Childless Adult Coverage in the District of Columbia

State Report

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INTRODUCTION

On March 7, 2002, the District of Columbia received approval for a Section 1115 waiver program called "Childless Adults Aged 50-64." The District received this waiver from the Centers for Medicare and Medicaid Services (CMS) to allow childless adults age 50-64 with incomes under 50 percent of the Federal Poverty Level (FPL) to enroll in the District's Medicaid program.[1] Under current law, adults without dependent children may not enroll in Medicaid regardless of how low their incomes might be, unless a state obtains a waiver. Enrollment began on February 20, 2003, and as of June 30, 2003, there were 941 individuals enrolled.

This paper provides an overview of the District's efforts to cover low-income childless adults. It is based interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults. It generally focuses on policies in effect before 2004.

OVERVIEW OF WAIVER PROGRAM

Benefits

Childless adults receive the same benefits as the existing Medicaid population. Benefits include: inpatient, outpatient and ambulatory medical and surgical services; home health services; hospice services; physical, occupational, and speech therapies; prescription drug services; and transportation services. The program currently operates under a fee-for-service system.

Eligibility

The first phase of the waiver, which is currently in place, covers the 50-64 year-old childless adult population with incomes up to 50 percent of the FPL. The second stage is intended to cover this same age category but would expand to cover people with incomes up to 100 percent of the FPL and to adults under age 28 with incomes up to 50 percent of the FPL. As of June 2003, there were no immediate plans to begin enrollment for this phase.

Financing

Funding allocated for the Phase 1 group of enrollees covered by the current waiver is $6 million. The total amount of funding allocated to covering the full population eligible for Medicaid under this waiver (adults 50-64 with incomes up to 100 percent of the FPL and adults under age 28 with incomes up to 50 percent of the FPL) is $12.8 million. The entire amount will be financed by Disproportionate Share Hospital funds (DSH) allocated to the District as part of the technical correction when the District's federal match rate was increased to 70 percent.[2] Thus, about $9 million of the total would be paid for by the federal government and about $3.8 million by the District.

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[1] The Federal Poverty Level (FPL) was $15,260 for a family of three in 2003.

[2] To put this funding in a larger perspective, the FY 2003 budget of the Medical Assistance Administration (MAA) is $1.2 billion (out of a total $5 billion budget for the District). The District's share of this Medicaid spending accounts for $330 million, with $879 million brought in from the federal government (DCPCA Health Justice Update. April 20, 2003).

Enrollment Process

The District's Medicaid program is run by the Medical Assistance Administration (MAA), a division of the Department of Health. Application, enrollment, and re-certification for the program, however, is the responsibility of the Income Maintenance Administration (IMA), located in the Department of Human Services.

To target potential enrollees, all participants in the District's now-defunct "Medical Charities Program" who now qualify for Medicaid under the waiver were sent an early application form to enroll in Medicaid. Even those individuals whose Medicaid coverage was terminated were sent an application because their names and information were still on MAA's mailing list. Re-enrollment can occur through common applications shared among TANF, food stamps and Medicaid at one of eight decentralized IMA service centers or by mail. Re-certification under these programs occurs every six months, and adults who qualify for Medicaid are automatically enrolled in the program during this re-certification process. Additionally, people applying for cash assistance who are found eligible for Medicaid are enrolled. Since the initial mailing, there has been no formal outreach, but enrollment specialists at community clinics and social workers have been active in getting people informed and enrolled.

The program is has an enrollment cap of 2,400 enrollees or its budgeted $6 million, whichever comes first. MAA requested a temporary suspension of enrollment in order to assess expenditures up to that date, but subsequently withdrew its request after finding that the program was within budget. IMA is continuing to process applications for the program as of July 2003. If or when the budget/enrollment cap is reached, applicants will be placed on a waiting list and subsequently enrolled according to order on the list.

HISTORY AND BACKGROUND

Many low-income, childless adults in the District had recently acquired health benefits prior to the waiver approval. The conversion of DC General Hospital into an urgent care center without inpatient capacity in 2001 prompted the formation of the Alliance. The Alliance serves as a safety net health care program for adults age 18-64 who are uninsured and not eligible for Medicare or Medicaid (prior to the waiver), with incomes at or below 200 percent of the FPL. Enrollment is now estimated at about 25,000 residents.[3] The Alliance is fully funded through District dollars and is free to individuals who meet the eligibility requirements. Every member of the Alliance is assigned a primary care provider and enrollees have access to primary care services, specialist services, hospital services, emergency room care, trauma services and coordinated care services. Re-enrollment into this program also occurs every six months. Unlike Medicaid, however, the Alliance is not fully comprehensive insurance–-it is a publicly supported, limited benefits program.

A recent study looking at the numbers of uninsured adults in the District found that there were approximately 50,600 adults aged 18-64 who were uninsured; 60 percent have

[3] "Bankruptcy to Breakthroughs: A Proposed DC Health Care Finance Strategy." DCPCA. February 24, 2003.

incomes below 200 percent of the federal poverty level.[4] Serving this population adequately and efficiently will require the District to meet recent challenges related to maintaining the viability of Greater Southeast Hospital, the only hospital east of the Anacostia River. Greater Southeast declared bankruptcy in January 2003, forcing the Department of Health and the City Administrator to work closely with the hospital to maintain its JCAHO accreditation while it reorganizes, thereby assuring the continued receipt of vital Medicare revenues. Access to care for low-income residents will also require the provision of indigent care by several other hospitals in the District and a fair allocation of DSH funds to compensate these providers for at least a portion of their uncompensated care.

As the city makes the transition from its previous heavy reliance on DC General for indigent care, which generated escalating cost overruns in an inefficient delivery model, to a new system, it will have to navigate through difficult waters. Serious problems with outside contractors led the city to bring the management of the Alliance in-house. The challenges facing the city now are to (1) streamline the enrollment and oversight processes, (2) become a more effective purchaser of health services for lower-income residents, and (3) learn how to manage the care of chronically and critically ill patients so that city dollars result in better access to health care services at a reasonable cost.

FINDINGS

Waiver Development

When the idea of this waiver was first placed on the table, there was some controversy about going forward with the request to CMS. After some sparring among MAA, the City Council, and the Control Board, MAA was able to obtain Council approval for a waiver to fund the expansion with DSH funds. In recent years, though, MAA has experienced a very large turnover in staff–primarily in all of the top leadership positions. This may have been one factor contributing to a delay in program implementation.

The District first chose to cover the 50-64 age population based on a variety of considerations. First, this population includes a large number of retirees who no longer have access to employer-sponsored coverage. Second, according to the District's Behavioral Risk Factor Surveillance System (BRFSS), the percentage of this population that reports fair or poor health is more than three times that of younger adults and more than five times that of children. Additionally, according to the data, 28 percent of the entire 50-64 population has high blood pressure compared to 4.7 percent of adults age 20 to 29. Third, providing insurance coverage to this population will help to provide continuity of care when the population eventually becomes Medicare eligible. Finally, the District hopes to study the extent that primary care is being accessed and the impact on utilization patterns for inpatient and outpatient care, in order to develop a managed care program in the future.

The District has an extremely tightly knit population and this dynamic plays an important role with any new government program that is implemented. When residents see and hear the experiences of their peers receiving insurance, they also want the same opportunities. This makes it difficult to run a waiver program in which one small sub-set

[4] Lurie, N, and M. Stoto. "Health Insurance Status in the District of Columbia." RAND. October 22, 2002.

of the population in need is eligible for services while larger numbers of others with similar problems are not eligible.

Impact of Waiver Coverage

The individuals who qualify for Medicaid under the waiver are a very "needy" population. Since the income threshold of approximately $4,430 per individual per year is extremely low, a substantial proportion of enrollees are homeless. They also have multiple health conditions due to delaying or forgoing care over the years. The District has a considerable number of community clinics and organizations that seek to assist the homeless and vulnerable populations.

While no data is available yet on the impact of the new eligibility under the waiver on patterns of care, much less health outcomes, anecdotal stories paint a gripping picture. A large majority of the patients seen in these clinics are childless adults that have a variety of problems – diabetes, HIV, hepatitis, and hypertension. Prior to the waiver, the treatment of these illnesses caused a huge drain on the resources of the clinics, which relied on charitable donations or out-of-pocket payments. Providers at the clinics were faced with the daunting task of asking a homeless individual to pay for a simple diabetes test or a hypertension pill that could potentially prevent long-term adverse consequences from these diseases.

Now that these individuals are enrolled in Medicaid, they are able not only to get these basic tests and services without paying, but also obtain care from specialists. In addition to the direct care under Medicaid, enrollees are also able to benefit from the transportation services given to patients to take them to and from their appointments. Given the demographics of the population served under the waiver, one of the biggest challenges is simply getting these patients to an office or a clinic. This vital linkage may now be addressed.

Another positive result from this waiver is the improvement in choice and access to services. As described above, the population served by the waiver is a very medically needy group of individuals. Access to specialty care, prescription drugs, and basic medical services are three integral steps that improve primary and preventive care.

Areas for Improvement

The first major challenge is to claim available federal dollars that have been left on the table. Currently, the District is the sole payer for the Alliance, whereas Medicaid is financed jointly by the District (30 percent) and the federal government (70 percent). The waiver should start a larger process of transitioning very poor patients from the Alliance to Medicaid. This will not only allow the District to experience significant savings, but also provide these individuals with fully comprehensive health insurance.

Another area for improvement is to find a way to effectively manage the care of the high-risk population covered by this waiver. Older, very poor adults frequently have complex health care needs. As noted earlier, many are homeless and there is a high incidence of chronic illness and disability. This calls for intense medical management, coordinated services and an integrated health care delivery model. Properly managed care should hold the potential to improve health and functional status while lowering costs. Yet, the District has no immediate plans to develop a managed care program for this group.

District officials are apparently concerned that managed care organizations would either charge high premiums to reduce the risk of serving a very needy population, or refuse to participate in the program.

Originally, the waiver population was to be enrolled in the city's Medicaid managed care program. The District, however, was not able to establish capitation rates before enrollment began. Clients are currently being served under the fee-for-service program until actuarial studies can be completed. Once completed, enrollees will be transferred into the District's Medicaid managed care program. While this is no panacea and may present some challenges related to assuring access to services, the District should explore the feasibility of a managed care arrangement. This might include, for example, an immediate needs assessment for new enrollees, the assignment of a case manager, the formulation of an individually customized case management plan, a plan for medication management, and the monitoring of ambulatory-sensitive emergency department visits and inpatient admissions.

Another challenge is to increase the presence of enrollment workers at clinics and community centers to help patients navigate the enrollment process. This includes a stronger push for a "Single Point of Entry"–where an enrollee's vital information is entered into a centralized web-based database and a list of the programs the person is eligible for is available along with the necessary enrollment forms. This idea has been strongly promoted by the DC Primary Health Care Association.

While it is common for states to have separate offices for enrollment and administration, this has posed a challenge in the District, particularly with respect to eligibility criteria. The fact that the Medicaid program has not had a permanent director since October 2002 may have led IMA, which would normally be the group that operationalizes the program, to be engaged in some program management activities as well.

LESSONS LEARNED

As discussed above, transitioning the individuals who are now eligible for coverage under the waiver from the Alliance into Medicaid can save the District considerable dollars. In fiscal year 2003, referring Alliance patients to Medicaid and supporting a Single Point of Entry system would save the District an estimated $1.96 million, and further savings estimated at $3.13 million could be realized in fiscal year 2004.[5] The surprise, then, is that the delays in program implementation are causing the District to leave substantial available federal matching dollars on the table. As of May 2004, 24,560 childless adults of all ages were enrolled in the Alliance, many of whom could qualify for matching federal funds under an enlarged waiver.

Another surprise stems from the enrollment patterns. The expectation was that enrollment would be "front-ended," with high enrollment numbers in the beginning months, then tapering off in later months. However, so far, what actually has occurred is an equal distribution in enrollment numbers from month to month. As stated above, enrollment into Medicaid is tied to enrollment into other public programs, which have a six-month re-certification timeframe. When these programs are coordinated and the city

[5] "Bankruptcy to Breakthroughs: A Proposed DC Health Care Finance Strategy." DCPCA. February 24, 2003.

develops a combined application, the Medicaid program for childless adults will have a successful enrollment tool.

One additional lesson learned by MAA regarding the waiver process was the importance of input offered by stakeholders in the health care community such as the population served, consumer advocates, health and policy experts and government officials in order to avoid conflicts over implementation once the program starts. MAA also learned from other states that cover similar populations to pay close and frequent attention to enrollment and submitted claims.

DISCUSSION

The DSH money used to pay for the waiver population would otherwise go directly to the hospitals while the District would still be responsible for paying for this population through the Alliance (100 percent local dollars). In the short and long term, greater use of federal matching funds provides obvious financial benefits. Unlike most states, at this point, the District is not faced with drastic budget cuts in their health insurance programs. In fact, if the District develops an effective screen-and-enroll process that redirects potential Alliance members to Medicaid where they are eligible, it will save money.

To further this argument, it was recently revealed that the Alliance needs an extra $33.5 million to fund the remainder of fiscal year 2003. While there are different opinions on who is at fault, according to the District's City Administrator, $12 million of this deficit was due to doctors and hospitals billing the Alliance for patients who should have been or were covered by Medicaid.[6] This may even include people who reside in Maryland or Virginia who are eligible for Medicaid in those states.

Additionally, access barriers related to obtaining affordable pharmaceuticals under the Alliance model poses a significant challenge. While prescription drugs are a covered service under the Alliance, prescriptions are only paid for at a select group of pharmacies in the District. Conversely, Medicaid will pay for prescription drugs at most pharmacies in the District. Another benefit to having Medicaid as opposed to the Alliance is that payments to specialty care providers are consistent. The District is experiencing an exit of these providers under the Alliance because of payment issues, whereas Medicaid does not experience these challenges.

[6] Goldstein, Avram. "Health Network's Finances Roil D.C." The Washington Post. June 8, 2003; C01.

SOURCES

Communication with Morgan Tucker. Department of Health. Medical Assistance Administration. August 2003.

Conversation with Rob Langelier, HIV/AIDS Policy Specialist, and Rene Walis, Deputy Director, DC Primary Care Association. May 2003.

Conversation with Linda Plitt Donaldson, Director of Advocacy and Family Services, So Others Might Eat (SOME). May 2003.

Conversation with Dr. Mikelle Saulsby, Medical Director, So Others Might Eat (SOME) Medical Clinic. June 2003.

Medicaid Reform Committee Minutes. DCPCA. March 21, 2003.

DCPCA Health Justice Update. April 20, 2003.

Questions and Answers about the DC Healthcare Alliance. Whitman Walker Clinic. www.wwc.org/GLBT_health_services/alliance.htm