DC Fiscal Policy Institute
15 Years

An Affiliate of the
Center on Budget and Policy Priorities
820 First Street NE, Suite 460
Washington, DC 20002
(202) 408-1080 Fax (202) 408-1073
www.dcfpi.org

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What's In The Proposed FY 2017 Budget For Health Care?

SUMMARY OF THE PROPOSED FY 2017 HEALTH CARE BUDGET

- The proposed FY 2017 budget includes $3.6 billion in federal and local funds for health care, an increase of less than one percent from FY 2016, after adjusting for inflation. The health budget reflects essentially flat funding from both local and federal sources.
- The proposed budget would maintain a tax on hospitals that was adopted in 2016 on a one-year basis, and that revenue will help maintain the rate at which hospitals are reimbursed for Medicaid services. In addition, the budget continues a fee on outpatient hospital services, also adopted in 2016 on a one-year basis, to increase Medicaid payments for these services. The $17 million in local funds from these tax and fee increases will allow the city to collect $40 million in federal Medicaid matching funds.
- A rule that restricts participation in the Healthcare Alliance program will be maintained. The Alliance provides health care to low-income residents who are not eligible for Medicaid. The program requires a 6-month, face-to-face interview requirement for beneficiaries to maintain their eligibility, a requirement which has proved a barrier for eligible residents to keep the benefit. The budget increases funding for the program substantially, from $52 million to $58 million, solely due to higher costs per participant.
- The proposed budget reflects reductions in a number of public health initiatives, including pregnancy prevention grants to community providers, school-based health centers, tobacco cessation, and a program to help low-income residents buy fresh produce at farmers' markets.
- Local funding for the Maternal and Child Health Home Visiting Program will provide home-based instruction for parents so that kids enter school healthy and ready to learn. The budget keeps $2 million to support approaches proven to be effective.
- The FY 2017 budget reflects plans to create a "Health Homes" program for residents with multiple chronic health conditions, including chronically homeless residents. The Health Homes plan offers a bundle of services and care coordination that will improve care and enhance access to federal funds.
- The proposed budget provides one-time funding of $2 million to support United Medical Center. The District provides occasional support to UMC. The initial budget for FY 2016 did not include an appropriation for UMC, but a payment of $10 million was authorized in the middle of the fiscal year.

The District has a variety of programs that are aimed at improving health and health care access for District residents. The agencies that run these programs include:

- **The Department of Health Care Finance:** which manages the District's Medicaid and Healthcare Alliance programs. These programs provide health insurance for low income residents and are a large reason why the District has near universal health coverage.
- **The Department of Health:** which manages public health programs like school nursing, HIV/AIDS prevention and screening, maternal and child health home visiting programs, and some nutrition programs.

- **The Department of Behavioral Health:** which funds and manages mental health and substance abuse clinics throughout the city. The program also operates mental health programs in schools and the District's psychiatric hospital, Saint Elizabeth's.

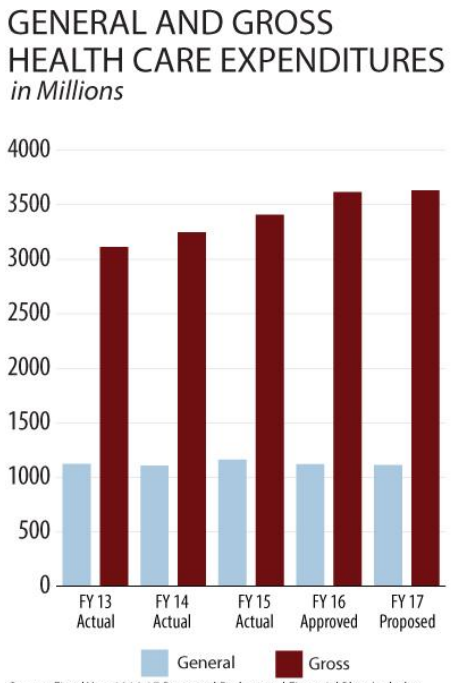
The proposed FY 2017 budget for these agencies totals $3.63 billion in local and federal funding. This represents a $16 million, or 0.4 percent increase from the FY 2016 budget, after adjusting for inflation. (Unless otherwise noted, all figures are adjusted for inflation to equal FY 2017 dollars.)(See **Figure 1**.)

The budget reflects essentially flat funding from both local sources and federal Medicaid funds. While there is some increase in Medicaid funding resulting from higher enrollment and utilization of services, the budget also reflects a reduction in the federal share of funding for certain groups of residents who became eligible for Medicaid as a result of DC's implementation of the federal Affordable Care Act. The federal government picked up 100 percent of these Medicaid costs in 2015 and 2016, and will cover 95 percent in FY 2017.

The District also budgets for the DC Health Benefit Exchange Authority — a fund outside of the District's general operating budget which is not reflected in the totals above. The Exchange operates DC Health Link, the District's online portal for health insurance plans and financial assistance for those plans. The Exchange's funding for FY 2017 is $35 million, a 4 percent increase from FY 2016.

Figure 1

DC's Health Expenditures Will Be Flat In FY 2017



Source: Fiscal Year 2014-17 Proposed Budget and Financial Plan. Includes Departments of Health Care Finance, Health, and Behavioral Health. All figures adjust for inflation in FY 2017 dollars.

Medicaid Spending Will Not Grow Beyond Inflation

Total funding for Medicaid provider payments, including both local funds and the federal match, equals $2.9 billion in the proposed FY 2017 budget. This is roughly the same as in FY 2016, but it is 9 percent higher than in FY 2015, after adjusting for inflation (see **Figure 2**). Medicaid is administered by the Department of Health Care Finance (DHCF) and now accounts for 95 percent of its budget.

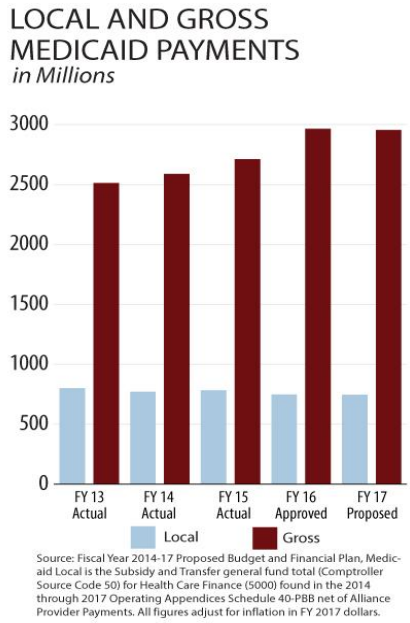
The increase since FY 2015 stems mostly from increases in Medicaid enrollment, which grew by 7 percent in FY 2015 and is expected to grow 4 percent in 2016 and 3 percent in 2017. About 250,000 residents – more than one-third of DC residents – receive health care through Medicaid.

Despite the overall increase, the District's local contribution to Medicaid will fall modestly in FY 2017, to $688 million. This is $8 million lower than in FY 2016 and $40 million less than in FY 2015. This reflects the fact that in recent years the federal government has picked up a larger share of DC's Medicaid costs for some participants. Normally, the District is responsible for 30 percent of Medicaid costs, while the federal government pays for the other 70 percent. This has changed in two ways:

- In 2016, the federal government is paying 100 percent of the Medicaid costs for groups of DC residents who became eligible for Medicaid as a result of the federal Affordable Care Act, such as childless adults with incomes up to 200 percent of the federal poverty line. The federal reimbursement falls to 95 percent in 2017 but this is still far higher than DC's standard 70 percent federal Medicaid match.
- Starting in FY 2016, the federal government is covering 100 percent of the costs of services in the Children's Health Insurance Program, which covers low-income children not eligible for traditional Medicaid.

Figure 2

Medicaid Provider Payments Have Increased in Recent Years, With Feds Covering a Larger Share



Source: Fiscal Year 2014-17 Proposed Budget and Financial Plan, Medicaid Local is the Subsidy and Transfer general fund total (Comptroller Source Code 50) for Health Care Finance (5000) found in the 2014 through 2017 Operating Appendices Schedule 40-PBB net of Alliance Provider Payments. All figures adjust for inflation in FY 2017 dollars.

The FY 2017 budget continues two hospital provider taxes based on hospital revenues for in-patient and out-patient services that were adopted in 2016 on a one-year basis. The taxes will be used to maintain Medicaid reimbursement rates for hospital services for beneficiaries not in the city's managed care program, who primarily are elderly residents and residents with disabilities or chronic conditions. The District reimburses hospitals for 98 percent of the costs for in-patient services, far above the national average of 87 percent. Without a continuation of this tax, reimbursement rates would likely have been cut.

Together, the hospital taxes and outpatient fee will raise $17.1 million in dedicated local funding, and this will generate $40 million in federal Medicaid funds.

Some Concerns with the FY 2017 Budget for Health Insurance Coverage

Dedicated Fund Expenditures will be diverted from health care: The proposed FY 2017 budget uses accumulated resources in the "Healthy DC Fund" to fund other parts of the city's overall budget – reducing the fund by $6 million in FY 2017. This follows a similar sweep of Healthy DC Fund resources in 2016. The reduction leaves less money available for future health care policy changes to the Alliance and the local portion of the Medicaid program.

Medicaid Cost Pressures: One issue that could continue to put upward pressure on costs are problems with case management and care coordination in the Managed Care Program. About 70 percent of Medicaid beneficiaries are enrolled through one of the three Managed Care Organizations

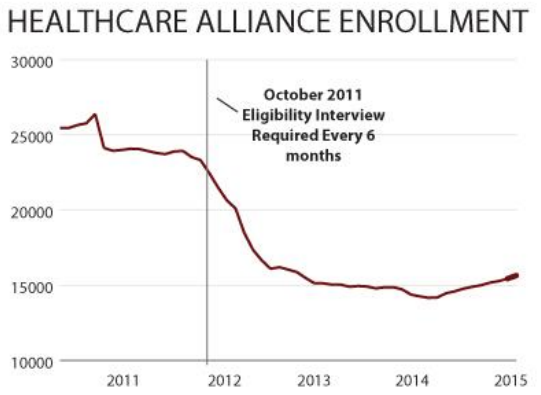
(MCOs), yet it is unclear whether the population is getting the services and supports that they need. For example, the Department of Health Care Finance estimates that the MCOs paid more than $35 million in expenses related to avoidable emergency room visits, hospital admissions and readmissions.[1] Moreover, the department's quarterly performance reports show that in the first year of the MCO's contracts, the companies failed to establish strong case management and care coordination programs among their enrollees.[2] This means that many residents with complex health needs may not be getting timely access to the services that they need. Poorly managed care also affects the *fiscal* health of the District.

No Change to Rules that Restrict Access to Health Care for Immigrants: The Healthcare Alliance provides health insurance coverage to low-income residents who are not eligible for Medicaid. In recent years, as Medicaid eligibility has expanded in DC under the federal Affordable Care Act, participants in the Alliance are largely immigrants who are ineligible for Medicaid under federal law, including undocumented immigrants.

While the Healthcare Alliance plays a critical role in ensuring access to care for DC residents, program rules adopted in 2012 have made it hard for eligible residents to maintain their health coverage, leading to a large drop in participation. Despite clear indications of this problem, the FY 2017 proposed budget takes no steps to improve access to the Alliance.

Figure 3

Alliance Enrollment Continues to Decline Under Interview Requirements



Source: November 2010 to November 2015 MCAC Enrollment Reports, Department of Health Care Finance

Since October 2011, the program has required participants to have a face-to-face interview every six months at a DC social service center to maintain their eligibility. This has proved a barrier for eligible residents to keep the benefit. Enrollment in the Healthcare Alliance declined sharply in 2012 and has largely remained unchanged since then. (See **Figure 3**.)[3] From October 2011 to October 2012, the first year of the policy, the number of DC residents in the Alliance dropped by one-third, from 24,000 to 16,000. Enrollment has fallen and risen modestly since then, but remains close to 16,000.

The intent of the six-month recertification was to discourage ineligible people from applying for the Alliance, but evidence among legal service provider cases and data analysis by the Department of Health Care Finance suggest that it is creating a barrier for *eligible* enrollees to maintain coverage under the program. In each month during FY 2015, between 56 percent and 71 percent of monthly Alliance re-certifications were not completed.[4]

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[1] Department of Health Care Finance, DHCF Budget Presentation for FY 2017 at Medical Care Advisory Committee Meeting, March 2016.

[2] Department of Health Care Finance, Managed Care Organization Quarterly Performance Report, February 2015.

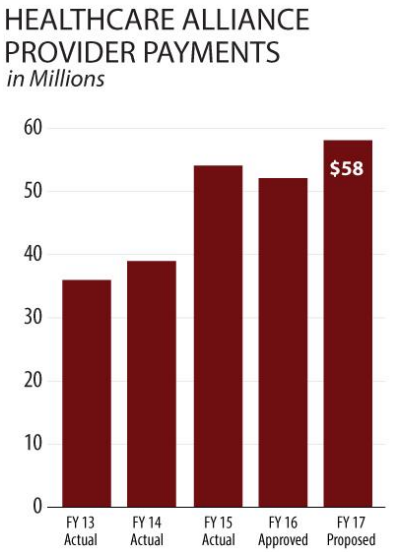
[3] Medicaid expansion in 2010 shifted 32,000 residents from the Alliance Program to Medicaid. However, after a period of stable enrollment, caseloads begin to decrease after a six-month, in-person recertification began in FY 2012.

[4] Department of Health Care Finance, DHCF Budget Presentation for FY 2017 at Medical Care Advisory Committee Meeting, March 2016.

The six-month recertification requirement also creates problems for other residents seeking public benefits. This is because Alliance applicants represent a large share of residents at DC's social service intake centers each day, and their applications take longer than the average visit to these centers. The Alliance recertification rules thus contribute to long lines and wait times – and to clerical errors such as lost paperwork – at DC's overcrowded social service centers. Data collected in 2015 suggest that Alliance recipients make up one-fourth of service center traffic in a given month, even though they represent a very small portion of service center clients.[5] Wait-times for Alliance recipients seeking to re-certify at a service center are longer than wait-times for Medicaid recipients[6] – reflecting the language and case-management needs of the Alliance population.

Figure 4

Funding for the Alliance Will Rise in FY 2017 Due to Higher Per-Participants Costs



Source: Fiscal Year 2014-17 Proposed Budget and Financial Plan. All figures adjust for inflation in FY 2016 dollars. Includes Alliance Pharmacy Benefit.

Proposed funding for the Healthcare Alliance in FY 2017 is $58 million, an 11 percent . (See **Figure 4**.) The increase does not reflect an anticipated increase in enrollment or notable changes in how the program is delivered. Instead it merely reflects an increase in per-participant costs, which also happened in FY 2015. This suggests that the Alliance membership includes a growing number of older residents and other residents with serious health problems.

The Department of Health Care Finance noted in 2015 that it might consider expanding the re-certification period from six months to a year and allowing community health centers to assist in the application process. This would have an initial cost to the District, as more participants maintain their coverage, but could lower the payment rates per enrollee, as younger and healthier residents rejoin the program. However, as of April 2016, the Department has not presented any information to analyze the very low rate of Alliance participants who re-certify, and it has not put forth any proposals to modify the eligibility process.[7]

Some Public Health Programs Will Be Cut in FY 2017 and Others Will See Increases

The FY 2017 budget for the Department of Health is $287 million, a $20 million increase from FY 2016. (See **Figure 5**.) Most of that increase reflects an "intra-District" transfer from the Department of Health Care Finance, to buy $15 million of pharmaceutical drugs through DOH's purchasing program. When this is excluded, the DOH budget increase is $5 million, or 2 percent.

This change reflects changes to a number of public health services, including both expansions and cuts. The cuts to public health programs include:

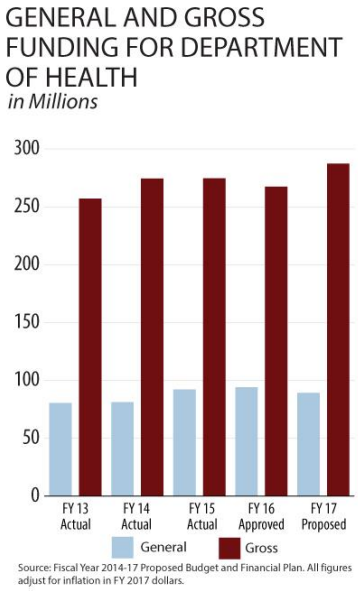
[5] Wes Rivers, DC Fiscal Policy Institute Chelsea Sharon, Legal Aid Society of the District of Columbia, "Testimony for Public Oversight Hearing on the Performance of the Economic Security Administration of the Department of Human Services," District of Columbia Council Committee on Health and Human Services, March 12, 2015.
[6] Ibid.

[7] Department of Health Care Finance, DHCF Budget Presentation for FY 2017 at Medical Care Advisory Committee Meeting, March 2016.

- **Pregnancy Prevention Grants:** The proposed budget eliminates $1.3 million in pregnancy prevention grants to community-based service providers.
- **Tobacco Control:** The proposed budget reduces resources for the District's tobacco control program to $1 million in FY 2017, down from $1.4 million in FY 2016. This funding will likely support a telephone "quit-line" which helps people quit with cessation products like nicotine patches and gum, and grants for community groups to do outreach and education. This is far below the $11 million recommended by the U.S. Centers for Disease Control for DC's tobacco control needs.
- **Produce Plus:** The budget eliminates funding for this program, a cut of $350,000. Produce
- Plus helps low-income residents purchase fresh fruits and vegetables from farmers' markets.
- **School-Based Health Centers:** The proposed FY 2017 budget cuts $430,000 from school-based health centers.
- **Healthy Development for High School Girls:** The budget cuts $569,000 in one-time funding for initiatives focused on promoting healthy development in girls attending traditional public and public charter high schools.

Figure 5

Local Funding for DOH Will Fall in 2017, While Overall Budget Will Grow



The budget increases include:

- **HIV Services:** The budget reflects a $6 million increase in funding for HIV/AIDS services, from $78 million in FY 2016 to $84 million in FY 2017. The increase is entirely from federal funds, including the Ryan White program – which supports medical, pharmaceutical, and support services for people with HIV/AIDS – and the Centers for Disease Control's program to provide support services for men who have sex with men (MSM).

Other public health programs will see flat funding in FY 2017:

- **Changes to School Nursing Program:** The school health services program, formerly known as the school nursing program, is being restructured based on information gathered from a school health needs assessment conducted this fiscal year. Funding will remain the same as in FY 2016.
- **Maternal and Child Health Home Visiting:** The FY 2017 budget sustains important locally funded investments in child and maternal health, including $2 for the DC Home Visiting program. The program supports home visiting models that have been proven to improve early childhood health and development. Home visitors provide instruction to parents by:

  - Targeting expecting parents and families with children under age five.

- Identifying signs that children may be at risk for unhealthy development, such as a lack of prenatal care or a family history of substance abuse.
- Teaching parenting practices to overcome barriers to success, like activities to help their child be ready for school, access to community resources, and health screenings and immunizations.
- Improve cognitive development and educational outcomes.

While the FY 2017 budget maintains the Home Visiting program, the funding level allows the city to serve only a fraction of the low-income families who could benefit from these services.

Mental Health and Substance Abuse Services Have Been Expanded Using Federal Funds

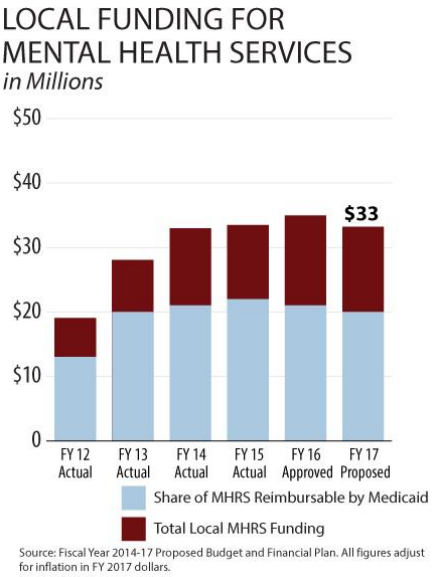
The Department of Behavioral Health's (DBH) budget is funded primarily through local funds, with only a portion of mental health services drawing a federal Medicaid match. Federal matching funds for mental health and substance abuse services are included in DHCF's budget, while local matching funds are included within the DBH's budget. The FY 2017 budget includes a small reduction in local funding for the Medicaid Mental Health Rehabilitative Services (MHRS) because the federal Medicaid program will begin to cover more of these expenses. (See **Figure 6**.) The budget also reflects an increase in federal funding for substance abuse treatment.

Mental Health Rehabilitation Services and Health Homes: The proposed FY 2017 budget includes $33 million in local funds for MHRS mental health providers, a $2 million reduction (7 percent). The Department of Behavioral Health is able to meet current needs because the federal government will reimburse for more services and at greater rates.

The FY 2017 proposed budget also reflects a second wave of implementation of a "Health Homes" program initiated by the District in 2016. Health Homes, a provision of the federal Affordable Care Act, provides funding to bundle services and care coordination for people with both mental health issues and chronic diseases. The first phase of the District's program focused on residents with severe mental illness. The second phase, for 2017, will focus on residents with multiple chronic health conditions, including residents who are chronically homeless. Under Health Homes program, the federal government reimburses DC for 90 percent of costs (as opposed to the normal 70 percent rate) for the first two years of the program. This will allow DC to improve services and save money in the near term.

Figure 6

Provider Payments for Mental Health Services in FY 2017 Are Far Higher Than in FY 2012



Substance Abuse Treatment Will Expand with Federal Funding: Funding for the Addiction Prevention and Recovery Administration (APRA) within the Department of Behavior Health in the

proposed FY 2017 is $38 million, up from $34 million in FY 2016. This largely reflects an increase in expected federal funding from a new federal grant to provide evidence based treatment services to assist veterans and others who experience chronic homelessness, according to DBH officials.

School-Based Mental Health Services for Children: The proposed FY 2017 budget for the school-based mental health program is about $7 million, the same as in FY 2016. Currently, the program has funding for a program manager and mental health professionals that cover 70 District schools, part of an effort to provide a mental health program in every school as called for under the South Capitol Street Memorial Act adopted in 2012. The budget does not bring the District closer to the goal of having a mental health clinician in each school.

Mental Health Services in Child Care Settings Will Expand: The proposed FY 2017 budget expands the Healthy Futures program from 26 early care and education centers to 71. Healthy Futures offers mental health consultation services to early care and education providers and family members to promote social emotional development, prevent escalation of challenging behaviors and provide appropriate referrals and services. The program uses a nationally recognized model and has shown positive results, including lower than national average expulsion rates and improved self-regulation in children with challenging behaviors. Healthy Futures is currently in 26 centers, which make up less than 5 percent of the child development centers and home-based child care providers in the District. The FY 2017 budget would expand the program to 71 sites.[8]

Funding for the DC Health Benefit Exchange Authority Will Allow it to Maintain Technology and Provide Assistance to Consumers

The FY 2017 budget allocates $35 million in funding for the DC Health Benefit Exchange Authority (Exchange), which operates DC Health Link, the District's online portal for Medicaid, private health insurance plans and financial assistance for those plans. This is a 4 percent increase from FY 2016. The Exchange generates funds through a broad-based assessment on health insurance plans operating in the District. Its budget is concentrated on contractual services for information technology (IT) and assistance to help consumers access insurance and benefits through the Exchange.

DC Health Link has given small businesses and individuals an easy way to shop for health plans and to get help to pay for them. As a result, almost 23,000 people have enrolled in private health plans through the individual market in the 2016 open enrollment period – including 6,000 new customers. DC Health Link is also attracting a younger, and thus healthier age mix, with 61 percent of those 6,000 new customers being under the age of 34.

The increase in the Exchange's budget for FY 2017 largely reflects new funding for IT staff to improve operations of DC Health Link, and additional staffing in the division to help small businesses acquire insurance for their employees. The proposed budget also increases funding for consumer education and outreach, including production of outreach materials, advertising and "navigators" to help consumers through the eligibility and enrollment process for private health plans on DC Health Link and Medicaid.

[8] This is based on testimony from Sharra E. Greer, Children's Law Center, before the DC Council Committee on Human Services, April 6. 2016.