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Improving Health Outcomes with Better Access, Improved Oversight, and Sustainable Programming

Recommendations to the New Mayor and DC Council

Summary

Over the past 15 years, the District has implemented several policies to expand access to affordable health care for District residents – the creation of the DC Healthcare Alliance program, early adoption of the Affordable Care Act (ACA), and expansion of Medicaid to a large number of low-income residents. As a result, the rate of uninsured residents in DC is the second lowest in the country, when compared with states.

But even with high coverage rates, health disparities persist, with poor health outcomes disproportionately affecting residents with low-incomes and those who live east of the Anacostia River. To improve these outcomes, the District needs to craft policies beyond expanding insurance coverage, by ensuring eligible residents are accessing programs they need, improving oversight and performance standards, and creating sustainable funding streams for our health programs.

This transition brief details three ways in which the next administration can achieve a more effective and sustainable healthcare system. To that end, the brief recommends:

- ***Make Changes to the Healthcare Alliance program to improve access for eligible residents.*** The DC Healthcare Alliance program provides health insurance to 14,500 low-income residents who are not eligible for Medicaid or Medicare. However, stringent application rules make it difficult for eligible residents to maintain access to the program and have contributed to a sharp drop in participation. The District can align Alliance's application requirements with Medicaid, which will help more eligible residents get benefits and reduce uncompensated health care.

- ***Increase Oversight of Medicaid Managed Care Organizations (MCO's) to Improve Outcomes and Access.*** The District could better connect residents on Medicaid with basic health services, which would improve health outcomes and avoid use of costly and unneeded services. The District uses a managed care approach for 175,000 Medicaid beneficiaries, or about a quarter of the District's residents. But there is limited oversight and few performance standards for the companies contracted to provide this care, and as a result poor health outcomes persist. Stronger oversight, contract stipulations, and performance evaluation are needed to ensure that residents are getting access to the best care possible.

- ***Improve Sustainable Sources of Local Financing for Medicaid.*** Across the country, states are increasingly using taxes on health care providers to draw down billions in federal Medicaid funds, yet the District has reduced its provider tax collections. Strengthening DC's health provider taxes makes sense for a number of reasons, particularly that every $1 in taxes results in over $2 in federal contributions to health services. Health provider taxes also could help the District prepare to sustain Medicaid if the new Congress seeks to cut federal funding.

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Issue #1: Reforming the Healthcare Alliance Program

The District of Columbia operates a local public health insurance program, the DC Healthcare Alliance ("Alliance"), which serves low-income residents who are not eligible for programs such as Medicaid or Medicare. While the program is intended to expand access, it has strict and frequent requirements to re-certify eligibility, which make it difficult for eligible residents to maintain their benefits. Restructuring the program to be more accessible would improve health outcomes and reduce uncompensated care.

Who does the Alliance Serve? For the most part, the Alliance operates similarly to DC's Medicaid program, but with key differences in eligibility and benefits. Unlike Medicaid, participants do not have to be U.S. citizens. They must prove DC residency, have an income below 200 percent of the federal poverty level ($23,340 for a single person in 2014), and limited savings and assets. The program largely serves undocumented immigrants, the elderly, and residents with complicated and expensive health needs.

The Alliance covers a broad array of health services, including preventive care, prescription drugs, dental services, immunizations, and hospital care. However, the services are not as comprehensive as those provided under DC's Medicaid program; one notable distinction is the lack of coverage for mental health services in the Alliance.

What are the Barriers to Keeping Alliance benefits? Since 2011, the Alliance program has required recipients to re-certify their eligibility every six months through a face-to-face interview. The policy is unique to Alliance, and quite different from the electronic or mailed annual renewals used in DC Medicaid. This face-to-face interview was enacted to deter documented cases of fraud, waste, and abuse in a program that serves non-U.S. citizen enrollees whose identity and residency can be difficult to verify.

Since the policy began, Alliance enrollment has shrunk by about more than 10,000 enrollees – to about 14,800 – which appears to at least partly reflect barriers faced by eligible residents.[1] Legal service providers and community health workers have reported that eligible Alliance enrollees with full-time jobs and limited access to child care find it difficult to complete the frequent interview requirement. The re-certification often involves multiple trips because of a lack of language assistance, long lines, and delays in processing information.

Moreover, Department of Health Care Finance has collected further evidence that the requirement may act as a barrier to eligible residents. They found that between half and 67 percent of Alliance re-

[1] DC Department of HealthCare Finance (DHCF) Medical Care Advisory Committee Enrollment Reports, November 2010 to September 2014.

certifications are never completed.[2] Moreover, wait-times for Alliance recipients seeking to re-certify at a service center are twice the wait-times for Medicaid recipients – reflecting the language and case-management needs of the Alliance population. These suggest significant barriers to maintaining coverage and that many eligible residents are losing or forgoing coverage as a result of the requirement.

Other Implications for the District. For the District, this requirement appears to be leading to higher costs, not only in terms of uncompensated care for providers, but also higher costs to the program, as residents avoid primary care and only sign up for the Alliance until they are sick. Requiring in-person interviews every six months also increases DC's administrative costs unnecessarily.

The fiscal year (FY) 2015 budget for the Alliance program is just over $50 million, an increase of $9.6 million from the approved FY 2014 budget of $41 million. The increase is not tied to growing enrollment, but instead higher utilization costs for the current program population. This suggests that Alliance membership includes a large number of older residents and others with serious and costly health problems. If young, healthy residents are forgoing preventive coverage because of the requirement, the costs could continue to rise.

Policy Recommendations. The District is in the process of implementing a new online information system for Medicaid and a number of other public benefits programs, and the city could use this as an opportunity to modify the rules of the Alliance program. Such policy changes could also save the District money through lower administrative costs and reduced incidence of uncompensated care. The following are three major changes recommended by 11 community organizations in October 2014:[3]

- ***Change the six-month recertification requirement to an annual recertification.*** Switching to a 12-month recertification period will help Alliance members who have to take time off of work to recertify, and often must wait for hours to see enrollment staff. This change would put the Alliance program's rules more in line with Medicaid, and ease long lines and wait times at DC's social service intake centers. This will speed up processing times of applications and keep more residents on the program.

- ***Allow community health workers to assist with parts of the recertification.*** Unlike with Medicaid, a recertification currently is required to take place at a Department of Human Services service center. This increases the traffic at service centers and puts strain on staff. If Alliance beneficiaries can complete their recertification with community health workers, the applications will have fewer problems and be processed faster, reducing the need for residents to make multiple trips. Community health workers already have strong

[2] DC Department of Health Care Finance (DHCF) Budget Presentation for FY 2015, Presentation for the Medical Care Advisory Committee, April 2014, slide 38 of 42, http://dhcf.dc.gov/publication/dhcf-fy15-budget-presentation (accessed July 14, 2014).

[3] Bread for the City, Children's Law Center, Community of Hope, DC Fiscal Policy Institute, DC Primary Care Association, La Clínica del Pueblo, Legal Aid Society of the District of Columbia, Legal Counsel for the Elderly, Mary's Center, Unity Health Care, Inc., Whitman-Walker Health

relationships with the Alliance community, and can help alleviate language and cultural barriers in the application process.

- ***Allow Alliance participants to apply online***. DC's new online public benefits eligibility system for Medicaid verifies identity and residency using a variety of existing databases. Yet the Alliance program still uses a paper application. Fully incorporating the Alliance into the electronic application process would mean that many beneficiaries would never need to visit a service center in person.

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Issue #2: Increase Oversight of Medicaid Managed Care Organizations (MCO's) to Improve Outcomes and Access.

DC's Medicaid program connects 175,000 residents to health services using a managed care approach provided by three contracted companies. While the size of enrollment means that the District is doing well to cover all of its residents, some beneficiaries are not getting the care they need. As a result of limited oversight and few performance standards, the managed care organizations (MCOs) who provide Medicaid services have failed to drastically improve health outcomes or contain cost-drivers in the program, such as utilization of unnecessary and costly services.

Stronger oversight and evaluation of Medicaid managed care is critical to lessening health disparities among low-income residents and improve the general health outcomes for the broader public.

How Does Managed Care Work? The District currently contracts with three managed care organizations to provide health services used by single adults and families with children – AmeriHealth DC, MedStar Family Choice, and Trusted Health Plan. Most Medicaid enrollees (other than people with disabilities or those who are elderly) must choose or are assigned to one of the three MCOs.[4] The District pays each MCO a fixed fee per member per month. In return, the MCO reimburses doctors and hospitals for health care services used. The District is now in the second year of a five-year contract with the three Managed Care Organizations. In fiscal year 2014, the District spent more than $900 million on MCO services.[5]

How effective are the MCOs? With contracted managed care at the heart of DC's Medicaid program, the District needs to make sure that this system promotes and ensures regular visits among adults, timely preventative and screening services for children, and ease and effectiveness of referrals between specialties. Regular access to a primary care doctor and coordinated referral with behavioral health and other specialty services can lead to better overall health for an individual beneficiary and lower costs for the District.

Yet, early evidence from the MCO contracts suggests they could be doing more to manage costs and connect residents with comprehensive and continuous care.

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[4] A fourth MCO covers a limited population of children with special needs, Health Services for Children with Special Need (HSCSN).

[5] Department of Health Care Finance. District of Columbia's Managed Care Quarterly Performance Report (January 2014-March 2014). October 2014.

- ***Declining rate of primary care visits.*** Only 70 percent of adults see a primary care doctor at least once per year, a rate that has fallen since the onset of the contracts.[6] Seeing a primary care doctor regularly makes it more likely that patients are managing health needs and reduces the likelihood of needing more costly services. This may reflect that patients are not being appropriately referred or informed about their options by the MCO. It may also reflect that MCO's are not reconnecting patients with their primary care doctor after an initial visit or a trip to the hospital.

- ***High rates of emergency room use.*** Between 60 and 70 percent of emergency room visits by DC Medicaid beneficiaries are for basic care that does not require an ER. A large portion of these visits could have been avoided by regular visits to a primary care doctor. Over-utilization of emergency rooms cost the MCO's about $6 million over the first nine months of the contract.

- ***High rates of hospital re-admissions.*** Many Medicaid beneficiaries who seek hospital care end up being re-admitted. The newest report suggests that half of those readmissions could be avoided through improved discharge planning and better service delivery and follow-up care. Inpatient readmission costs another $10 million, and coupled with overutilization of ER costs at $6 million, they yield $16 million in costs that could be significantly reduced with better care coordination and delivery.

- ***Low utilization of mental health services.*** About 4 percent of the MCO's spending is going toward behavioral health services – which seems low given the history of mental health needs among DC residents. In FY 2013, the MCOs served only 6,600 beneficiaries with some outpatient services[7] -- a tiny fraction of the total MCO population. Given the mental health issues are often co-occurring with other physical health issues, further study of the mental health referrals is needed.

- ***Questions about adequacy of health provider networks.*** Medicaid beneficiaries may also face barriers in getting access to a primary care doctor through their MCO's provider network. MCO contracts require a certain number of primary care physicians per number of enrollees and that the MCO have a sufficient mix and geographic distribution of doctors to cover the population's needs. The contracts also have distance (within five miles) and appointment wait-time standards. However, most of the metrics are self-reported by the MCO and only the number of doctors available are reported in the MCO's performance report. Listings in the MCO provider directories often include incomplete and erroneous information and duplication of doctors and addresses. Further study is required to determine the adequacy of the MCO provider networks.

Policy Recommendations. The following policies that will increase oversight and evaluation of the program, in hopes of improving health and decreasing avoidable costs:

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[6] Ibid.

[7] Department of Health Care Finance, FY 2013 Mental Health Utilization Data, Cell G34.

- ***Set baselines for performance and outcomes of the Medicaid MCO population.*** The District could undertake a thorough examination of health outcomes of the Medicaid population in managed care to assess the quality of care they are receiving. This could include analysis of the health status of the Medicaid population under the MCO contracts compared with outcomes in prior years.

  It would also be important to compare the experiences of MCO beneficiaries with those in the portion of DC's Medicaid program that pays providers directly for the services used by the elderly and persons with disabilities (known as "fee for service Medicaid"). The comparison could help assess whether MCO's are managing the care of Medicaid recipients, using measures such as ER visit rates for routine care, average wait-time for seeing a primary care doctor, and speed of referrals for certain specialty/mental health care.

- ***Promoting and improving care coordination for every patient.*** Appropriate care coordination means that patients' needs are quickly identified and that they are referred to an appropriate provider. Many primary care and mental health clinics take on a care coordination role by acting as a "medical home" to their patients, providing on-going care, and storing and sharing electronic health records. It is important that there is cooperation and referral between the MCO and the systems of care within health clinics and mental health providers. It is also important for MCO's to help facilitate referrals and limit administrative burdens that impede providers from connecting and sharing information.

- ***Increasing oversight of provider networks and developing regulatory standards for network adequacy.*** Beyond contractual obligations, the Department of Health Care Finance and the Department of Securities, Insurance, and Banking need authority and resources to ensure providers have adequate networks of doctors and other health professionals to meet client needs. This means monitoring wait-time and accessibility of hours, distance, and geographic distribution standards that are specific to the District and account for communities with high health needs. Capacity should be built for more robust "secret shopper" programs and audits of provider directories.

- ***Establishing pay-for-performance benchmarks and standards for MCO's.*** The District is currently developing metrics for quality improvement for the MCOs in order to create a system that incentivizes value and improved health outcomes. The District should engage the public in developing metrics such as ER visit rates for routine care, hospital readmissions, average wait-time for seeing a primary care doctor, and speed of referrals for certain mental health/specialty care services.

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Issue #3: Improve Sustainable Sources of Local Financing for Medicaid and the DC Health Exchange

The District has made a strong commitment to providing comprehensive health insurance coverage to low income residents, and as a result, spends about $3 billion on its Medicaid program. The majority of that money comes from federal reimbursements, which cover 70 percent of health costs for many beneficiaries and 100 percent of costs. The District is receiving $2.1 billion in federal Medicaid payments this year, or 22 percent of the FY 2015 Budget.[8] The city's local contribution totals $900 million, making it one of the largest use of local funds.

DC stands out because most of its local funding for Medicaid comes from general tax revenues, while many states rely heavily on taxes paid by health providers and insurers. Provider taxes make sense for several reasons. Perhaps most important, every dollar in provider taxes generates federal matching funds – in DC the match is $2.33 in federal funds for every $1in local funds – that are used to pay for services provided by hospitals and other health providers. In addition, provider taxes are a more stable source of revenues that do not tend to fall sharply during periods of economic decline. Finally, the recent change in congressional leadership could create real threats to federal Medicaid funding. The District needs a local funding strategy – including provider and insurer taxes –to support the program if those threats become reality.

Federal Cutback Risks. Between 2011 and 2013, several proposals emerged to reduce federal spending on state Medicaid programs, in hopes of reducing the federal deficit. These plans ranged from changing the Medicaid program into a state block grant to decreasing the rate at which states are reimbursed. The proposal to change federal Medicaid payments to a block grant would reduce funds available to the District by $434 million annually by 2022.[9]

Many States Rely on Provider Taxes. Provider taxes have advantages over general funds when funding state portions of Medicaid payments. First, provider taxes can help states weather economic downturns. Demand for medical services is not affected by economic downturns, which means that provider taxes can raise revenue for programs even when other revenues, like property and income taxes, are on the decline.[10] Second, provider taxes are often used to bolter reimbursement for Medicaid providers or expand Medicaid services. In other words, a small tax can often lead to increased revenues for health providers.

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[8] DCFPI analysis of the FY 2015 Budget and Financial Plan.

[9] FY 2015 inflation adjusted figure in "Jobs At Risk: Federal Medicaid Cuts Would Harm State Economies," Families USA, 2011, pg. 3. http://familiesusa.org/sites/default/files/product_documents/Medicaid-Cuts-Hurt-State-Economies.pdf

[10] William Goodman, Bureau of Labor Statistics, "Employment in Service Industries Affected By Recessions and Expansions," 2001, pg. 7.

For these reasons, states are increasingly looking to health care provider taxes – fees or assessments raised on revenue generated from hospitals, nursing homes, managed care organizations, and intermediate care facilities – as sustainable mechanisms to fund state share of Medicaid payments. Between 2008 and 2012, state Medicaid dollars from provider taxes nearly doubled, to a total of $18.7 billion or 10 percent of all state and local funds.[11] As of FY 2013, 50 states (including DC) had at least one tax on providers, with the most common taxes being levied on inpatient hospitals and nursing homes.[12] To a lesser extent, states are also taxing managed care organizations (MCOs).

The District Is Reducing Its Reliance on Provider Taxes. For Medicaid, the District currently taxes facilities that care for persons with intellectual or developmental disabilities and nursing homes.[13] DC also taxes premium revenue from the Medicaid managed care organizations and other health insurance companies, with those funds being divided to fund Medicaid, the DC Health Exchange, the Office of the Health Care Ombudsman, and the Department of Insurance, Securities and Banking. Currently, there are no other provider taxes.

But the District recently scaled back its provider taxes by eliminating a tax on hospitals. In FY 2015, the District is expected to collect $69 million in provider taxes, down 34 percent from $105 million in FY 2014.[14] The large decrease is due to the District sunsetting a $27 million hospital bed tax. The tax charged $3,800 per bed, and was used to maintain inpatient and outpatient provider reimbursement during the recession. The District also lost a $5 million contribution from the hospital and medical services corporation, which also expired at the end of FY 2014.

These revenue cuts mean that the provider taxes are only a small portion of the District's local Medicaid contribution – less than 10 percent of local contributions to Medicaid. The District is now one of only 13 states that do not have a tax on inpatient hospitals. With such a small contribution from providers, the District has some flexibility to follow other states' lead and make provider taxes a larger part of its Medicaid funding strategy.

Policy Recommendations. Provider taxes are a sustainable funding source that can increase the District's protection from federal spending decisions and local economic downturns.[15] Under Medicaid rules, a provider tax must be broad-based across a class of providers and must be uniform across each group of providers. For example, a tax on hospitals must cover all hospitals and the rate has to be the same for each of them, regardless of the number of Medicaid patients the hospital sees. Moreover, if a hospital is taxed, those revenues cannot be tied directly to Medicaid services designed to reimburse the hospital for the taxes it paid.

Two good options for provider taxes for DC are:

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[11] US Government Accountability Office, "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved Data Collection," July 2014, pg. 18-19. http://www.gao.gov/products/GAO-14-627

[12] Kaiser Family Foundation, "Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction," 2013 http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/

[13] Taxes revenue at a rate of 5.5 percent and 6 percent, respectively.

[14] Office of the Chief Financial Officer, "DC Tax Facts 2014," 2014.

[15] One risk to provider taxes is a federal proposal to place limitations on state's ability to collect provider taxes. Given the District's low level of reliance on provider taxes and states' resistance to the idea, this is a low risk.

1) ***Reinstating the Hospital Bed Tax.*** The tax could be used to benefit a broad array of health care providers and would give us District flexibility if its general tax revenues decline due to an economic slowdown.

2) ***Increasing Assessment Health Insurance Companies.*** The Insurance Premium Tax and the Health Exchange Assessment generate about $66 million for health programs (Medicaid and non-Medicaid), at a tax rate of 3 percent on health insurance premium revenue. The broad-base of health insurance companies allows the District to raise a significant amount of revenue at a low rate, minimizing the impact on premium prices. A small increase to these assessments could raise more money for the Medical program.