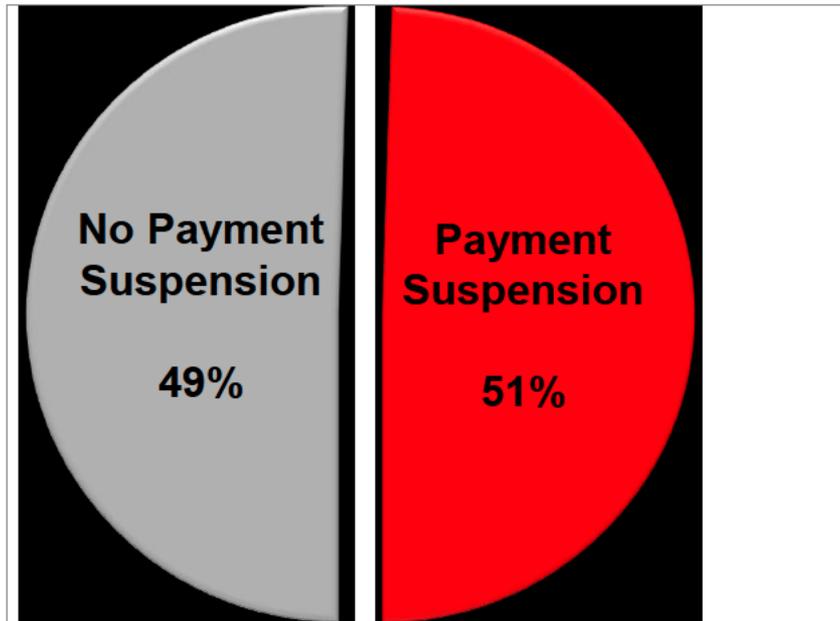


Source: Data reflects final claims from MMIS, including adjustments, paid during FY13

# A Significant Number Of Home Health Care Agencies Were Placed Under Payment Suspension Sanctions In February And March 2014, Potentially Impacting Many Beneficiaries

## Payment Sanction Rate For Home Health Care Agencies

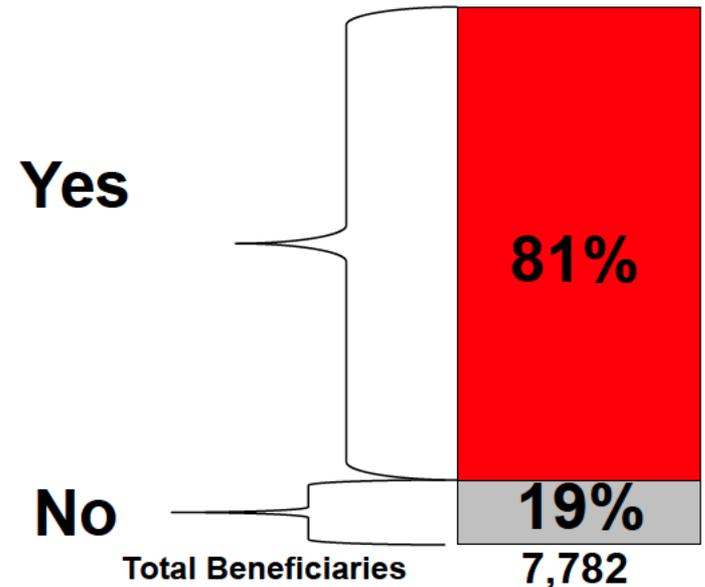
Payment Sanction Rate For Medicaid Home Health Agencies



Home Care Agencies 37

Number of PCA Beneficiaries Served By Agencies Facing Sanctions

Is Beneficiaries' Agency Under Payment Suspension?



# Summary Of Challenges In Medicaid Program

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- ❑ DHCF must continue to pursue policies that address a range of challenges faced in the Medicaid program.  
For acute care services:
  - Pursue balance between inpatient and outpatient hospital reimbursement policies that encourage efficiency in care delivery
  - Ensure rate adequacy for managed care plans to avoid problems encountered in recent years which placed some health plans in difficult financial positions
  - Reduce unnecessary hospitalization for both managed care and fee-for-service beneficiaries through improved care coordination strategies
  - Implement an aggressive managed care oversight program to improve the performance of the District's health plans
  
- ❑ For long-term care:
  - Address the over reliance on nursing home care, especially for persons who do not meet minimum level of care requirements
  - Arrest the growth of the State Plan personal care benefit through aggressive monitoring and improved control over access to this benefit using an independent contractor
  - Ensure the proper transfer of beneficiaries from home care agencies under the suspicion of fraud to agencies that have not been reported for credible allegations of fraud

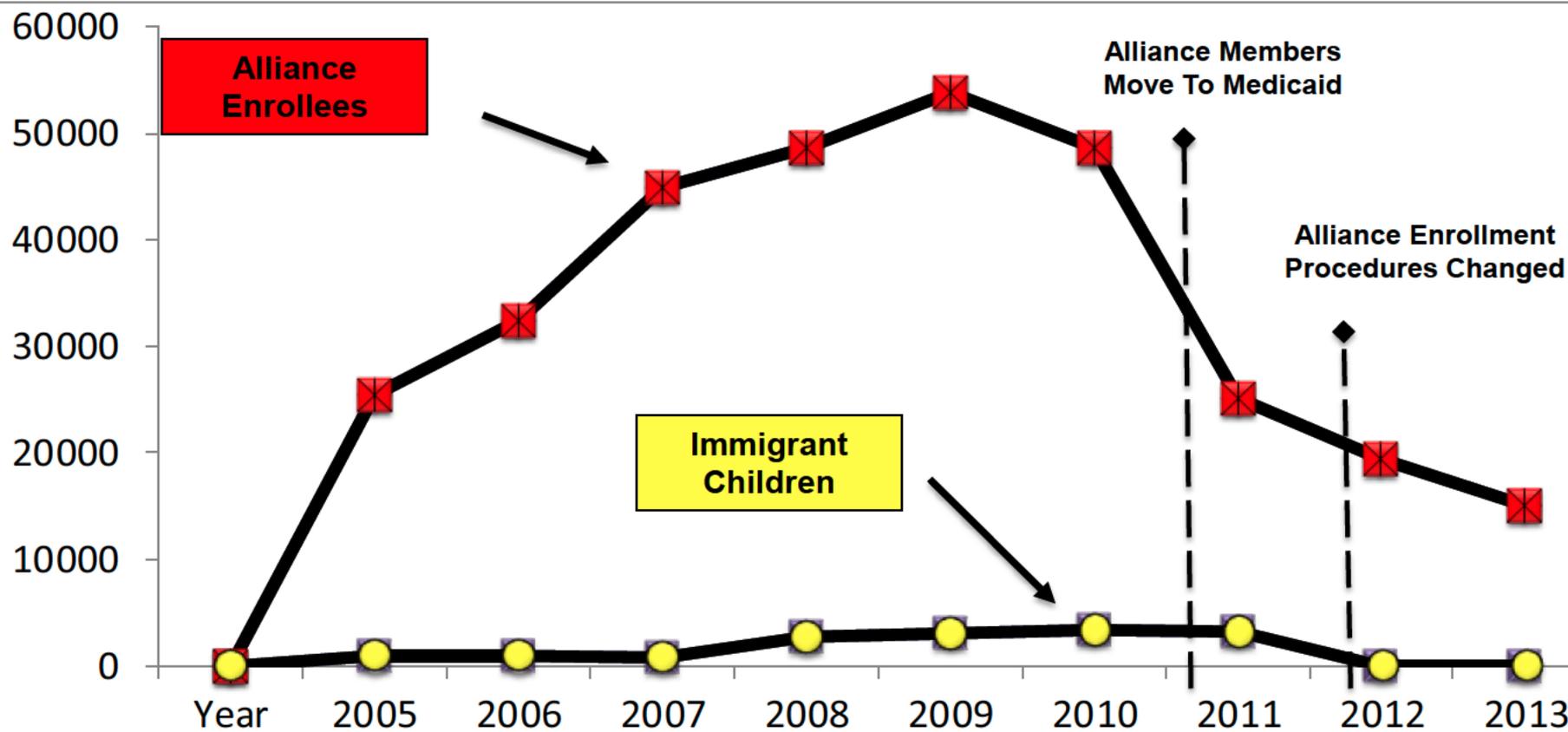
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# Face-to-Face Recertification Policies, Established In 2012, Have Further Dampened Alliance Enrollment Levels

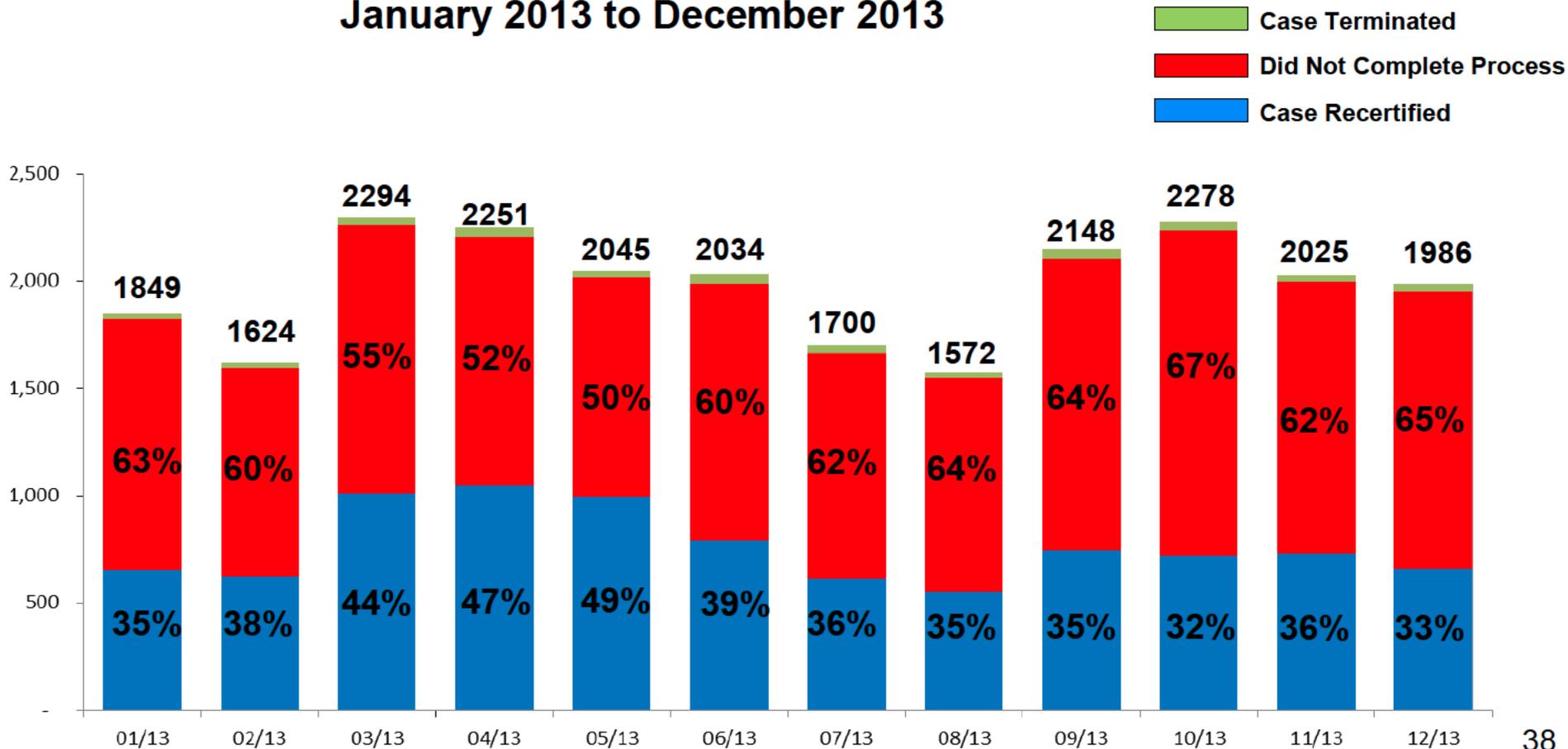
## Enrollment Trends For Alliance And Immigrant Children, 2005-2012



Sources: Excludes ineligible individuals – persons who failed to recertify due to lack of follow-up, moving out of the District, or had excess income, or passed away. Data for 2000-2009 data was extracted by ACS from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports.

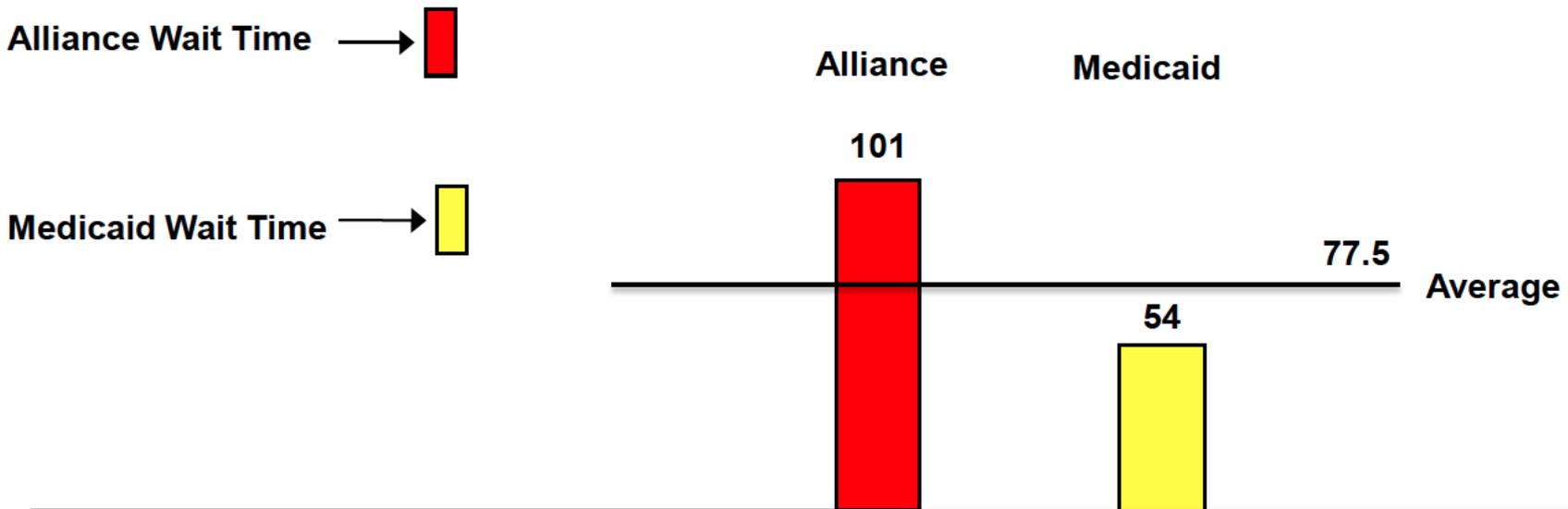
# Consistently At Least Half And Up To 67 Percent Of Alliance Recertifications Are Terminated Prior To Completion

Outcome Of Alliance Recertification Process, January 2013 to December 2013



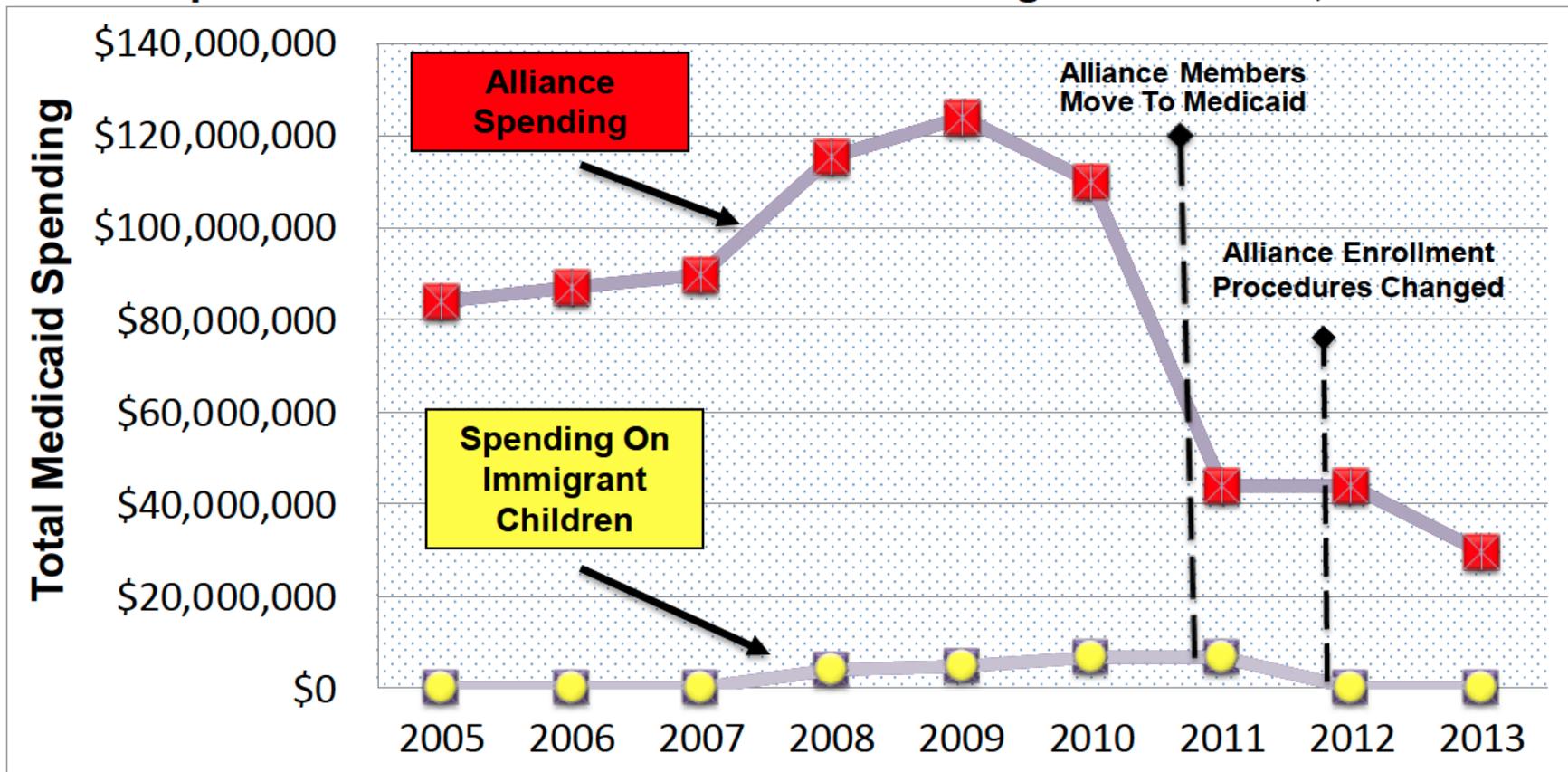
# Wait Times For Alliance Face-To-Face Recertifications Are Almost Twice The Length Of Wait Times For Medicaid

Comparison Of Average Alliance And Medicaid Wait Times (in minutes) For Recertifications, September 2013 to February 2014



# Partially As A Result, Alliance Program Spending Continues To Decline

## Expenditure Trends For Alliance And Immigrant Children, 2005-2012



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).

# Although Overall Alliance Costs Are Declining, The Per-Member Per-Month Cost Associated With The Care For Beneficiaries Who Now Access The Program Has Grown

## Weighted Average Capitation Rate For Alliance Members, October 2009 to April 2015



# Conclusions And Key Questions Regarding The Alliance Program

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- ❑ The Alliance recertification process, which requires face-to-face interviews, has twice the average wait time as Medicaid recertifications and appears to have dampened Alliance enrollment growth
  - A high rate of Alliance recertifications terminate without the applicant completing the process
  - At the same time, it appears that persons with higher care needs are disproportionately enrolling in Alliance
- ❑ Does this mean that eligible persons who are not sick are self-selecting out of the program rather than endure a lengthy recertification? Or, is the recertification process serving as a deterrent to those who are not District residents?