Perspective on B17-076

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Perspective on B17-076

Before the Committee on Health
Council of the District of Columbia

June 20, 2007

Chairman Catania, Chairman Gray, and other distinguished members of the Committee on Health:

My name is Nicole Lurie. I am a volunteer physician at Bread for the City, and the Paul O'Neill Alcoa Professor of Policy Analysis at The RAND Corporation. For the past nine years, I have been involved in analyzing data to inform health policy in the District.

I write in support of the concepts incorporated in B17-076, which consolidates administrative, billing and claims processing functions in one single Health Finance Agency. The advantages of doing so are substantial. First, it is designed to increase efficiency, accuracy and reduce waste, which would reduce administrative Medicaid costs. One important consequence, if this efficiency can be realized, would be enhancing the amount of federal reimbursement the District will receive from Medicaid, as more claims will be submitted correctly and paid. This will, in turn, obviate the need to spend local dollars on these matched funds, freeing them for additional investment in health care and public health.

In addition, a consolidated administrative structure has the potential to greatly enhance the ability to analyze health care data. Those who try to use such information for policymaking could obtain data from one source, rather than trying to gather and put together information from multiple sources with different formats and different levels of accuracy. This should make it easier to know how and where health care dollars are being spent, and to monitor and improve the quality of care provided with those dollars. Since the District has a rate of uninsured that is lower than many other places in the country, improving quality may prove to be as important a strategy as

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increasing insurance coverage in terms of its effect on the health of DC residents. Finally, the enhanced ability to analyze these health care data means that they can be harnessed for public health improvements, by highlighting both clinical areas and small geographic areas where the needs and potential for improvements prove to be the greatest, again enabling the District to spend savings that accrue in ways that are most likely to improve the public’s health.

If done well, splitting health care financing and public health functions should enable each agency to concentrate on its unique mission. This is particularly important for public health, because numerous studies have shown that the contributions of health care alone are usually insufficient to improve health. Yet, much of the energy of DOH is spent dealing with health care financing-related issues, when it also needs to focus on the determinants of health that a public health system can best address.

For this proposed arrangement to work, however, both the new agency and DOH must have, as each of their priorities, a process to facilitate data collection, analysis and exchange regarding health care spending and health outcomes. In addition to the exchange of information at Mayor’s cabinet meetings, this might be done statutorily or through memoranda of understandings signed between these and other relevant human service agencies. I believe it would also be wise to develop a reporting and accountability structure to ensure this occurs, by requiring a minimum set of jointly produced reports on the District’s health, sharing a budget to produce them, and by monitoring the timeliness of data sharing.

The concepts incorporated in this legislation could present an important opportunity for the District to continue to make progress in developing efficient, high quality health care and public health systems to improve the health of all DC residents. Thank you.