Council of the District of Columbia Council
Committee on Health
David Catania, Chair

Fiscal Year 2012 Budget Request Act of 2011 and
Fiscal Year 2012 Budget Support Act of 2011
Budget for the Department of Health Care Finance

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The leaders of our city have a set of tough choices to make this budget cycle, and those choices will reflect the priorities and values of District residents and our government. Universal access to healthcare is a critically important value that the FY 2012 budget should protect. Chairperson Catania, because you have been a leader in the effort to secure universal healthcare in the District, the Legal Aid Society of the District of Columbia asks for your leadership again to avoid changes to the D.C. Healthcare Alliance program that will, in effect, make healthcare coverage in the District universal in name only.

Legal Aid is pleased that the Department of Health Care Finance's proposed FY 2012 budget does not, thus far, include potentially devastating measures such as capping enrollment for the District's medical assistance programs, covering fewer optional Medicaid services, or cutting Medicaid or Alliance reimbursement rates even further. We urge the Council to avoid pursuing such changes during this budget deliberation process. We are concerned, however, about the Mayor's proposed $12 million cut to the D.C. Healthcare Alliance program, which it expects to achieve through a revised, untested recertification process. We believe that the policy will do more to disqualify those who are actually eligible for the Alliance than it will do to deter enrollment by ineligible people. We also have several concerns about the administrative issues that would likely accompany this new recertification process.

I. D.C. Healthcare Alliance

The Alliance provides critically important healthcare coverage for low-income District residents who, for various reasons, do not qualify for Medicaid. Although health care reform

[1] The Legal Aid Society was formed in 1932 to "provide legal aid and counsel to indigent persons in civil law matters and to encourage measures by which the law may better protect and serve their needs." Legal Aid is both the oldest and largest general civil legal services program in the District of Columbia. Over the last 79 years, tens of thousands of the District's neediest residents have been served by Legal Aid staff and volunteers.

Legal Aid is a member of the Fair Budget Coalition and supports the Coalition's budget priorities. Legal Aid is also a supporter of the Invest in DC campaign and urges the Council not to retreat from the partially balanced approach taken in the Mayor's proposed budget.

expanded Medicaid eligibility to cover many District residents who were formerly on the Alliance, there remain thousands of low-income District residents who, for various reasons, do not qualify for Medicaid under the new healthcare law. Therefore, the Alliance is an essential aspect of the medley of programs that help the District reach Chairperson Catania's long-held goal of guaranteeing truly universal healthcare for District residents.

A. Proposed Cut to the D.C. Healthcare Alliance

The proposed Budget Support Act proposes a change to the Alliance recertification process that will ostensibly save the District $12 million. Instead of an annual recertification that requires the submission of a comprehensive form, each Alliance enrollee will have to go through a face-to-face recertification with a case worker in order to retain benefits.

Lurking behind this approach is the belief that a large number of the remaining Alliance beneficiaries should not be enrolled in the locally-funded program, either because they are not District residents, because they are eligible for other programs like Medicaid or Medicare, or because of some income-eligibility issue. In the past – prior to the establishment of DHCF – the District has been criticized for the poor administration of the Alliance and has needed to devote additional resources to training workers to administer the program.[2] In 2009, DHCF instituted elevated requirements for documentation of D.C. residency to address some of the shortcomings of the past.[3] However: (1) there is no evidence that those problems are ongoing under the new administrative structure; and (2) most of those problems, even if they were ongoing, would not necessarily be improved by requiring more frequent and in-person recertification. The errors that plagued the Alliance eligibility process before the establishment of DHCF were primarily errors involving incomplete paperwork and mistakes by staff. Nothing about the proposed changes would address these types of issues; in fact, they would likely worsen them by stretching IMA staff even more thinly. The massive shift of Alliance enrollees to the Medicaid program because of early opt-in to healthcare reform, and the reforms to the Alliance program that have already been instituted, make reliance on outdated perceptions of Alliance administration problematic.

B. Deterrence of Eligible District Residents

Legal Aid does not oppose reasonable, appropriate efforts by the Department of Health Care Finance to limit Alliance eligibility to its intended beneficiaries. We agree that only D.C. residents should receive the Alliance. However, we are concerned that the proposed funding cut and recertification process would do more to deter qualified individuals who need the Alliance for healthcare coverage than it would do to curb waste or fraud.

Our experience as legal services providers suggests that, while in-person recertification may in fact lower the Alliance rolls, it will likely do so for the wrong reasons and will leave

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[2] *See* Susan Levine, *D.C. Health Alliance Faulted on Eligibility Control*, *Washington Post*, Feb. 28, 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/02/27/AR2008022704108.html.

[3] *See* Press Release, *DHCF Implements Controls to Alliance Program*, Aug. 21, 2009, http://newsroom.dc.gov/show.aspx/agency/dhcf/section/2/release/17926/year/2009.

many of our clients without the health coverage to which they are entitled. Legal Aid assists clients who have been terminated from medical assistance programs, not because they do not qualify, but because of problems with the recertification process. There are a multitude of problems with these processes that range from lack of notice, miscommunication between caseworkers and Alliance or Medicaid enrollees, and other bureaucratic obstacles. We do our best to resolve these issues for our clients, but most people faced with recertification and other health access-related problems are unable to attain access to an attorney to help them navigate the system.[4] They slip through our system's cracks – and many others who are fully eligible for the Alliance will join them if the recertification provision of the Budget Support Act is adopted. Making this process even more cumbersome and time-consuming (for both the enrollee and the agency) will do just as much or more to exclude eligible Alliance beneficiaries than it will to disqualify those who may be ineligible.

Research, both nationally and in other jurisdictions, supports our belief that introducing this type of red tape to the process of applying for the Alliance would mean that qualified people would lose coverage. Increased frequency of the process and the requirement for face-to-face recertification would introduce problems related to transportation (the time and cost travel to various social services offices can sometimes be prohibitive), employment (in many of our clients' low-paying and/or part-time jobs, the need to absent from work for a day or more to recertify for the Alliance will cause them to lose wages and could cause them to lose their jobs), and documentation (the trouble of securing required documentation), among others.[5]

Language access would likely also become a larger issue with more frequent and in-person recertification; miscommunication between a case worker and an applicant with limited English proficiency (LEP) is a serious risk under the reconfigured Alliance program. Under the current paper certification process, even if a form is not available in an enrollees' own language, the enrollee can receive assistance in completing the form and providing documentation. However, despite the District's under the Language Access Act, a face-to-face meeting is nonetheless likely to intimidate an enrollee or leave the enrollee with less information than is necessary to ensure that coverage is not unduly lost.[6]

C. Administrative Barriers to Proper Implementation

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[4] *See* DC Access to Justice Comm'n, *Justice for All? An Examination of the Civil Legal Needs of the District's Low Income Community* 83-84 (Oct. 2008) (estimating unmet legal services needs in the District), *available at* http://www.dcaccesstojustice.org/files/CivilLegalNeedsReport.pdf.

[5] *See* M. Robin Dion & LaDonna Pavetti, Mathematica Policy Research, *Access to and Participation in Medicaid and the Food Stamp Program: A Review of the Recent Literature* at xiii (exec. summ.) (Mar. 7, 2000), http://www.mathematica-mpr.com/publications/pdfs/accesslitreview.pdf. *See generally* Center for Healthcare Strategies, *Reducing Barriers to Health Care: Practical Strategies for Local Organizations* (2007) (identifying barriers across several states related to transportation, limited English proficiency, lack of understanding of the processes for eligibility, and others), *available at* http://www.chcs.org/usr_doc/CKF-AI_Toolkit.pdf.

[6] *See generally* E. Feinberg et al., *Language Proficiency and the Enrollment of Medicaid-Eligible Children in Publicly Funded Health Insurance Programs*, Maternal & Child Health J. (2002), at 5-18. This article focuses on children and Medicaid but also makes the larger point that limited English proficiency has been a significant barrier to accessing programs that provide health coverage to individuals with low incomes.

The Budget Support Act would increase the frequency and change the locus of the recertification process. These changes would drastically increase the workload of the IMA staff, despite reductions in the number of staff. Aside from Legal Aid's general concerns about increasing administrative red tape, we also have specific questions that should be resolved before the administrative process is expanded. Most notably, the proposed recertification process ignores the fact that IMA already has extreme difficulties processing applications and recertification forms in a timely manner.

The difficulty of applying for or recertifying for benefits in person is well-documented and well-known. As noted above, our clients at Legal Aid have, on a fairly regular basis, lost benefits because they never received notification that they needed to recertify, because a staff member misplaced or misunderstood their documents, or simply because travel or other life circumstances interfered with their ability to meet the recertification deadline. A January 2010 *Washington Post* story profiled several District residents who had to wait up to seven hours, or return to the service centers on multiple days, to apply for and/or recertify their eligibility for safety net programs.[7] Which staff would be responsible for carrying out face-to-face recertification? Does IMA have adequate staff to be able to conduct these interviews in a meaningful way without undue delay?

Chairperson Catania, you have been a leader in the efforts to secure universal healthcare for District residents, both through advocacy of the Alliance but also through the Healthy DC program and other programs, policies, and legislation. We urge you and the other members of the Committee on Health to consider the likely effects of the Alliance changes on health care access in the District.

II. Provider Reimbursement Rates & Limitation of Optional Medicaid Services

As noted above, the current proposed budget does not propose cutting provider rates or decreasing optional services. Protecting these aspects of Medicaid and the Alliance during this difficult budget cycle demonstrates the District's concern about providing quality health care services to low-income residents. We are hopeful that during the challenging budget negotiations process, neither the reimbursement rates for Medicaid and the Alliance nor the range of services provided will be placed on the chopping block. Changes to reimbursement rates would make it more difficult to recruit new Medicaid and Alliance physicians at a time when the number of enrollees in these medical assistance programs – particularly Medicaid – is likely to grow. Limiting of optional services under Medicaid would mean that many health problems faced by low-income District residents would go untreated. We urge the Council to refrain from introducing such policy changes as budget deliberations proceed.

III. Enhancement of Health-Related Revenue

As a member of the Fair Budget Coalition, Legal Aid supports an increase in the current hospital bed tax from $1,500 per bed to $3,000 per bed. This new revenue would fund Medicaid

[7] Tim Craig, *Frustration Among Poor D.C. Residents Grows at Understaffed Assistance Center*, Wash. Post, Jan. 19, 2010, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/01/18/AR2010011803863.html.

services in a way that would take advantage of the 70/30 federal match rate and protect the enrollment eligibility and the essential but – to the federal government, "optional" – services covered under the District's Medicaid program.

It is worth noting that in 2010, DHCF proposed a one-percent assessment on hospital patient revenue for FY 2011, a move that could have generated over $25,000,000 of revenue for the health care safety net. Unfortunately, that policy was changed to the bed tax which meant significantly less revenue for DHCF[8] at a time when the agency has experienced an unexpectedly high increase in Medicaid enrollment (even higher than the 5.8% increase the agency predicted for FY 2011 and much higher than the Council's estimation.) With the increased demand for Medicaid physicians, at the very least this Committee should increase the bed tax to generate critically-important revenue that can stabilize, and perhaps even support a small restoration of, Medicaid provider rates.

Finally, beyond the healthcare realm, the Council could generate additional revenue by ending the tax break for DC residents who invest in out-of-state bonds. This tax break unjustifiably rewards District residents for spending money outside of the District. While people certainly have the right to invest their money however they see fit, there is no reason that the District should give them a windfall for doing so. Ending this tax break could generate millions of dollars in additional revenue that could help save health care access for low-income District residents.

We understand the Chairperson's desire to preserve revenue-enhancement measures for instances when they are fair and absolutely necessary. We would not suggest an enhancement if the long-term health of our medical safety net were not at risk in the proposed budget. The bed tax is one of very few ways that truly universal health coverage can be maintained during these budget times and beyond. This measure would be far more manageable and reasonable than a service cut or provider pay cut that would only affect providers that serve Medicaid patients.

IV. Conclusion

Legal Aid recognizes that economic times are tough in the District, and that the $322 million shortfall requires District leaders to make difficult choices about how we will spend limited funds. This budget is, in some ways, an improvement over those submitted during previous administrations. However, the proposed changes to the D.C. Healthcare Alliance are highly problematic. The amount of savings is purely speculative, and the barriers erected by increasing the red tape associated with health care access would be steep. Legal Aid urges this committee to eliminate the Budget Support Act's cumbersome and administratively taxing revision to the recertification process, but to maintain the proposed budget's avoidance of enrollment caps and service restrictions.

[8] The bed tax generated $6,285,000 – 75% less than the assessment would have produced.