



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 FY 2016 BUDGET FOR HEALTH CARE?

SUMMARY OF THE FINAL FY 2016 HEALTH CARE BUDGET

- The FY 2016 budget includes \$3.5 billion in federal and local funds for health care, an increase of 3 percent from FY 2015, after adjusting for inflation. The budget relies more heavily on federal funds to cover health care costs, while reducing the use of local funds.
- The budget includes a new tax on hospitals, for one year, to help maintain the rate at which hospitals are reimbursed for Medicaid services. In addition, the budget includes a fee on outpatient hospital services to increase Medicaid payments for these services. The \$16.4 in local funds from these tax and fee increases will allow the city to collect an additional \$38 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 keeps funding for the program at \$51 million.
- 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 \$2.5 million to support approaches proven to be effective.
- The FY 2016 budget creates a “Health Homes” program for mental health services and covers adult substance abuse under Medicaid. These will improve care and enhance access to federal funds. The Health Homes plan offers a bundle of services and care coordination for people with mental health issues and co-occurring chronic illness. The program allows the District to draw down more federal dollars for better services. Medicaid coverage for substance abuse also allows DC to create savings and serve additional residents in the future.

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 FY 2016 budget for these agencies totals \$3.5 billion in local and federal funding. This represents a \$93 million, or 3 percent, increase from the FY 2015 *revised* budget, after adjusting for inflation. (Unless otherwise noted, all figures are adjusted for inflation to equal FY 2016 dollars.) See **Figure 1**.

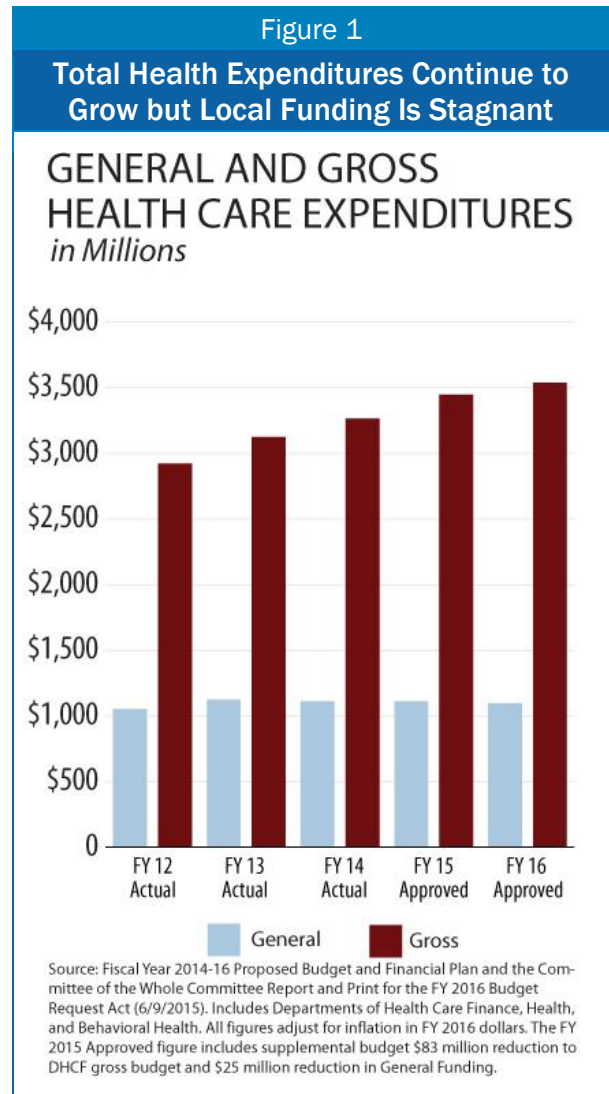
The increase is largely attributable to growing costs and enrollment in the Medicaid health insurance program. In fact, federal Medicaid dollars for the Department of Health Care Finance contributed to all of the growth in gross healthcare funding. All three agencies had reductions to local funding, totaling \$14 million or about 1 percent, so that total local health funding continued to hover just above \$1 billion.

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 2016 is \$33 million, an 11 percent increase from FY 2015.

Medicaid Spending Will Grow Due to Enrollment, But DC’s Local Share Will Decline

Total funding for Medicaid provider payments, including both local funds and the federal match, would grow from \$2.7 billion to \$2.8 billion in FY 2016 (See **Figure 2**). Medicaid is administered by the Department of Health Care Finance (DHCF) and now accounts for 94 percent of its budget.

The increase stems mostly from increases in Medicaid enrollment. Enrollment has grown steadily at nearly 4 percent per year since 2012. The FY 2016 budget includes \$28 million to address rising enrollment and changes in utilization of services.



Despite the overall increase, the District’s local contribution to Medicaid will fall in FY 2016 to \$682 million, a \$6 million reduction. Here’s why: normally, the District is responsible for 30 percent of Medicaid costs, while the federal government pays for the other 70 percent. This will change in two ways:

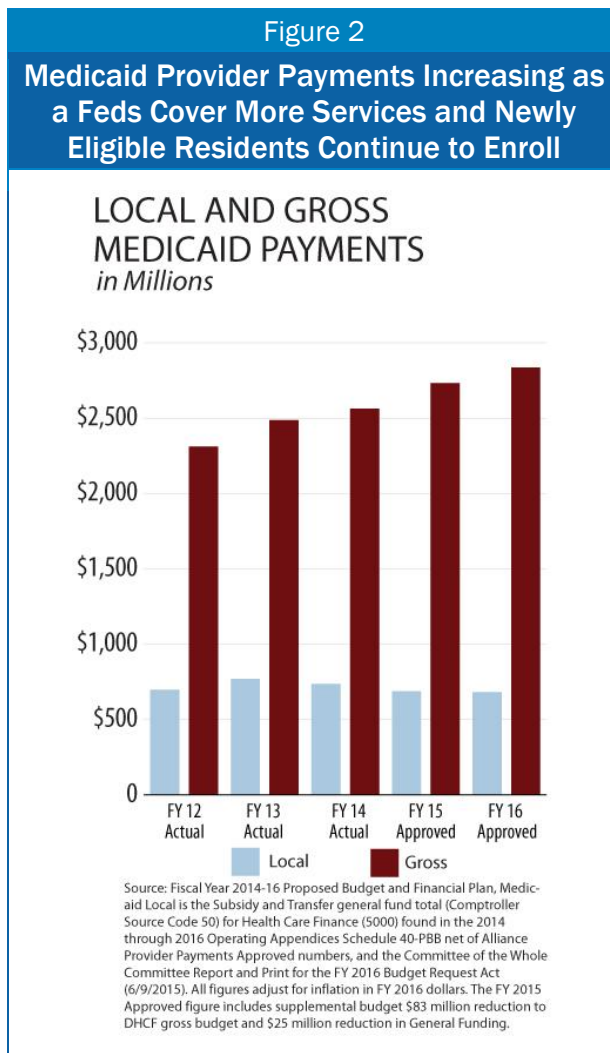
- In 2015 and 2016, the federal government will pay 100 percent of the Medicaid costs for groups of DC residents who became eligible for Medicaid as a result of the federal Affordable Care Act, such as childless adults with incomes up to 200 percent of the federal poverty line.
- Beginning in FY 2016, the federal government will cover 100 percent of the costs of services in the Children’s Health Insurance Program, which covers low-income children not eligible for traditional Medicaid.

Beyond meeting growing needs, the FY 2016 budget presents a couple of changes to funding going toward the Medicaid program. Here are the largest areas:

Maintaining Fee-For-Service Hospital Reimbursement Rates: The FY 2016 budget raises a hospital provider tax for one-year to maintain Medicaid reimbursement rates to hospitals for in-patient hospital services for the District’s “fee-for-service” beneficiaries. These are hospital services for beneficiaries not in the city’s managed care program; largely the elderly, or residents with disabilities or chronic conditions. The District reimburses hospitals for 98 percent of the costs, far above the national average of 87 percent. The initial budget proposed for FY 2016 would have cut reimbursement rates, but the new hospital tax allowed those cuts to be reversed.

Managed Care Organizations (MCOs), which receive per capita payments from the District for every Medicaid enrollee they serve, also will also see an increase in rates, because the per capita payments are based in part on rates in the District’s fee-for-service program. The FY 2016 budget also raises a \$150,000 fee per hospital, which will help raised Medicaid reimbursement rates for outpatient care.

Together, the inpatient hospital tax and outpatient fee will raise \$16.4 million in dedicated local funding, and this will generate \$38 million in federal Medicaid funds.

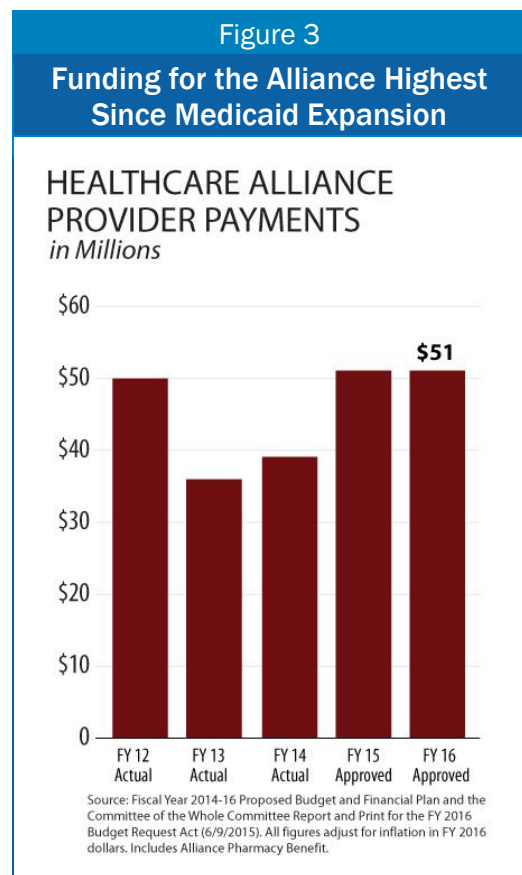


Tying Payments to Personal Care Service Providers Closer to Actual Costs: In the fall of 2014, DHCF collected cost reports from home health care providers to reassess what rates they should pay and to determine what it would take to increase wages for home health care workers to the DC living wage – now \$13.80 an hour. The analysis concluded that a reduction in the rate would match provider costs while still allowing them to pay for wage increases. The new rates will result in a \$9 million loss to PCA services. On top of this, during Council review of the budget, the agency found that lower than expected utilization will reduce funding for PCA services by another \$3.3 million. Further monitoring of providers by DHCF will be needed to see if the reduced rate is sufficient to result in greater wages for workers.

Some Concerns with the FY 2016 Health Budget

Dedicated Fund Expenditures will be diverted from health care: The FY 2016 budget uses accumulated resources in the “Healthy DC Fund” to help to balance the city’s overall budget over the course of the financial plan – reducing the fund by \$23 million over the next three years. 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. Over 73 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 MCOs’ 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 effects the *fiscal* health of the District.



¹ Department of Health Care Finance, DHCF Budget Presentation for FY 2016 at Medical Care Advisory Committee Meeting, April 2015.

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

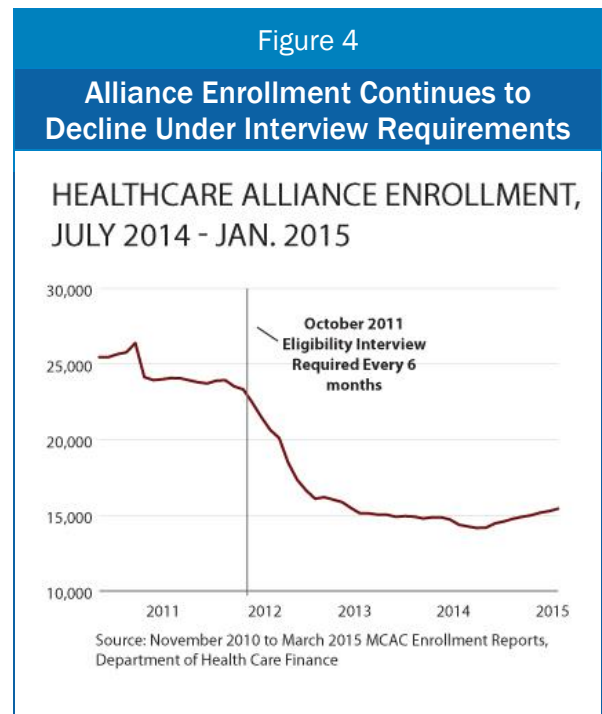
FY 2016 Budget Does Not Change Rules that Restrict Participation in the Healthcare Alliance Program

Funding for the program in FY 2016 is \$51 million, flat funded from FY 2015. (See **Figure 3**.) Between FY 2014 and FY 2015 the program saw a 35 percent funding increase resulting from higher utilization costs for existing participants, while enrollment remained largely unchanged. This suggests that the Alliance membership includes a growing number of older residents and other residents with serious health problems.

Enrollment in Healthcare Alliance has been on the decline for the last five years, largely as a result of changes in how the program is run (See **Figure 4**).³ At the beginning of FY 2012, the Department of Health Care Finance instituted a requirement that all participants visit a DC social service center in person every six months to re-certify their eligibility. Since the policy was implemented, enrollment has fallen dramatically — bottoming out at 14,000 in FY 2014. There are some indications that enrollment has rebounded to 15,000 enrollees in FY 2015, possibly as a result of expanded outreach efforts due to health reform.

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 FY 2014, between half and 67 percent of monthly Alliance re-certifications were never completed.⁴ Moreover, wait-times for Alliance recipients seeking to re-certify at a service center are twice the wait-times for Medicaid recipients⁵ — reflecting the language and case-management needs of the Alliance population. Data collected from earlier in 2015 suggest that Alliance recipients make up to 25 percent of service center traffic in a given month, even though they represent a very small portion of service center clients.

The Department is currently considering expanding the re-certification period from six months to a year and to allow community health centers to assist in the application process. The proposal will have an initial cost to the District, but could lower the payment rates per enrollee, as younger and healthier residents rejoin the program. At a budget briefing for the Medical Care Advisory



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 2015 at Medical Care Advisory Committee Meeting, April 2014.

⁵ Ibid.

Committee, the Department reported that the proposal could be provided as part of their review for the FY 2017 budget process.⁶

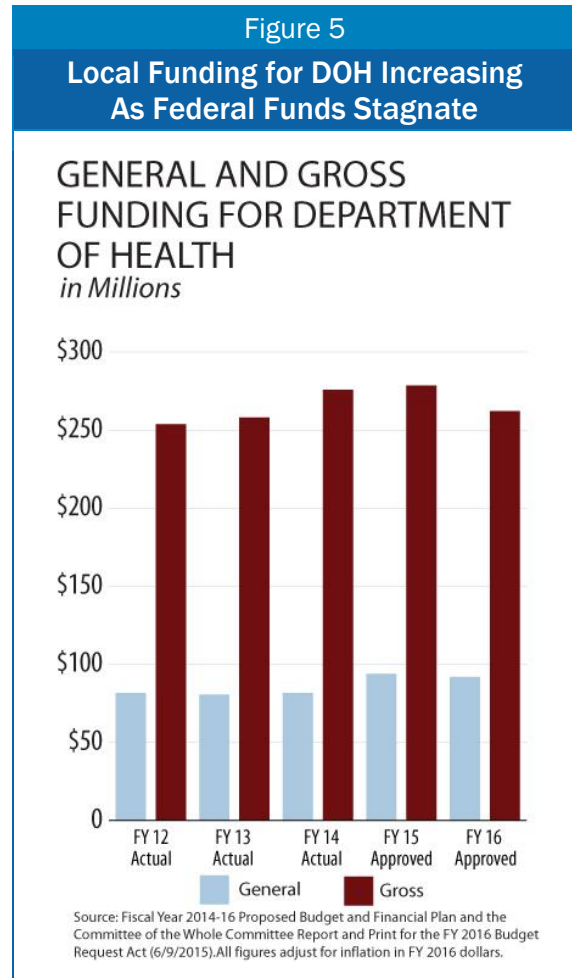
Funding for Some Public Health Programs Will Be Reduced in FY 2016

The FY 2016 budget for the Department of Health is \$262 million, a reduction of \$17 million or 7.3 percent (See **Figure 5**). The reductions reflect cuts in some federal grants and also some reductions in local spending. Some of the cuts will have an impact on public health services.

School Nurse IT-Infrastructure and FY 2015 One-Time Spending: The budget cuts \$700,000 for the pregnancy prevention fund – now at \$1.3 million. The budget also reduces the School Nurse Program by \$3 million, which delays IT improvements for the program’s system. The reduction for the program, which will be funded at \$17.5 million, will not lead to a decrease in the number of schools with nurses.

Tobacco Control Cut: The budget reduces resources for the District’s tobacco control program by \$2 million – eliminating an investment made on a one-time basis in FY 2015. Depending on the level of funding, the tobacco control program includes 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. The reduction leaves roughly half of a million dollars, mostly for a quit-line.

HIV Services: The budget reflects a \$5 million loss of federal bonus grants for Housing Opportunities for Persons with AIDS (HOPWA) and reduced funding for grants that help people purchase prescription drugs (AIDS Drug Assistance Program or ADAP). The reduction was offset in part with \$500,000 in new local funds. The Department of Health is also working with the Inter-Agency Council on Homelessness to ensure that persons with AIDS can transition to Permanent Supportive Housing and other programs that would prevent homelessness. The Department also believes that federal money for drug assistance may increase after the fiscal year begins.⁷



⁶ Medical Care Advisory Committee, Department of Health Care Finance, Agency Responses to FY 2016 Budget Questions, April 8th 2015.

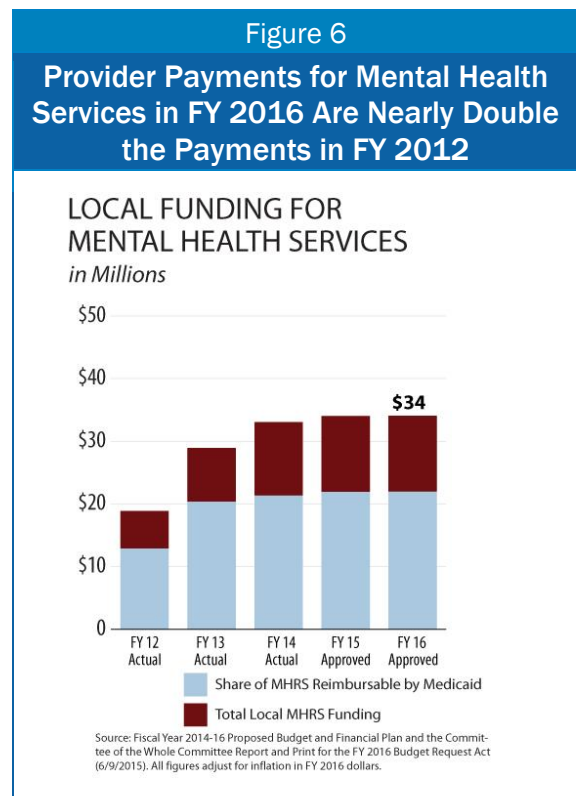
⁷ DC Primary Care Association Public Health and Finance Leadership Summit, DOH Budget Presentation, April 7 2015.

Healthy Start: The DC Healthy Start program, which provides prenatal and early childhood health supports for mothers and infants, lost half of its federal funding, falling to \$1.6 million in FY 2016. The program offers similar services to the Maternal and Child Health Home Visiting Program, but is not always supported by evidence-based practices. The budget sustains important locally funded investments in child and maternal health, including \$2.5 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.

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 2016 budget includes flat local funding for the Medicaid Mental Health Rehabilitative Services (MHRS) and reduces local money for substance abuse treatment, because the federal Medicaid program will begin to cover more mental health and substance abuse services (See **Figure 6**). Like the local Medicaid program in DHCF, DBH’s enrollment growth of newly eligible residents has led to the federal government paying for more of the Medicaid costs. Newly eligible residents account for 22 percent of MHRS beneficiaries.



Mental Health Rehabilitation Services and Health Homes: The budget includes no change to MHRS mental health providers, at \$34 million in local funding. This comes at a time when the number of people receiving mental health services and claims paid by the Department have increased steadily since 2008.⁸ The Department of Behavioral Health is able to meet growing need because the federal government will reimburse for more services and at greater rates.

⁸ Department of Behavioral Health FY 2016 Proposed Budget Presentation, April 10th 2015.

In FY 2016, the District will implement Health Homes, a program which will provide a bundle of services and care coordination for people with both mental health issues and chronic diseases. The program will help those who are already receiving community support services from DBH, but will replace and enhance those services. Under the new Health Homes program, the federal government will reimburse 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.

Substance Abuse Treatment: Local funding for the Addiction Prevention and Recovery Administration (APRA) within the Department of Behavioral Health shifts about \$5 million out of its budget line item. About \$1.5 million of these costs will be shifted to the Medicaid eligible MARS program, which will receive \$3.5 federal funding to maintain the total program at \$5 million. This is occurring because the District recently received approval from the federal government to cover adult substance abuse services through Medicaid. In FY 2015, substance abuse services were mostly funded through local and grant funding.

The budget for early childhood and school behavioral health did not change significantly, staying at about \$9 million. This includes flat funding for the School-Based Mental Health program. Currently, the program has funding for a program manager and mental health professionals that cover 71 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. However, only 58 schools currently have a clinician to provide prevention, intervention, and treatment services for students.⁹ The Department of Behavioral Health has faced difficulty in recruiting and hiring mental health professionals for the program. As of April 2015, the Department is pursuing a plan with the Deputy Mayor of Health and Human Services to train and hire a full complement of clinicians so that every school is served.

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

The FY 2016 budget allocates \$33 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 \$3 million or 11 percent increase from FY 2015. 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.

The Exchange's budget includes funding for IT investments to alleviate some of technology issues that occurred in FY 2015. This year, Health Link's underlying IT platform has had difficulty communicating with DC's outdated computer system for Medicaid. The Department of Human Services experienced several problems processing Medicaid applications and renewals that originated from DC Health Link's site – leaving some families with gaps in health coverage. The Department of Human Services, the Department of Health Care Finance, and the Exchange have agreed on a

⁹ Ibid.

plan to alleviate system problems and the money budgeted for IT improvements will help implement that plan.

The Exchange will fund \$10 million for call center operations and eligibility and enrollment services. The call center helps residents through the process of purchasing health insurance and applying for assistance. As part of those funds, the Exchange will add \$2 million for case-management staff for the Department of Human Services service centers. These staff will assist Medicaid and Exchange enrollees with identity proofing and complex eligibility cases.

The Authority's budget also includes an additional \$1.3 million in funds for consumer assistance and outreach — including production of outreach materials, advertising and the funding of two “navigator” positions at the DC Primary Care Association. Navigators will help consumers through the eligibility and enrollment process for private health plans on DC Health Link and Medicaid.

Federal funding for 35 in-person assister organizations will expire at the beginning of FY 2016. In-person assisters help people apply and enroll into private market health plans and Medicaid, and are located at community-based organizations where residents receive other services — such as tax preparation centers, libraries, health clinics, and churches. Now that these funds are expiring, the Exchange will have to assess the need for consumer assistance in their absence.