

What's In the Approved Fiscal Year 2019 Budget for Health Care?

By Jodi Kwarciany

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

- **The Department of Health (DOH)** 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 Health Care Finance (DHCF)** manages the District's public health insurance programs like Medicaid and the DC Healthcare Alliance. 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 Behavioral Health (DBH)** funds and manages behavioral health and substance use disorder clinics throughout the city. The agency also operates mental health programs in schools and the District's psychiatric hospital, St. Elizabeths.

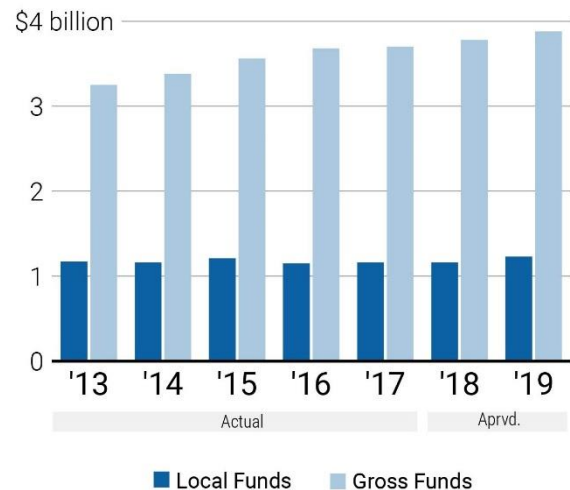
The approved fiscal year (FY) 2019 budget for these agencies totals nearly \$3.9 billion in gross funding, including both federal and local sources. This represents an approximate 3 percent increase, or nearly \$103 million, from the FY 2018 budget after adjusting for inflation (*Figure 1*). General funding, which includes local funds, dedicated taxes and special purpose revenue, will increase by 7 percent, or roughly \$78 million when adjusted for inflation.

SUMMARY

- \$3.9 billion in federal and local funds.
- 3% increase from FY 2018 after adjusting for inflation.
- Major investments in children's health, behavioral health, program eligibility systems and a new hospital.
- Key reforms to the DC Healthcare Alliance program remain unfunded.
- Important Affordable Care Act stabilization provisions, including an individual insurance requirement for health coverage.

FIGURE 1.

Health Care Spending Continues Steady Growth in FY 2019



Note: Includes Departments of Health Care Finance, Health, and Behavioral Health. All figures adjusted for inflation equal to 2019 dollars. Source: Fiscal Year 2015-19 Budget and Financial Plans.

In addition to DOH, DHCF and DBH, other agencies have health-related provisions in the FY 2019 budget. These include the Department of Human Services, the Office on Aging, and the Department on Disability Services. These agencies, along with the Department of Health Care Finance and Department of Behavioral Health, stand to receive a combined \$2.4 billion in federal Medicaid payments, nearly 99 percent of which is attributable to the Department of Health Care Finance. The Office of the Chief Financial Officer, which provides financial management services to the DC government and residents, has a role in the FY 2019 health budget as well – which will be highlighted later.

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 2019 is \$31 million, an 8 percent (\$2.6 million) decrease from last year, adjusted for inflation.

Health Coverage in the FY 2019 Budget

The approved FY 2019 budget for the Department of Health Care Finance (DHCF) is \$3.3 billion, an \$80 million or 2 percent increase from FY 2018 when adjusted for inflation. DHCF has the largest budget of all DC agencies, accounting for nearly 23 percent of the District's \$14.6 billion total budget.

A substantial portion of District residents receive their health coverage through programs provided by DHCF. About 259,000 residents receive health care through the District's Medicaid program, as well as nearly 19,400 children and adults covered through the District's DC Healthcare Alliance program and Immigrant Children's Program (ICP).¹

Like all states, the District is required by the federal government to provide a set of certain services, including inpatient hospital services, nursing home care, and emergency services. Additionally, the District chooses to provide an array of optional services for DC's Medicaid beneficiaries, including dental services and home health services.

Overall, FY 2019 budget changes for DHCF are largely the result of several drivers, including increased personnel services, increased fixed costs, provider payments, and the DC Access System (DCAS) project.

- Enrollment Growth and Increased Payments to Providers:** DHCF's FY 2019 budget calls for an increase of \$40.8 million in local funds due to projected growth in enrollment and increases in provider rates. In particular, DHCF anticipates an 8 percent increase in enrollment in the Elderly and Persons with Physical Disabilities (EPD) waiver program, which provides services in a home and community-based setting for individuals who are elderly or living with physical disabilities. There is also an anticipated 7 percent increase in enrollment in the District's Medicaid expansion population, which covers about 82,600 adults.²
- DCAS:** The FY 2019 budget includes nearly \$63 million in federal, local and intra-district operating funds for a new division under DHCF dedicated to implementing the DCAS, or District of Columbia Access System. DCAS is the eligibility system that serves as the platform to provide DC with a modern integrated eligibility system for multiple public programs. The DCAS project was transferred from the Department of Human Services (DHS) to DHCF in FY 2019. DHCF is working to implement the last phase of the DCAS project, slated to end in FY 2021, which will fully replace the District's legacy eligibility system, ACEDS. The project receives an enhanced match from the federal

government for funding; the District receives 90 cents back for every dollar it spends.³

DHCF has other notable increases in its FY 2019 approved budget:

- **Physician Supplemental Payment:** DHCF’s budget includes \$1.35 million in one-time local funds for a Physician Supplemental Payment in Wards 7 and 8. These funds will help support group practices that agree to provide certain health care services in Wards 7 and 8, knowing payments for these services under Medicaid often results in a loss.
- **Services for DDS and DBH clients:** In Intra-District funds, DHCF’s budget includes an increase of about \$10.3 million based on Memoranda of Understanding (MOUs) with the Department of Behavioral Health and the Department of Disability Services to provide Medicaid services to beneficiaries served by those agencies. Moreover, the DHCF budget includes \$200,000 to support a substance abuse Medicaid waiver and rate analysis for DBH.
- **DC Healthcare Alliance Program:** DHCF’s budget includes an increase of \$11 million due to continued increases in per-person costs for the DC Healthcare Alliance program (discussed in detail on pg. 5). The increase does not reflect a substantial increase in enrollment or significant changes to the Alliance’s burdensome enrollment processes.
- **Hospital Taxes:** The budget includes an increase of \$16 million through the reauthorization of dedicated taxes from District hospitals. These taxes, when paired with federal matching funds for Medicaid, help maintain reimbursement rates to hospitals for in-patient services for the District’s “fee-for-service” beneficiaries. These are hospital services for Medicaid beneficiaries not in the city’s managed care program—largely elderly residents 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 tax will allow the District to receive federal Medicaid matching funds of \$37 million. The taxes have been included in the budget every year since FY 2016, but each year only on a one-time basis.

There are several decreases in health care spending for FY 2019:

- **PACE Program:** The DHCF budget includes a decrease of \$328,190 due to a delayed start for the Program of All Inclusive Care for the Elderly (PACE), a model of care that integrates Medicaid and Medicare benefits for beneficiaries age 55 and older who wish to live in the community as an alternative to a nursing facility. The program is now slated to launch at its earliest in the fourth quarter of FY 2019. The program will launch a single site serving 200-300 individuals in Wards 7 and 8.
- **Disproportionate Share Hospital Payments:** The budget includes a decrease of \$1.4 million in disproportionate share hospital (DSH) payments. DSH payments are allotments from the federal government to qualifying hospitals that serve many Medicaid beneficiaries and uninsured individuals. The District has previously seen reductions in DSH payments due to the Affordable Care Act. Under the federal law, DSH payments have been reduced in recent years as increased health coverage rates lessen hospitals’ uncompensated care burdens. In FY 2019, however, the reduction in DSH payments reflects closure of the obstetrics unit at United Medical Center.
- **Medicaid Managed Care Organization Rate Savings:** The budget includes a decrease of \$4.5 million in local funds through a proposed 4 percent rate reduction for Medicaid Managed Care Organizations (MCOs).

In first year of pay-for-performance program, some successes after years of costly, avoidable health care services

A new program that rewards health plans for achieving high value in health care highlights the ongoing work needed to prevent avoidable costs in the District's Medicaid program: prior to its launch, nearly \$95 million in annual expenses for fee-for-service beneficiaries were potentially avoidable in 2015 and 2016.⁴

These figures are a part of DHCF's efforts to better understand health care spending, and reward health plans that improve beneficiaries' outcomes per dollar spent through care coordination and health management. Through the program, health plans work to meet the standards set by DHCF for three performance indicators: emergency room utilization for non-emergency conditions, potentially preventable hospitalizations – or admissions that could have been avoided with access to quality primary and preventive care – and hospital readmissions within 30 days of a previous admission. Since October 2016, health plans that have successfully met each standard receive financial incentives.⁵

Currently, there are three health plans that serve District Medicaid and DC Healthcare Alliance beneficiaries in managed care programs: AmeriHealth, MedStar, and Trusted. Of these, all three were able to meet DHCF's standard of reducing 30-day readmissions, and two out of three successfully met the standards of non-emergency ER use prevention and avoidable hospital admissions.⁶ Although \$95 million represents a substantial amount of avoidable services, by tracking outcomes and rewarding performance, the goal should ultimately be for DHCF to promote high value – rather than high volume – in health care.

Little improvement to rules that restrict access to health care for immigrants

The FY 2019 approved budget fails to include \$17 million necessary to implement a newly passed

[law](#) that would fix re-enrollment barriers in the DC Healthcare Alliance program. Instead, the budget relies on small fixes that are beneficial, but stop far short of alleviating burdens that prevent low-income individuals from accessing the benefits for which they are eligible.

The DC Healthcare Alliance program provides health insurance coverage to low-income residents who are not eligible for Medicaid. In 2010, the Affordable Care Act allowed DC to move many Alliance participants to Medicaid, giving participants access to a more comprehensive package of services and allowing the city to rely more on federal funds for health care. As a result of that shift, participants in the Alliance program today are largely immigrants who are ineligible for Medicaid under federal law, including undocumented immigrants and documented immigrants who have not yet met the 5-year waiting period for federal benefits.

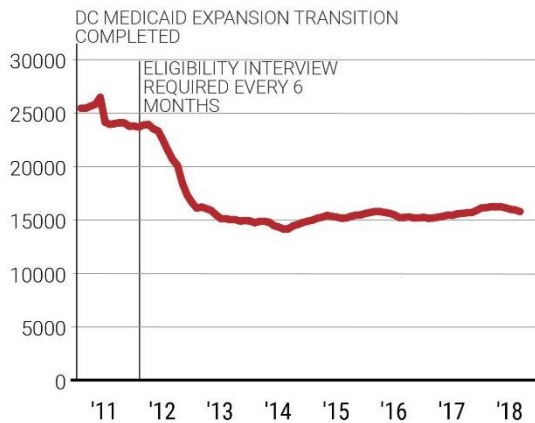
While the DC Healthcare Alliance plays a critical role in ensuring access to care for DC residents, program rules implemented in 2011 have made it hard for eligible residents to maintain their health coverage, leading to a substantial drop in participation. Despite clear indications of this problem, the FY 2019 budget made limited progress in reducing barriers to the program and increasing program enrollment.

Since October 2011, the program has required participants to have face-to-face interviews every six months at a DC social service center to maintain their eligibility. This has proved to be a barrier for eligible residents trying to maintain Alliance coverage. Enrollment in the Healthcare Alliance declined sharply in 2012 and has largely remained unchanged since then (*Figure 2*, pg. 5).⁷ During the first year of the policy from October 2011 to October 2012, the number of DC residents in the Alliance dropped by one-third, from 24,000 to 16,000.⁸ Enrollment has fluctuated modestly since then, but currently stands around 15,800, despite continued growth in the District's population.⁹

FIGURE 2.

Participation in the DC Healthcare Alliance Remains Mostly Flat

FY 2019 Budget Maintains Interview Requirements



Source: July 2010 to February 2018 MCAC Enrollment Reports, Department of Health Care Finance

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The intent of the six-month re-enrollment requirement was to discourage ineligible people from applying for the Alliance, but evidence suggests that it is creating a barrier for eligible enrollees to maintain coverage under the program. Previous data analysis by DHCF indicates that Alliance beneficiaries are less likely than Medicaid beneficiaries to retain coverage after their respective coverage periods end (Medicaid enrollees are covered up to one year and can re-apply online, unlike those in Alliance).

The six-month recertification requirement also creates problems for other residents seeking public benefits. Alliance applicants represent a large share of residents at DC’s five social service intake centers each day, and their application process takes longer than the average visit to these centers. The Alliance re-enrollment rules thus contribute to long lines and wait times—and to clerical errors such as lost paperwork—at the 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,¹⁰ and less than 7 percent of individuals covered under DC’s health insurance programs.¹¹

Funding for the DC Healthcare Alliance in FY 2019 is about \$77 million, a 17 percent increase from last year adjusted for inflation (*Figure 3*, pg. 6). 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 due in part to pharmacy and outpatient hospital spending, following on a substantial increase in FY 2017.

Legislation was adopted in 2017 to eliminate the six-month re-enrollment requirement and to address participation barriers in other ways, but the legislation has a cost attached to it because it would lead to increased program enrollment. However, the FY 2019 budget does not include the funding needed to implement these changes, which means the barriers are likely to continue.

The FY 2019 budget did include three initiatives that will provide modest support to Alliance beneficiaries:

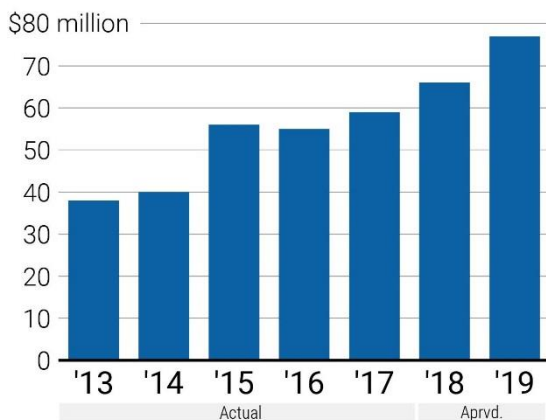
- **Public reporting requirement:** The budget includes \$200,000 to implement a public reporting [requirement](#) that will shed light on the experiences of Alliance beneficiaries as they re-apply for coverage at Economic Security Administration service centers.
- **Interview exemption:** The budget also includes language for a [waiver](#) to the Alliance’s face-to-face interview requirement for those who are hospitalized, disabled, or elderly, and caregivers.
- **ESA support:** The budget allocates an additional \$715,000 to the Department of Human Services budget, which will go toward increasing the number of social service representatives at five service center locations and adjusting hours to meet customer demand.

Additionally, the approved budget contains a [provision](#) intended to fund improvements to the Alliance included in the legislation adopted last year, like extending the enrollment period to one year, and allowing beneficiaries to re-apply for coverage at community health centers. Under this provision, DHCF is prohibited from reprogramming funds—shifting money from one program account to another—without active approval by DC Council. If this in turn reduces the amount of funds that are reprogrammed, it could result in accumulated unspent funds. Under the provision, once the unspent funds reach the level needed to fund the Alliance reforms, they will go into effect.

While efforts to fund critical Alliance reforms are commendable, there is no guarantee that this provision will work as intended. An attempt to restrict programming, a rarely used budget tool, would limit DHCF’s flexibility to fund service needs that arise during the year. If the Council ends up approving most reprogramming requests as a necessary use of funds, the provision may not end up generating much revenue to implement Alliance reforms.

FIGURE 3.

Funding for the DC Healthcare Alliance Continues to Rise Due to Higher Per-Participant Costs



Note: All figures adjusted for inflation.
Source: Fiscal Year 2015-19 Budget & Financial Plans.

Instead, the Mayor and DC Council should fully fund the legislation in FY 2020, at a cost of \$17 million, to improve our immigrant neighbors’ access to health coverage and care.

Public Health in the FY 2019 Budget

The FY 2019 budget for the Department of Health (DOH) is \$254 million, a nearly \$18 million and 8 percent increase from FY 2018 after adjusting for inflation. This increased funding comes in large part from the District’s general fund.

DOH includes funding in the FY 2019 approved budget for many programs:

- Tobacco Prevention and Cessation:** The FY 2019 budget includes [legislation](#) that will increase the District’s tobacco tax by \$2 per pack and help reduce tobacco use by DC’s youth over time. The increased tax is estimated to generate at least \$5 million. Revenue will support \$1 million in new funding for smoking cessation services and supports, bringing total funding for these efforts to \$1.9 million. Additionally, the new revenue will support the implementation of the previously-passed [law](#) that increases the District’s legal purchasing age for tobacco products to 21, and several components of [Birth to Three for All DC](#).
- Birth to Three for All DC:** Funding for a portion of health-related components in the District’s recently passed [Birth to Three for All DC](#) legislation are included in the DOH budget for FY 2019: \$300,000 will support HealthySteps, a pediatric primary care demonstration that helps coordinate care for families with children up to age 3. Just over \$710,000 will go toward DOH-based home visiting programs, which will complement the \$3.5 million in existing local and federal funding for DOH programs. Altogether, “Birth to 3” represents an important investment in early childhood, education, and family health. For more on the District’s early

childhood budget for FY 2019, see [DCFPI's Early Childhood Development toolkit](#).

- **Preventing Violence Against Women:** The FY 2019 budget for DOH includes a \$460,605 federal grant for implementing the Violence Against Women Act. This grant will help strengthen services to survivors of domestic violence, dating violence, and sexual assault by bolstering services available to victims and holding offenders accountable.¹²
- **School Health:** The budget includes \$4.4 million to support new components of the School Health Services Program (SHSP), including a legislative mandate for full-time clinical nursing coverage in all public and public charter schools in the District beginning August 1, 2018. For more on the District's education budget for FY 2019, see [DCFPI's PreK-12 Education toolkit](#).
- **Improving Birth Outcomes:** An increase of \$1.6 million in DOH's budget will support a preterm birth prevention pilot program, aimed at decreasing preterm births and improving the health of District infants. DOH will pilot with two birthing facilities to implement a two-year demonstration project. In addition, \$150,000 in one-time funds is included in the budget to support a study of racial and ethnic disparities in OBGYN services and outcomes in Wards 5, 7 and 8.
- **Defending Access to Health Care:** The FY 2019 budget includes \$107,000 for DOH to fund [Defending Access to Health Care](#) – recent Council legislation that requires insurers to cover certain health care services for women under the ACA without cost-sharing, including breast cancer screening and counseling, contraception, screenings for HIV, and counseling for sexually transmitted diseases.
- **Preventing Opioid Overdoses:** An increase of \$50,000 in one-time funding will go toward the purchase of opioid antagonist rescue kits.

These kits block the effect of opioids in the body and can help reverse opioid overdoses. For FY 2019, DOH is working towards connecting more individuals who experience overdoses with substance use disorder treatment, and reversing at least 50 percent of overdoses with Naloxone, a common opioid antagonist medication.

Mixed funding pictures in the FY 2019 budget for public health:

- **Pregnancy Prevention:** The budget removes \$666,219 in one-time funding that supported a teen peer sexual health educators' grant in the Community Health Administration (CHA). At the same time, the DOH budget includes \$735,000 – a mix of new and ongoing funding - to support Florence Crittenton Services for pregnancy prevention activities for teen and young adult women in Wards 5, 7 and 8, and additional funding for an agreement with the Department of Human Services for evidence-based and evidence-informed teen pregnancy reduction strategies.
- **Disease Prevention and Services for Persons Living with HIV/AIDS:** The FY 2019 budget for DOH includes \$350,480 within the HIV/AIDS, Hepatitis, STD, and TB Administration that will go toward the Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for Men Who Have Sex With Men of Color At Risk For And Living With HIV Infection. Moreover, the budget includes \$103,498 in private grant funds that will allow DOH to develop a replicable model program on best practices in HIV and/or hepatitis B and C screening and linkage to care. At the same time, the Administration will see a reduction of nearly \$300,000 for community-based HIV prevention services and a capacity-building program, and a \$50,000 reduction for burial assistance under the Ryan White Program, a national program that provides HIV-related health services.

Behavioral Health in the FY 2019 Budget

The FY 2019 budget provides a much-needed boost to the Department of Behavioral Health (DBH) so that the agency can better serve District residents. The FY 2019 budget for DBH is \$283 million, a \$5 million, or nearly 2 percent, increase from last year after adjusting for inflation. It is funded primarily through local funds.

Mental Health Rehabilitative Services (MHRS) spending will increase nearly \$5 million, or nearly 24 percent, in the FY 2019 budget after adjusting for inflation. The increased funding will help provide more mental health rehabilitation, substance use disorder, and community-based services to District residents.

Major funding initiatives in the FY 2019 budget:

- **School Based Mental Health:** The FY 2019 budget includes \$3 million to improve and expand services for the DBH School Mental Health Program (SMHP). The DBH SMHP offers mental health support to youth, families, teachers and staff in DC's public schools and public charter schools to reduce behavioral health-related barriers to learning. To date, the program has provided prevention, early intervention and treatment services to 57 schools.

The new funding will support increased partnership with community-based organizations to serve the District's highest-need schools. The \$3 million in funding includes \$1.9 million in grants to be awarded to community-based behavioral health providers, to support parent and teacher consultation, school team meetings, care coordination, and crisis management. \$524,000 will be devoted to developing a Community of Practice, which will help providers and schools begin implementing recommendations by the Task Force on School Mental Health. Lastly,

\$125,000 will support an evaluation of the first year of implementation.

- **Improvements to St. Elizabeths Hospital:** St. Elizabeths, the state psychiatric hospital for the District, will see an increase of \$2 million to open a transitional unit and increase bed capacity to reduce wait times. St. Elizabeths Hospital has experienced a 60 percent increase in pre-trial admissions over the past two years, affecting the hospital's ability to admit patients in a timely manner for court-ordered forensic evaluations. In addition, capital improvements totaling nearly \$3 million will help renovate the hospital's facilities and ensure safety for patients and staff.
- **Pre-Arrest Diversion Program:** DBH will receive \$1.6 million as a part of a criminal justice diversion program. This multi-agency collaboration will help divert individuals arrested or suspected for low-level drug offenses into social and behavioral health services, instead of the criminal justice system.
- **Immigrant Mental Health:** The approved budget includes one-time funds of \$200,000 to fund the [Study of Mental Health and Substance Abuse in Immigrant Communities](#) legislation that assesses the threat of federal immigration policies on the mental health of the District's immigrant community.

Reductions in the FY 2019 budget for behavioral health:

- **Pharmaceutical Services:** DBH will reduce spending in pharmaceutical services by nearly \$300,000 at the DBH pharmacy located at 35 K Street Northeast. These reductions are anticipated as DBH works more closely with health providers on improved benefits coordination, so that medications are provided only to uninsured individuals where the DBH pharmacy is a last resort.

Insurance Market and Reforms in the FY 2019 Budget

The FY 2019 budget includes a local health insurance requirement to maintain DC's coverage gains

The FY 2019 approved budget moves forward with a local individual health insurance requirement, which will help protect insurance coverage affordability and prevent more residents from becoming uninsured. This initiative adds the District to the list of jurisdictions like Massachusetts, New Jersey, and Vermont with similar laws on the books.

The new requirement follows the repeal of the Affordable Care Act's (ACA) "individual mandate," or requirement that all individuals obtain health insurance or pay a penalty, in December's federal tax bill. This policy change, along with other recent federal actions, jeopardizes the District's private insurance market and health coverage gains, potentially causing insurance premiums in the District to rise by nearly [14 percent](#) for ACA-compliant plans, and increasing the number of District residents who go without any health coverage. Through a local health insurance requirement, the District can maintain the protections of the federal law and support the health of DC residents.

The District's new requirement largely mirrors that of the previous federal requirement while including stronger protections for many residents. As the federal requirement ends after 2018, most DC residents will be required to maintain [minimum essential coverage](#) (MEC), or health insurance that is ACA-compliant. This covers most forms of insurance like employer-based coverage, health plans sold on DC Health Link, Medicare, and Medicaid. For the 96 percent of District residents who already have health coverage, this presents no change.¹³ Through the District's new requirement, the local [Immigrant Children's Program](#) (ICP) will now count as qualifying coverage. ICP has the same coverage as

Medicaid, but previously was not considered MEC.

Residents who do not maintain coverage must pay a penalty unless they qualify for an exemption. While the penalty structure is similar to that under the prior federal law, the list of exemptions available are attuned to local needs: the law broadens exemptions for lower-income residents, as well as those enrolled in the District's local Healthcare Alliance program (which does not have the same level of coverage as Medicaid).¹⁴

Any revenue collected from the insurance requirement will go into the Individual Insurance Market Affordability and Stability Fund, which will be used to provide outreach to uninsured District residents, provide information to residents about their health insurance options, and support other initiatives to increase insurance availability and affordability.

A local insurance requirement for DC came at the recommendation of the Affordable Care Act Working Group, through the DC Health Benefit Exchange Authority (HBX). HBX, which runs DC's local ACA insurance marketplace called DC Health Link, was asked by the Mayor to reconvene the Working Group this January and develop recommendations to protect DC's coverage gains amidst federal changes.

Funding for the insurance requirement is comprised of \$1.1 million; \$551,000 will support the Office of the Chief Financial Officer's (OCFO) Tax Administration and Information Technology programs, which will allow the OCFO to make needed changes to the District's tax code and publicize the changes for tax filing. An increase of \$549,000 will cover technology services in Information Technology related to the requirement.

The FY 2019 budget does not fund, however, other recommendations from the Health Benefit Exchange Authority's Affordable Care Act Working Group, including ways to reduce the

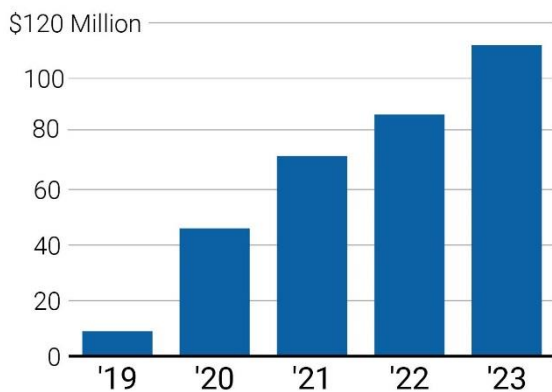
cost of health insurance for lower- and moderate-income District residents up to 400 percent of the federal poverty level. DC Council should include more investments to bring down costs for residents.

As of this writing, provisions are being considered by Congress that would prevent DC from having a local insurance requirement. This toolkit will be updated as this is resolved.

FIGURE 4.

\$326 Million Allocated For New Medical Center on St. Elizabeths Campus

Capital Funding Plan Spans Five Years



Note: Funding does not include \$14.3 million in planned improvements to United Medical Center from FY 2019 through FY 2022.
Source: FY 2019 Proposed Budget and Financial Plan

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Funding for the DC Health Benefit Exchange Authority maintains access to critical services while boosting outreach

The FY 2019 budget includes \$31 million for the DC Health Benefit Exchange Authority (HBX), which operates DC Health Link. DC Health Link is the District's online portal for applying to Medicaid, which includes private health insurance plans and financial assistance for those plans. This budget is an 8 percent increase from FY 2018 after adjusting for inflation, which maintains the funding needed for the agency's operations for DC Health Link.

The Exchange generates funds through a broad-based assessment on health insurance plans operating in the District. The largest shares of its budget are devoted to information technology (IT) operations, assistance to help consumers access insurance and benefits through the Exchange. HBX is now in its fifth year of operation and concluded its fifth open enrollment period for people purchasing individual coverage in February 2018. As of December 31, 2017, DC Health Link had about 18,000 residents enrolled in its individual market, and roughly 76,000 people covered through its small business marketplace (SHOP).

HBX's approved budget for FY 2019 includes approximately \$500,000 for consumer education and outreach. This added funding will help offset substantial federal cuts to health coverage outreach and enrollment efforts, which previously helped direct residents to DC Health Link to find their health coverage options.

Since it first opened, DC Health Link has served nearly 300,000 individuals, including 43,000 DC residents enrolled in private coverage and 78,500 enrolled through the small business marketplace (SHOP).¹⁵ Moreover, DC Health Link has been able to reap the benefits of its early investments, including a first-of-its-kind state partnership with Massachusetts where DC Health Link provides the technology and operational support for the Massachusetts SHOP marketplace. DC Health Link was recognized in 2017 as the top exchange marketplace in the country for its consumer comparison shopping tools.

Health Care Facilities in the FY 2019 Budget

The FY 2019 capital budget includes several initiatives to boost access to health services in the District

The FY 2019 capital budget includes \$326 million for the construction of a new medical center, replacing United Medical Center (UMC) and

creating an integrated health system east of the Anacostia River. In FY 2018, the District provided \$23.7 million to support UMC hospital operations. For the FY 2019 approved budget, \$10 million in local funds is allocated to support UMC operations.

The \$326 million will cover a five-year capital funding plan (*Figure 4*, pg 10). In FY 2019, funding will go to creating the initial infrastructure needed to support the medical center, replacing the adjacent men's shelter on the St. Elizabeths campus, and building permanent parking for the Washington Wizards basketball team's new practice center, slated to open later this year (a

portion of the land serves as temporary parking amid the stadium's construction). The new hospital will include 100 to 150 beds and will support a variety of services. Further details are dependent on the private-sector partner involved, a decision that the city will announce in the coming months.¹⁶

During this time, there will be an additional \$14.3 million in the FY 2019 capital budget invested in improvements for United Medical Center until FY 2022, just before the new medical center is slated to open in FY 2024.

¹ District of Columbia Department of Health Care Finance, Monthly Enrollment Report – June 2018.

² Ibid.

³ Ibid.

⁴ Department of Health Care Finance, Proposed FY 2019 Budget and Financial Plan, Presentation to the Medical Care Advisory Committee, March 28, 2018.

⁵ Ibid.

⁶ Ibid.

⁷ Medicaid expansion through the ACA in 2010 shifted approximately 33,000 residents from the Alliance program to Medicaid. However, after a period of stable enrollment, caseloads began to decrease after a six-month, in-person recertification requirement began for all enrollees in FY 2012.

⁸ Medicaid expansion in July 2010 shifted 34,000 residents from the Alliance Program to Medicaid when Medicaid eligibility was expanded under the Affordable Care Act. However, after a period of stable enrollment, caseloads begin to decrease after a six-month, in-person recertification began in FY 2012.

⁹ Department of Health Care Finance, Monthly Enrollment Report, March 2018.

¹⁰ 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.

¹¹ Department of Health Care Finance, Monthly Enrollment Report, June 2018.

¹² The United States Department of Justice, Office on Violence Against Women, "Grant Programs," <https://www.justice.gov/ovw/grant-programs>.

¹³ United States Census Bureau, "Selected Characteristics of Health Insurance Coverage in the United States," 2016 American Community Survey 1-Year Estimates.

¹⁴ The Alliance program does not qualify as MEC under the ACA, although beneficiaries have access to wrap-around services that fill in the gaps. Previously, some individuals enrolled in the Alliance program who filed tax returns could be subject to the federal health insurance requirement's penalty if they did not qualify for an exemption, despite Alliance coverage often being the only health insurance that Alliance beneficiaries could afford or qualify for. Under DC's local insurance requirement, Alliance beneficiaries will not be penalized for this. For more on what constitutes MEC, see federal guidance [here](#).

¹⁵ DC Health Benefits Exchange Authority, Enrollment Summary, January 8, 2017.

¹⁶ Department of Health Care Finance, Proposed FY 2019 Budget and Financial Plan, Presentation to the Medical Care Advisory Committee, March 28, 2018.