

THE DISTRICT OF COLUMBIA'S MEDICAID PROGRAM

Overview

Medicaid is a federal-state program created in 1965 to provide health insurance coverage to eligible low-income families and individuals.ⁱ DC and the states operate individual programs under federal guidelines, but are given a great deal of flexibility to determine who is eligible for the program and what health care services are covered. The federal government funds half or more of each state's program, based on the state's income level. Since the late 1990s, the federal government has covered 70 percent of DC's Medicaid expenses.

DC's Medicaid program serves approximately one out of every three residents. The District has opted to go beyond minimum eligibility requirements required under federal law, and the District has worked in recent years to expand the scope of who can be served by its Medicaid program, including opting for early implementation of some Medicaid provisions of the federal Affordable Care Act—the federal health care reform legislation passed in 2010.ⁱⁱ

This policy brief provides information on the District's Medicaid program and also identifies three key issues currently facing the Medicaid program:

- As enrollment in the program continues to grow amidst shrinking local resources, the District is looking at ways to reduce costs in the program without reducing services for those who need them.
- At the same time, the District is also trying to implement changes that will improve the delivery of services through improved coordination of mental health care.
- The District is also trying to improve its health information technology efforts.

Population Served by DC's Medicaid Program

Federal law requires states and the District to provide Medicaid coverage to low-income residents in several categories, including families with children, elderly populations, and people with disabilities. The 2010 Affordable Care Act requires DC and the states to expand Medicaid coverage to all low-income residents starting in 2014. Medicaid is an “entitlement” program, which means that in the states and the District, anyone who meets the eligibility rules for the program has a right to participate.

The District has chosen to set its Medicaid income eligibility levels above the minimum federal government requirements. DC has also opted to expand Medicaid coverage to all low-income DC

residents earlier than required under the Affordable Care Act, in large part because that generated savings in local resources.

- DC provides Medicaid coverage to children in families with incomes under 300 percent of poverty, or less than \$67,050 for a family of four. (Table 1 compares DC's income eligibility levels with the minimum federal requirements.) The eligibility level is also 300 percent of poverty for pregnant women.

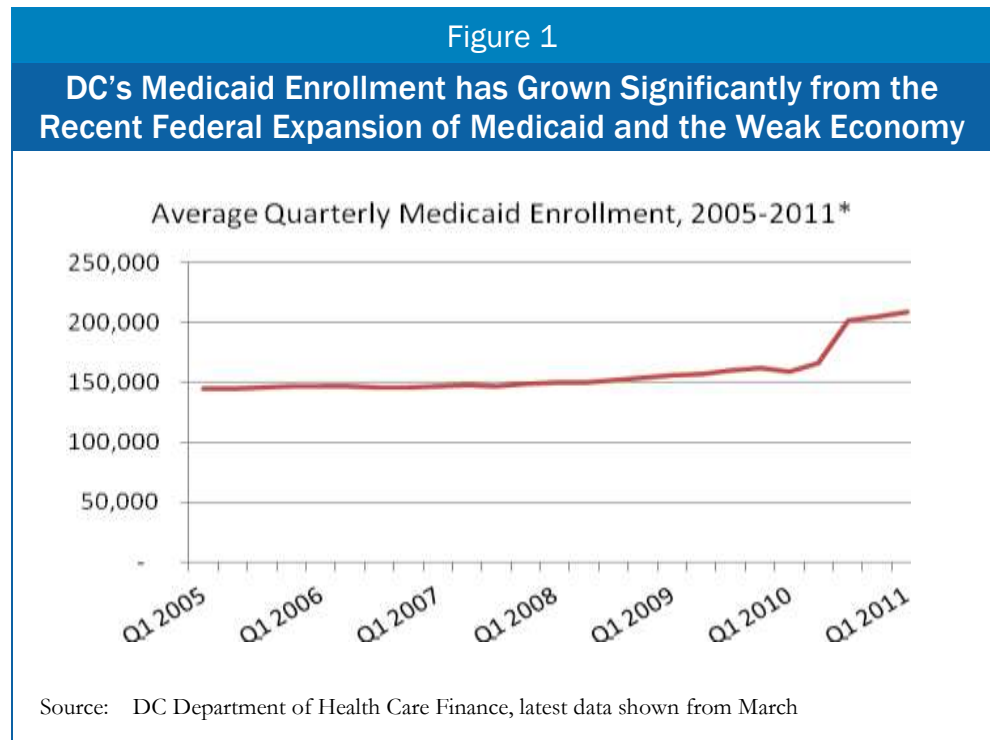
Table 1:
Population and Income Requirements for DC's Medicaid

Population (ages)	Federal Poverty Line (FPL) Requirements	Equivalent Income for Family of Four*
Children (age 0-18)	300%	\$67,050
Youth (age 19-20)	200%	\$44,700
Pregnant Women	300%	\$67,050
Elderly, (>65) blind, or disabled	100%	\$22,350
Adults (21-64)	200%	\$44,700

*Source: US Department of Health and Human Services

- DC's Medicaid eligibility for adults in families with children is set at 200 percent of poverty, or \$44,700 for a family of four.
- Elderly residents and those with disabilities are eligible for Medicaid in DC if their income is below 100 percent of poverty.

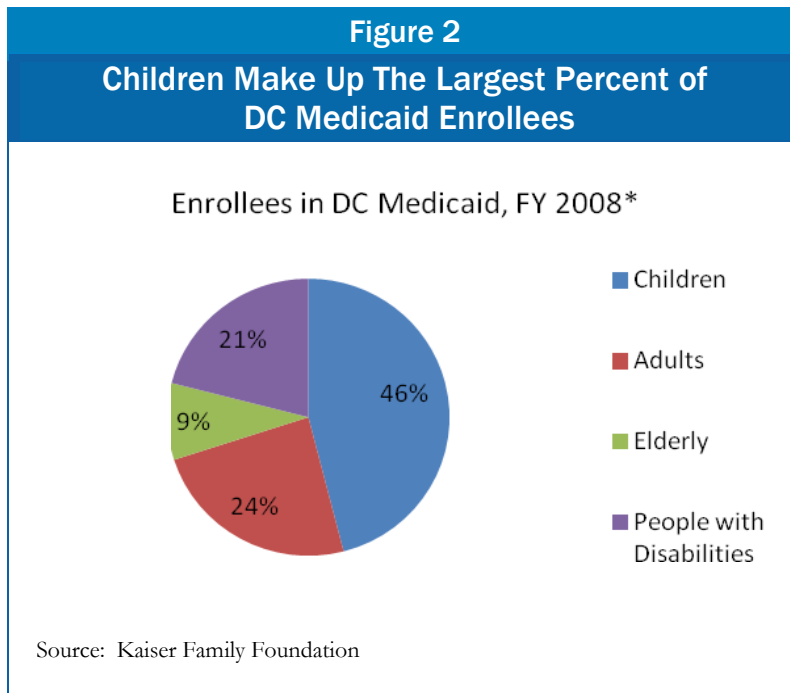
The federal Affordable Care Act requires states to extend Medicaid coverage to other low-income adults, particularly non-elderly and non-disabled adults without children, by 2014. The District took advantage of this option early, in 2011, and allowed all adults below percent of poverty to qualify for Medicaid. This allowed the District to move more than 30,000 residents enrolled



in the locally funded Healthcare Alliance program into Medicaid. Because DC receives federal

funding for 70 percent of Medicaid costs, while the Alliance is supported entirely with local funds, this made fiscal sense for the District and improved health services for eligible residents because Medicaid offers a broader array of services.ⁱⁱⁱ

Enrollment in DC’s Medicaid program saw minimal growth during the mid-2000s. But more recently, the District’s Medicaid enrollment has seen a dramatic expansion. (See Figure 1.) In fact, in the first quarter of 2009, average Medicaid enrollment was at 155,520 participants. By the first quarter of 2011, enrollment had grown by more than one-third, up to 208,610 participants.^{iv} The recent growth in the Medicaid program is the result of two factors.



- The majority of the recent growth is due to the implementation of the federal Affordable Care Act. As noted, the District has moved more than 30,000 residents who were enrolled in the DC HealthCare
- Alliance program — a locally funded health insurance program that serves low-income adults who are not eligible for Medicaid — into the District’s Medicaid program.
- The second reason for the recent growth in Medicaid is the weak economy and high levels of unemployment in DC. As thousands of DC residents have lost their jobs or had their hours cut back at work, many have turned to programs like Medicaid to help them meet their basic needs.

In DC’s Medicaid program (before the recent expansion), the majority of the enrollees in the District are children, which make up 46 percent of the enrollment. In contrast, the elderly make up only nine percent of the enrollment. (See Figure 2.) This is not surprising given that the District covers children up to 300 percent of poverty, while it covers elderly residents just up to 100 percent of the poverty line. In addition, the federal government provides a separate insurance program — Medicare — that covers the majority of people over 65 in the US. While the elderly and disabled account for a small share of enrollees, their costs are a much larger share, 73 percent as of Fiscal Year 2008.^v

Services Provided Under Medicaid

DC's Medicaid program pays doctors, hospitals, and managed care plans that contract with the city for services they provide for Medicaid participants. The District's Medicaid program does not require participants to pay any co-payments for Medicaid services.

Federal guidelines require that states cover certain services through Medicaid, including physician, midwife, and nurse practitioner services; inpatient and outpatient hospital services; nursing home and home health care services; lab and x-ray services; family planning services and supplies; and early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

DC has taken advantage of federal options to expand the scope of services provided under Medicaid, including dental and eye care, and a limited amount of mental health services.^{vi} Medicaid beneficiaries with less than severe mental health problems are allowed only ten mental health visits over their lifetime, while beneficiaries with severe mental health needs receive treatment from the DC Department of Mental Health.

The Medicaid program also reimburses hospitals for uncompensated costs that they incur by caring for the uninsured. These payments are known as disproportionate share hospital (DSH) payments.

Medicaid Funding

Medicaid is funded through a combination of federal and state funds. The federal government matches at least 50 percent of the costs, with states that have higher levels of poverty receiving higher contributions. Currently, the federal government matches 70 percent of the District's Medicaid cost, while the average matching rate is 59 percent.^{vii}

Both local and federal funding for DC's Medicaid program has increased in recent years. This is largely due to the significant increase in enrollment as a result of the expanded eligibility under the federal Affordable Care Act, which the District implemented in 2011, and the Great Recession. Also, the federal Recovery Act helped reduce the local contribution to Medicaid by increasing the federal share in FY 2009, FY 2010 and part of FY 2011. DC's share of Medicaid expenses were approximately 21 percent during that time. In FY 2012, however, DC's local contribution to Medicaid increased significantly to cover the expiring federal recovery funds available during the previous fiscal year. In FY 2012, local funding for Medicaid is \$642 million, an increase of 18 percent, or \$99 million over the FY 2011 budget, after adjusting for inflation. The FY 2012 gross funding (both local and federal) is \$2.1 billion, a four percent decrease from the FY 2011 budget of \$2.2 billion.^{viii} (See Figure 3.)

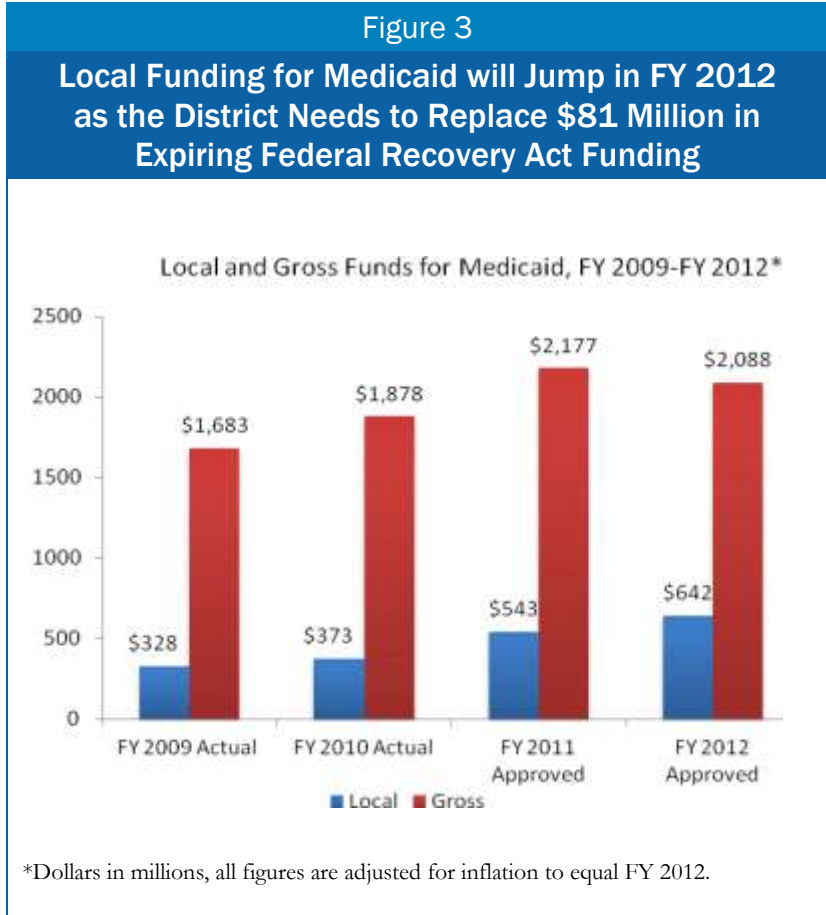
Current Issues

There are three major issues currently affecting DC's Medicaid program:

- Budgetary concerns due to increasing enrollment and shrinking local resources

- Coordination of mental health services
- Health information technology efforts

Budgetary Concerns: The District's Medicaid budget has grown significantly in recent years. In large part, the increases in the budget are due to increased enrollment as a result of expanded Medicaid eligibility and continuing high levels of unemployment. In addition, the costs of health care continue to rise nationally each year well beyond the cost of inflation. With costs rising and the DC budget struggling from the drop in revenues during the recession, the District has had to focus on ways to reduce costs in the Medicaid program without reducing services.



One area that has been explored to reduce costs is in the use of the long-term care and personal care assistant services. These two services are costly, particularly when used by people who are dual-enrollees in both Medicaid and Medicare, because they participate under Medicaid's fee-for-service plans. This means that the program is charged for each individual service these participants obtain, instead of a set rate under a managed care plan. While the fee-for-service enrollees account for less than a third of Medicaid enrollees, they account for almost three-quarters of Medicaid expenditures.^{ix}

The District looked to reduce costs in this area by placing a cap on the total hours of long-term care and personal care assistant benefits someone could use. (Long-term care consists of medical and non-medical help with daily tasks, not including institutional care.) The current cap is at 1,040 hours a year. However, that raised concerns among advocates and providers that people who needed the full 1,040 hours of services would be arbitrarily cut off. Instead, the District implemented a more rigorous application process to better target residents who need personal care.

Mental Health Coordination: There have also been some issues with the level of mental health services provided under Medicaid and the coordination of mental health care with the District's Department of Mental Health (DMH). The FY 2012 budget brought millions of dollars in cuts to mental health benefits. These cuts were made with the idea that the District would support mental health services for new beneficiaries using managed care organizations (MCOs) rather than DMH staff. However, the MCOs have not taken on these mental health patients and are still passing the patients on to the DMH. This has resulted in a 27 percent per-person reduction in mental health

funding available, because DMH's budget has shrunk while the number of people it serves has grown.^x

With the increase in enrollment in the Medicaid program, this arrangement promises to continue to be a problem involving both provider capacity and adequate services provision. Since the managed care organizations are not taking on the cases for which they have received funds, a re-evaluation of funding allocations or incentives to provide care should be addressed.

Health Information Technology Efforts: A final major issue with DC's Medicaid program is to operationalize and maintain a 21st century health information technology which is critical to successfully implementing ACA. Initially, the District took a leadership role, in collaboration with DC Primary Care Association (DCPCA), in implementing health information technology in DC's network of primary care physicians and health centers. This expansion in health information technology was built on a regional health information organization (RHIO) model designed by DCPCA, and is expected to reduce costs and improve the coordination of health care services, including between primary care and behavioral health services. Health information technology can allow for reduction of medical errors, elimination of duplicative testing, better care for complex illnesses, and an improved ability for the city to understand what it pays for and how often. Progress on this effort, however, has slowed in 2012 as the federal government expressed its preference for implementing a less costly electronic health record (EHR)—DIRECT—than the DCPCA-designed RHIO. The District government is now encouraging individual practitioners to adopt the web-based DIRECT model consistent with federal guidance. Lastly, the District government is no longer funding the RHIO as of 2012.

Two primary health information technology initiatives coordinated out of the District's Department of Health Care Finance include the Medicaid EHR (Electronic Health Records) Incentives Program and the State Health Information Exchange. Most states have already launched their incentives programs. However the District will likely not begin its incentives program until 2013. A number of providers in the District have already invested in the adoption and upgrade of EHR under the assumption that they would qualify the first year that such incentive payments are available under ACA. Yet no such payments have been made to eligible providers as of August 1, 2012. Regarding the health information exchange, the District government issued a Request for Proposals to secure a vendor which will build technology platform for the State Health Information Exchange. The exchange will need to be operationalized by October 1, 2013 so District residents have sufficient time to review health insurance options and to formally select coverage which is effective on January 1, 2014.

Continued delays in implementing the DC Medicaid EHR Incentive Program and the State Health Information Exchange ultimately lead to lost opportunity to build patient-centered medical homes in DC. Such delays will lead to less than optimal health care delivery to individual patients, and may create barriers to care for those individuals who rely on public coverage as their source for primary health insurance.

ⁱ For more information on the overall Medicaid program, see the Center for Budget and Policy Priorities Medicaid factsheet - <http://www.cbpp.org/files/policybasics-medicaid.pdf>.

ⁱⁱ For more information on the Affordable Care Act, visit <http://www.healthcare.gov/>.

ⁱⁱⁱ The residents that remain in the Alliance largely are undocumented immigrants who are not eligible for Medicaid.

^{iv} Data requested from District of Columbia's Department of Health Care Finance.

^v Kaiser Family Foundation. State Health Facts - Distribution of Medicaid Payments by Enrollment Group, FY2008. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4>.

^{vi} District of Columbia Department of Health Care Finance, "DC Medicaid/Alliance and Me," <https://www.dc-medicare.com/dcwebportal/nonsecure/medicaidAndMe>.

^{vii} Ibid.

^{viii} DC Fiscal Policy Institute, "What's in the Proposed FY 2012 Budget for Health Care?" May 2011, <http://www.dcfpi.org/wp-content/uploads/2011/04/Health-Care-Toolkit.pdf>

^{ix} Baskerville, Sharon, DC Primary Care Association. "Oversight Hearing on DC Department of Health Care Finance," March 10, 2011, <http://www.dcpca.org/wp-content/uploads/DCPCA-Testimony-for-DHCF-Oversight-Hearing.pdf>

^x District of Columbia Behavioral Health Association. "Issue Brief: Impact of Health Care Reform on the District's Medicaid Mental Health Programs." June 2010.