FY2024

BUDGET OVERVIEW

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#FAIRSHOT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

FY 2024 BUDGET

Medical Care Advisory Committee (MCAC)

March 23, 2023

Presentation Outline

- ☑ District's Budget Challenge For Mayor Bowser's Proposed Financial Plan
- ❑ DHCF's Focus on Resilience in FY2024
- ❑ Overview of FY2024 Budget Proposal
- ❑ Enrollment Trends and the DC Access System
- ❑ Investments in Provider and Health Care Workforce
- ❑ Program Trends
  - Health Care Delivery System
  - Long Term Care
  - Behavioral Health

This Budget Was Developed After A Three-Year Struggle With The Pandemic

It's time to focus on our city's long-term growth.

The Budget Environment We Faced.

- We have spent the last three years responding to and recovering from the pandemic.
- The investments we made in DC's Recovery Plan are working – we have more jobs, lower unemployment, more visitors, and our hotels and restaurants are filling up again.
- However, the long-term impacts of high inflation and telework are having a significant impact.
- This FY 2024 *Fair Shot Budget* acknowledges the economic realities we face by prioritizing the most critical investments needed to make DC a place people want to call home, do business, and visit.

Shrinking Resources And Escalating Costs Created A Budget Crisis

Our resources are shrinking

- February CFO forecast showed a drop in revenues of more than $390 million largely due to:

- A slowdown in the economy as a result of high inflation and a drop in the stock market
- A reduction in revenues from falling commercial real estate values as the long-term impacts of telework began to take hold
- The end of a historic, once-in-a-lifetime influx of federal funds that pumped more than $8 billion of grants into DC government, universities, hospitals, and non-profits, and $8 billion of direct payments into the DC economy over just four years

While we have significant cost increases

- **$558M** to fully fund all collective bargaining agreements with our teachers, firefighters, police officers, school principals, and many more critical DC government workers
- **$481M** to fully fund DC government retirement accounts
- **$124M** to fund cost increases and inflation for existing school, parks and recreation, and library projects
- **$722M** to fund increases to the UPSFF, leasing costs, utility costs, and Medicaid increases

After the CFO released their February revenue estimate, the District was facing a $1.7 billion deficit.

How Did The Mayor Balance The Budget

- Tapped the fiscal stabilization reserve **($257M)**
- Worked with CFO to certify **$578M** in anticipated Automated Traffic Enforcement revenue from new cameras approved in FY 2022 and FY 2023
- Maximized federal reimbursements from the pandemic **($148M)**
- Made **$373M** of reductions, including the elimination of 749 vacant positions
- Reprioritized federally-funded Recovery Plan investments
- Maximized use of special purpose revenue and dedicated tax fund balances
- Funded most programs and services at pre-pandemic levels
- Made tough decisions to right-size programs

FY 2024 BUDGET OVERVIEW

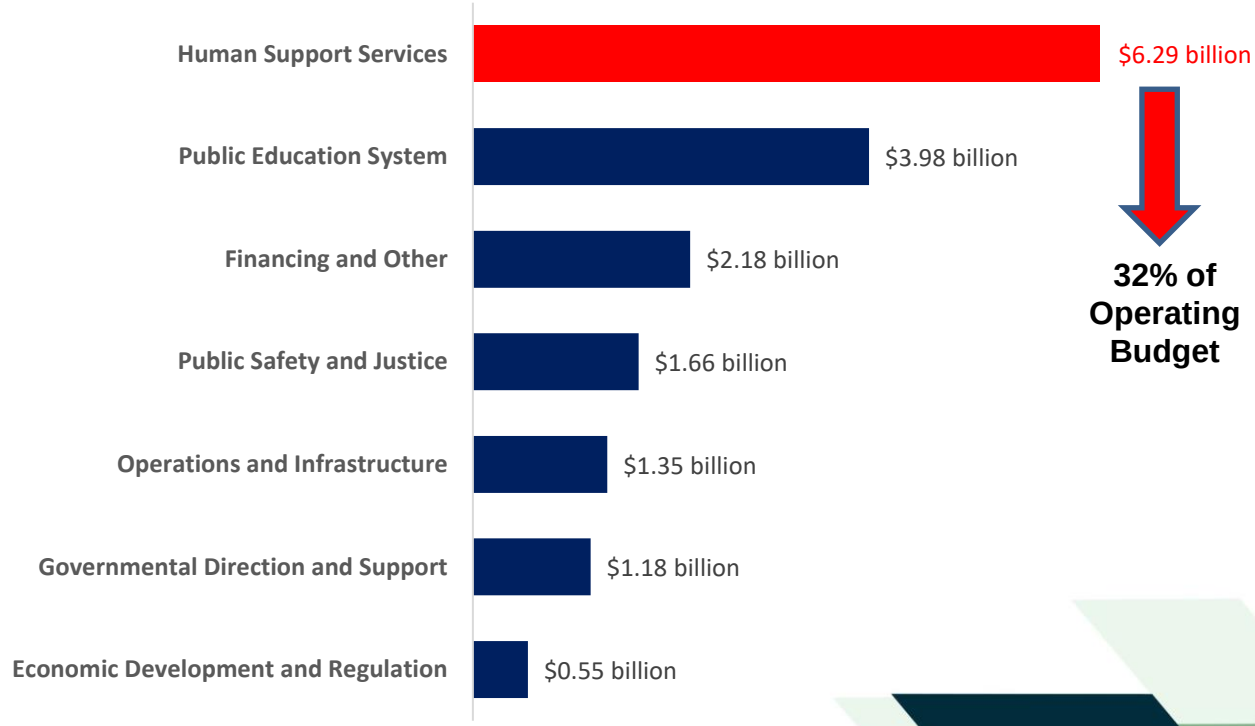
OPERATING BUDGET

- **$19.7B** gross funds budget
- **$10.6B** Local Funds budget
- Local Fund resources decrease by **$110M** or -1% compared to the FY 2023 Approved Budget

MOST SIGNIFICANT INCREASED INVESTMENT

Collective Bargaining Agreements, Retirement Accounts, Schools, Medicaid, Fixed Costs and Facilities Maintenance, plus Debt Service to support planned capital investments

FY 2024 OPERATING BUDGET



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DHCF Established Three Strategic Priorities to Guide Reform Efforts – Expanded to Include PHE Efforts

VISION *the future we aim to create*

All residents in the District of Columbia have the supports and services they need to be actively engaged in their health and to thrive

MISSION *what we do and who we serve*

The Department of Health Care Finance works to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia

VALUES *the principles that guide our work*

Accountability – Compassion – Empathy – Professionalism – Teamwork

STRATEGIC PRIORITIES

- Building a health system that provides whole person care
- Ensuring value and accountability
- Strengthening internal operational infrastructure
- Unwinding from the Public Health Emergency (PHE)

Agency Priorities Promote Resilience in the Health System and Ready for Returning to Normal Operations

Building a health system that provides whole-person care

- Award new managed care contracts with a five-year base period
- Collaborate with the Department of Behavioral Health to ensure the successful integration of behavioral health services into the managed care program to better coordinate care for better outcomes
- Expand program options for beneficiaries in both Medicaid and Medicare to include PACE
- Continue strengthening maternal health
  - New doula services benefit
  - Facilitate the Perinatal Mental Health Task Force
- Enable HCBS providers to participate in health information exchange through the ARPA-funded Digital Health Technical Assistance project
- Continue offering practice transformation technical assistance to an array of providers to achieve clinical and operational excellence
- Expand the Produce Rx program to other locations

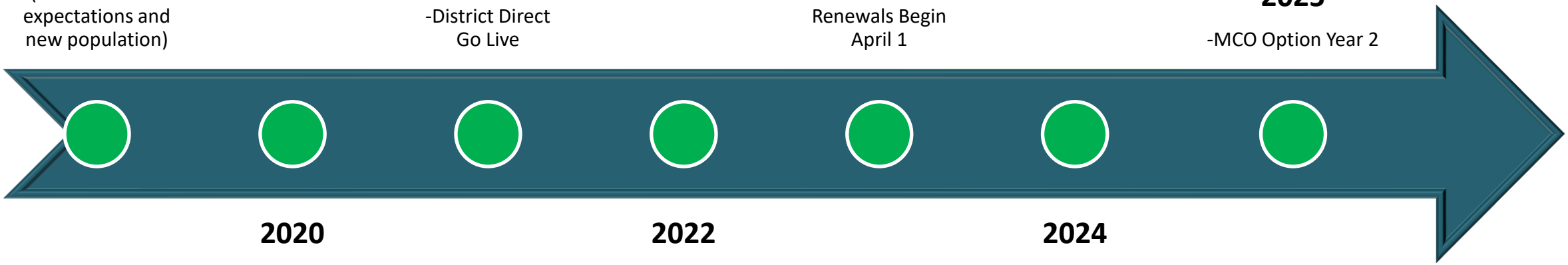
Agency Priorities Promote Resilience in the Health System - Continued

- **Ensuring value and accountability**
  - Presented initial draft of value-based purchasing framework
  - PACE site opened to first dual eligible patients

- **Strengthening internal operational infrastructure**
  - Implemented strategies to engage staff better
  - Launched onboarding work group to better new staff process
  - Developed data management and governance

- **Unwinding from the Public Health Emergency (PHE)**
  - Issue operational plan for unwinding and returning to normal operations
  - Developed and implemented communication strategy and disseminated toolkit to government and community partners

DC Medicaid Reform Milestones Begin to Build a System of Resilience



2019

-Issue MCO RFP (with increased expectations and new population)

2020

-Implement new MCO contracts (17,000 FFS transition to MCO)

2021

-MCO Contract Option Year 1

-Issue MCO RFP

-District Direct Go Live

2022

--Implement Dual Choice

-Implement PACE

-HCBS Digital Health TA Launches

2023

-Implement new MCO Contract

-PACE Launched

-Medicaid Renewals Begin April 1

2024

-MCO Contract Option Year 1

- Behavioral Health Carve-In

-Enhanced Wages for DSP

-New Provider Rates

2025

-MCO Option Year 2

Our Proposed FY24 Budget Continues to Build System Resilience

Whole Person Care

- Implement Behavioral Health Integration
- Develop 1115 Behavioral Health Transformation Waiver
- Continue Technical Assistance Projects to promote patient-centered care

Value and Accountability

- Enhance DSP Wages
- Implement results from various provider rate studies
- Continue Home and Community Based Initiatives through ARPA

Unwinding and Returning to Normal Operations

Impacts of the End of the Federal Public Health Emergency

Key Points: On January 30, 2023, the Biden Administration announced that the PHE will end on May 11, 2023

- When the PHE hit in 2020, DHCF took deliberate steps to ensure District residents had access to health coverage
- DHCF fulfilled its role by utilizing various temporary flexibilities (summarized below) that allowed the District to streamline eligibility and enrollment, increase provider payments, and expand covered services

PHE and Emergency Authorities for the Medicaid Program

Authority	Effective Date	Termination Date	Example*
Medicaid State Plan Amendments	March 1, 2020, or later date selected by the state	End of the federal PHE or any earlier date selected by the state	DC SPA- 20-01- Temporary 20% increase to nursing facility rates
Appendix K (Home and Community-Based Services Waivers)	January 27, 2020 or any later date elected by the state	Up to 6 months following the conclusion of the federal PHE	§1915 (c) HCBS Waiver Appendix K: Temporary 15% addition to assisted living facility rates
Medicaid §1135 Waivers	March 1, 2020	End of the federal PHE	District §1135 Waiver Request: Temporarily suspend Medicaid FFS prior authorization requirements

- While most of these flexibilities will end on or near May 11, 2023, DHCF is taking action to make some service and reimbursement changes permanent. Plans are provided in greater detail in DHCF's Operational Plan for Unwinding

Extension of Enhanced Provider Rates

Key Points: Some provider rates that were enhanced during the PHE will be extended beyond May 11, 2023, for example:

Continuing Enhanced Provider Rates		
Service/Program	**Enhanced Rate or Programmatic Flexibility**	**Expiration Date**
ICF/IID Reimbursement	15% reimbursement increase to the Direct Service cost center will be extended for two (2) months following the conclusion of the federal PHE.	11-Jul-23
Nursing Facility Reimbursement	20% reimbursement increase to all facility rate components will be extended for two (2) months following the conclusion of the federal PHE.	11-Jul-23
Home Health and PCA	Reimbursement of overtime rates, quarantine rates, and staffing agency rates to Home Health Agencies for Skilled Nursing, Private Duty Nursing, and Personal Care Aide (PCA) will be extended for six (6) months following the conclusion of the federal PHE.	11-Nov-23
My Health GPS	All assessment, reimbursement, and programmatic changes to My Health GPS implemented during the PHE will be incorporated into the permanent State Plan.	Permanent Change
Elderly and Physically Disabled (EPD) §1915(c) HCBS Waiver	DHCF intends to amend the EPD Waiver to make increased assisted living rates permanent until a more comprehensive reimbursement methodology update is established.	Permanent Change

- Additional continuing programmatic flexibilities and enhanced PHE rates are reviewed in greater detail in the District's Operational Plan for Unwinding

The Consolidated Appropriations Act Sets the End Date of Continuous Enrollment

Key Points: The omnibus decouples the continuous enrollment from the federal PHE declaration. It also provides a phase out of the enhanced FMAP through December 2023

- **Continuous enrollment ends March 31, 2023**
  - DHCF is restarting eligibility determination by mailing 60 & 90 day notices starting April 1, 2023
- **Establishes phased-out enhanced FMAP and establishes additional requirements states must meet to remain eligible for enhances funding:**
  - FMAP Remains 6.2% through March 2023
  - 5% April – June 2023
  - 2.5% July – September 2023
  - 1.5% October – December 2023 (FY24)
- **Extends funding for Children's Health Insurance Program (CHIP) through Federal Fiscal Year 2029**
- **Requires 12-month continuous Medicaid and CHIP coverage for children, effective January 1, 2024**
- **Makes the current state option to provide 12-month continuous postpartum coverage in Medicaid and CHIP permanent**
  - Previously only permitted as a 5-year demonstration under American Rescue Plan Act (ARPA)
- **Enhanced Provider rates continue to be tied to the PHE declaration and therefore will continue based on when the federal PHE ends.**
- **This legislation does not impact ARPA Maintenance of Effort requirements**

In FY2024, DHCF Was Able To Realize A Savings of $11.1M As A Result of The Updates To The Federal Decisions Related To The End of The PHE and Establishment of The Consolidated Appropriations Act

Increase In Cost:	
Continuation of eligible Federal PHE Provider Rates (October and November 2023)	$1,743,260
Net Impact of Enrollment as a Result of Federal Consolidated Appropriations Act	2,674,904
Increases in FY24 DHCF Budget	**$ 4,418,164**

Savings:	
Last Quarter of Enhanced FMAP (1.5% or 71.5% FMAP)- October- December 2023	(15,468,985)
Savings to the District	**$ (11,050,821)**

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The DHCF FY2024 Mayor's Proposed Local Budget Maintains Services, Rates and Eligibility During An Economic Downturn

Agency FY2023 Approved Budget	**$954,955,220**
Less One Time Funding:	(62,885,420)
Revised FY2024 Baseline Budget	**$ 892,069,800**
Budget Adjustments:	
Savings Initiatives	(73,500,390)
Restoration of Budget Reductions and Increases	166,570,677
Adjusted FY2024 Local Budget	**$ 93,070,287**
Mayor's Enhancements	**1,773,088**
DHCF FY2024 Mayor's Proposed Local Budget	**$986,913,175**

The DHCF FY2024 Mayor's Proposed Local Budget Maintains Services, Rates and Eligibility During An Economic Downturn

Maximizing Revenue

- **$10.1M** Shift Provider Spending to Healthy DC Dedicated Tax Fund Balance (available due to EFMAP savings)
- **$3.1M** Shift Physician Spending to Third Party Liability Special Purpose Revenue
- **$2.8M** Shift BH Rate Inflation & Cost of Redesign for Childless Adults to HCBS ARPA funding
- **$2.9M** Shift Home Health inflation to HCBS ARPA funding

Administrative Savings

- **$2.3M** Reduction of 16 Local FTE's (31 total) and Vacancy Savings
- **$583K** Contracts
- **$387K** Supplies, Training and Professional Services
- **$11K** IT Assessment Adjustment

Note: All local reductions represent ~55% of the total Impact; the remaining ~45% is reduced in Medicaid Payments

Program Efficiency Savings

- **$11.3M** Establish payment ceiling for MCO hospital rates based on cost data
- **$9.7M** Net Impact of Omnibus Act & sunset of the PHE
- **$2M** Sunset of District ARPA funding; absorbed within DHCF budget
- **$461k** Alignment of Specialty Hospital rates

FY2024 Investments To Ensure DHCF Is Able To Ensure Continuity of Care, Maintain Rates and Eligibility To District Residents

$117.2M

- Support the continuation of the Alliance program to ensure eligible District residents continue to receive healthcare through the program

$18.1M

- Maintain hospital provider taxes at current levels to support anticipated FY24 hospital fee-for-service cost

$1.3M

- Increase efficiency in LTCSS eligibility processing by transferring 22 FTE's from DHS to DHCF, so they are more closely aligned with Division of Eligibility Policy, DC Access System, and LTC Administration staffing and resources

$500K

- Continuation of the Produce Rx grant which builds off of past successes and will offer more healthier food selection opportunities for eligible Dc residents

DHCF's FY2024 Year Over Year Comparison by Appropriated Fund

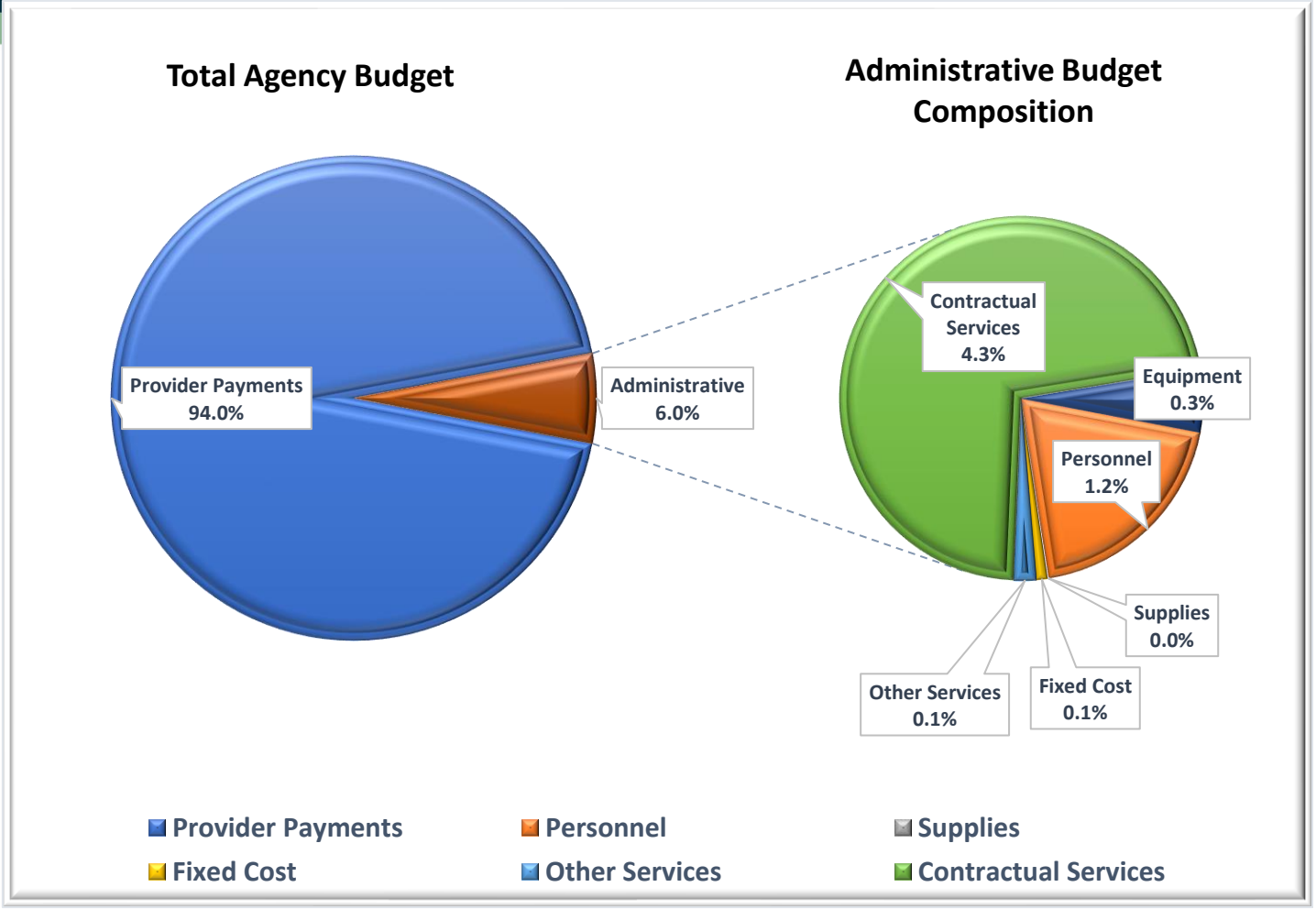
Appropriated Fund		FY 2023 Approved Budget	FY 2024 Proposed Budget	YoY Budget Change	% Change
0100	Local	954,955,220	986,913,175	31,957,954	3.3%
0110	Dedicated Taxes	105,105,077	114,535,958	9,430,881	9.0%
0150	Federal Payments	2,000,000	-	(2,000,000)	-100.0%
0200	Federal Grants	5,174,115	4,550,493	(623,622)	-12.1%
0250	Federal Medicaid Payments	2,663,283,089	3,180,056,342	516,773,254	19.4%
0400	Private Grants	365,701	100,000	(265,701)	-72.7%
0600	SPR Revenue (Type)	5,643,542	8,805,546	3,162,004	56.0%
0700	Intra Districts	-	-	-	0.0%
Grand Total		**3,736,526,743**	**4,294,961,514**	**558,434,771**	**15.0%**

Variance Explanation

- **Local:** Increase in local funds to support the Mayor's investments in health care and replace enhanced FMAP received in previous years due to the Public Health Emergency
- **Dedicated Taxes:** Alignment of budget to anticipated revenue collection to support provider payments and administrative cost. DHCF will use $10.1M in fund balance; available due to prior years of receiving EFMAP which required less dedicated tax (or local) match
- **Federal Payments:** The District ARPA funded projects were sunset at the end of FY23; The Transportation for Alliance Pregnant Mothers ($480k) and Practice Transformation Efforts ($1.5M) will be funded through other resources
- **Federal Grants:** the SUD grant expired in FY23; it is not accounted for in FY24 budget
- Federal Medicaid: The FY23 Approved budget assumed the EFMAP would sunset during FY22, the budget will be adjusted upward to align with the EFMAP reducing the delta between FY23 and FY24. FY24 aligns with anticipated Medicaid participation, including one quarter of EFMAP at 1.5% (or 71.5%)
- **Private:** DHCF did not awarded the grant in FY23
- **O-Type:** Alignment of budget to anticipated revenue collection and reflection of the utilization of fund balance in 3rd party Collections of $3.1M

94% of the FY24 DHCF Budget Continues to Support Services to District Residents

FY2024 Budget Allocation



Spending Category	FY24 Budget	FY23 Budget
Provider Payments	$4,039,070,874	$3,488,160,569
Administrative	255,890,640	248,366,174
Total Budget	**$4,294,961,514**	**$3,736,526,743**

Administrative Spending Category	FY24 Budget	FY23 Budget
Personnel	$50,097,392	$49,137,849
Supplies	346,478	326,945
Fixed Cost	2,562,999	2,691,226
Other Services	5,063,983	2,275,598
Contractual Service	183,632,944	181,464,487
Equipment	14,186,845	12,470,069
Total Administrative Cost	**$255,890,640**	**$248,366,174**

FY 2024 Provider Payment Budget Assumptions

- The Federal Public Health Emergency Will End as Scheduled in May 2023
- COVID Provider Rate Relief
  - ❑ For Home and Community Based Waiver Providers Continues through November 2023
  - ❑ For All Other Providers Ends in FY 2023
- Medicaid Recertifications Resume in April 2023, and Require 14 Months to Process Entire Enrolled Population
- 1.5% Enhanced Federal Medicaid Reimbursement for the First Quarter

- Living Wage & Minimum Wage Increases Included
- FY 2023 New Initiatives Continue – PACE, Doula Services, 12 Month Enrollment Period for Alliance
- Fee-for-Service Spending Forecast Based on Actual Spending through August 2022 with Adjustments for Known Policy Changes
- Historic Inflation / Cost Trends Included
- MCO Budgets Based on Estimated Actuarially Sound Rates
- FY 2023 One-Time Spending Removed

FY2024 Proposed Budget for Provider Payments Assumes a 15.8% Increase Over the FY2023 Approved Budget

Medicaid Provider Payments

- 17.1% increase over FY2023
- Budget supports institutional and community health care cost for services received through the Fee For Service (FFS) Medicaid program

Medicaid Public Provider Payments

- 2.5% increase from FY2023
- Budget supports the federal share of cost for District agencies that provide care on behalf of the Medicaid and Alliance programs

Alliance Provider Payments

- 7.9% decrease from FY2023
- Budget supports the capitation payments made to MCO's to provide care for Alliance beneficiaries

FY2024 Provider Payments Budget Projected to be Lower than FY23 Projected Expenditures Due to Lower Enrollment and Expiration of Enhanced Rates

Provider Payment Category	FY2022 Expenditures	FY2023 Approved Budget	FY2023 Proposed Expenditures	FY2024 Proposed Budget*	YoY Variance (%)	YoY Variance ($)	Variance Explanation
Hospital	259,792,378	207,759,741	215,817,995	237,426,785	21,608,790	10.4%	FY24 budget factors in growth observed in FY22
Hospital Support Funding	8,000,000	8,000,000	8,000,000	-	(8,000,000)	-100.0%	Considered one timefunding, not budgeted in FY24
ICF/IID	95,120,608	95,071,301	98,880,897	93,185,166	(5,695,731)	-6.0%	Only 1 quarter of enhanced rates in FY24
Skilled Nursing Facility	325,035,228	280,961,725	309,380,270	295,327,295	(14,052,975)	-5.0%	Only 1 quarter of enhanced rates in FY24
Primary Care (Physicians, Clinics and FQHC)	88,473,238	108,185,501	110,221,612	93,692,335	(16,529,278)	-15.3%	FQHC reduction associated with shift back to APM from PMPM
Other (Medicare Part A, B, etc)	135,902,930	150,334,943	182,973,170	152,311,668	(30,661,502)	-20.4%	
DME	19,652,853	24,747,697	20,327,961	21,275,076	947,116	3.8%	
Behavioral Health (Inc. BH Waiver)	233,748,888	185,970,726	239,948,184	239,711,056	(237,128)	-0.1%	
Skilled Care	26,826,576	37,037,896	31,828,226	26,284,604	(5,543,622)	-15.0%	FY24 budget lower than current year projections as a result of lower enrollment and elimination of enhanced rates
LTCS (incl PCA and PACE)	129,789,696	87,530,235	106,874,116	137,954,643	31,080,527	35.5%	PACE will ramp up to 200 beneficiaries in 24. FY23 estimates assume we will end the year at 75 beneficiaries.
DSNP	116,635,671	190,178,368	196,491,785	216,382,667	19,890,882	10.5%	Assumes a return to pre-pandemic utilization levels
EPD Waiver	180,095,597	194,661,428	207,114,882	146,987,469	(60,127,413)	-30.9%	FY24 reflects full year of DSNP beneficiaries excluded from estimate
DD Waiver	320,944,582	312,507,057	331,622,200	343,869,116	12,246,917	3.9%	
IFS Waiver	216,488	5,975,703	5,704,522	6,651,564	947,042	15.8%	Increased beneficiary utilization budgeted in FY24
Emergency Medicaid	29,607,634	30,779,561	33,131,517	35,829,677	2,698,160	8.8%	
Medicaid MCO	1,723,431,324	1,440,443,110	2,106,910,715	1,894,462,647	(212,448,068)	-14.7%	Lower enrollment due to PHE unwinding
Alliance MCO	157,084,195	127,276,202	98,964,546	117,199,057	18,234,511	14.3%	Higher anticipated enrollment and capitation rates in FY24
Permanent Supportive Housing	-	56,599,147	52,931,660	49,874,726	(3,056,934)	-5.4%	
Total	**3,850,357,887**	**3,544,020,340**	**4,357,124,256**	**4,108,425,551**	**(248,698,706)**	**-7.0%**	

Note: FY24 Budget includes interagency funding that supports the provider payment category

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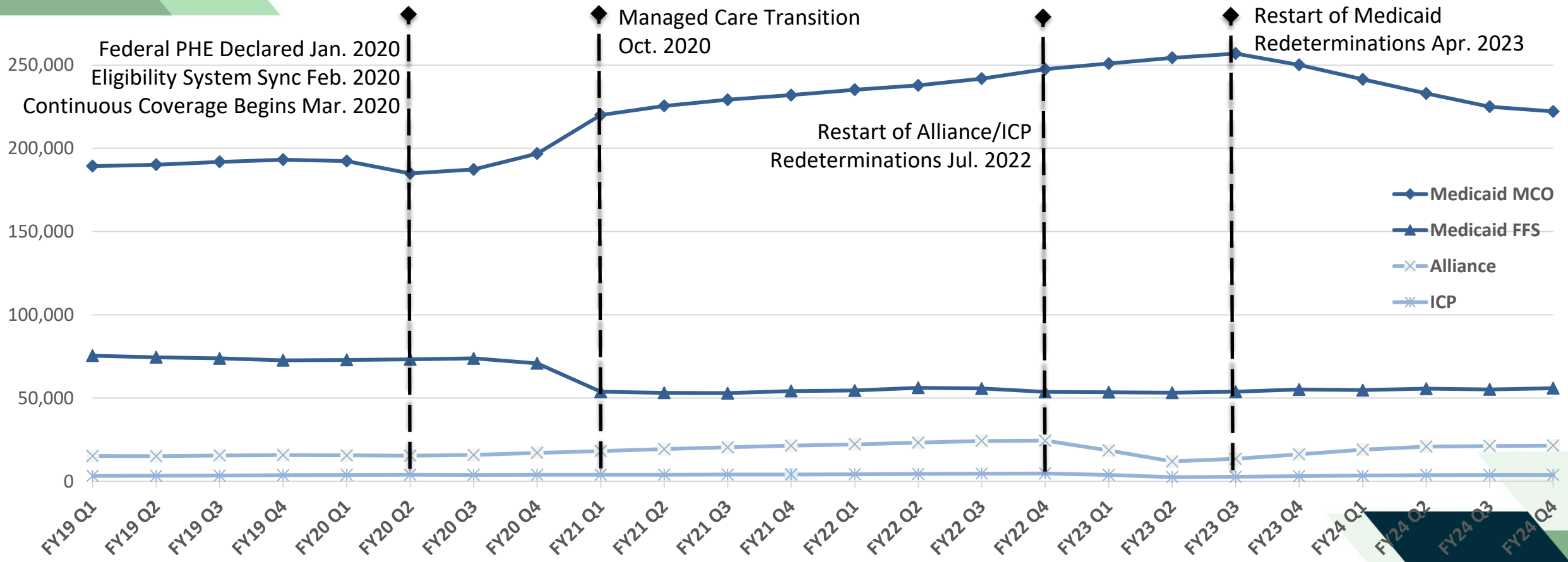
Enrollment Is Expected to Normalize in 2024 Following a Restart of Medicaid Renewals in 2023

DHCF Average Monthly Enrollment by Quarter, FY 2019 to FY 2024



Note: MCO figures on this chart exclude Medicare dual eligible special needs plan (D-SNP) coverage.

FY2024 Enrollment Assumptions For Formulation

Medicaid

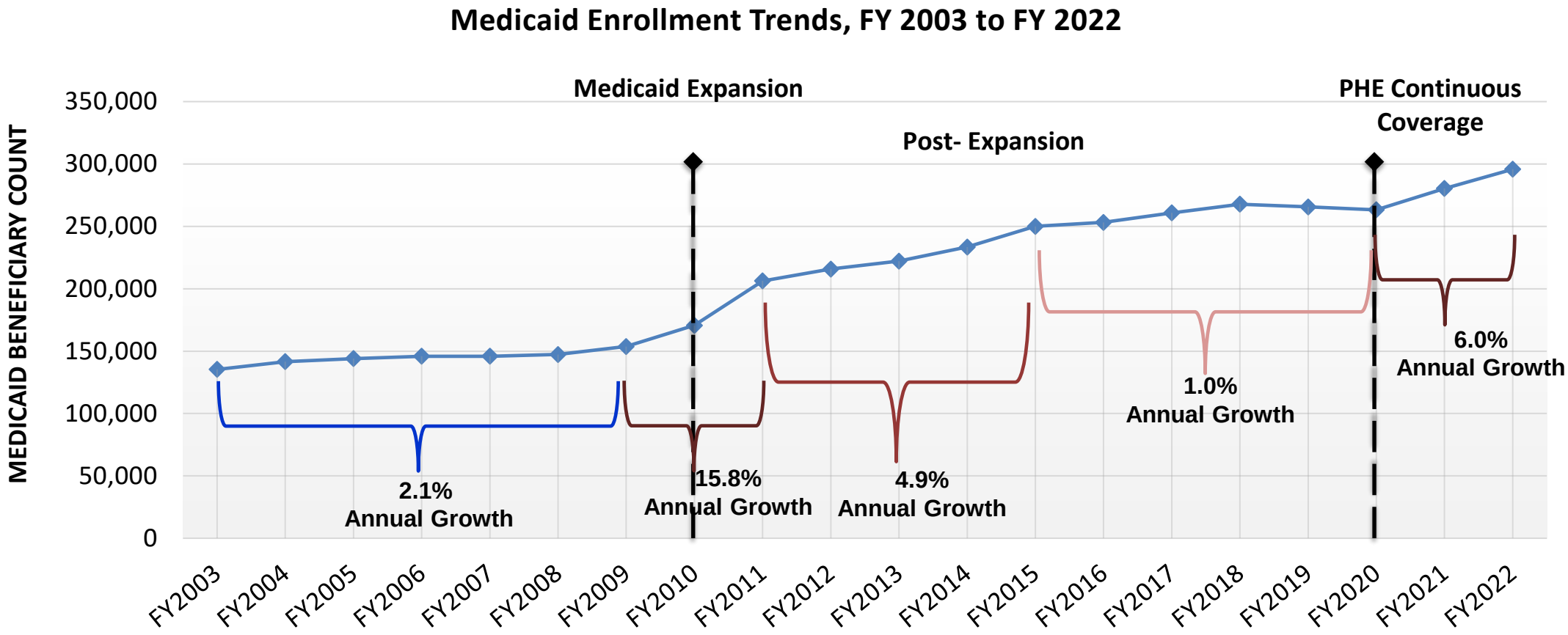
- After a three-year pause in Medicaid eligibility redeterminations to meet a federal continuous coverage requirement, which lead enrollment to grow by more than 20% since February 2020, DHCF will restart routine renewals on April 1 as directed under the Consolidated Appropriations Act, 2023.
- Redeterminations will occur on a rolling basis through May 2024. While DHCF projects that total Medicaid enrollment will decrease by more than 10% during this time (e.g., as individuals who no longer meet income or other eligibility requirements disenroll), the number of beneficiaries is expected to remain above pre-PHE levels through the end of FY 2024 and beyond.
- Prior enrollment projections assumed a January 2023 end to the continuous coverage requirement based on federal guidance available at the time. Current projections reflect a federally legislated end of the requirement by April 1 and are therefore higher.

FY2024 Enrollment Assumptions For Formulation

Alliance and Immigrant Children's Programs

- Alliance and ICP beneficiaries received continuous coverage from February 2020 through August 2022, with program enrollment growing by more 50% during this time.
- Renewal rates have been relatively low to date, but DHCF projects that Alliance and ICP enrollment will ramp back up over the next 12 months (e.g., when individuals seeking care realize their coverage has lapsed).
- As with Medicaid, the number of Alliance and ICP beneficiaries is expected to remain above pre-PHE levels over the long run. This is due in part to changes that include removal of the face-to-face interview requirement for both programs and a change from 6-month to 12-month renewal periods for the Alliance.

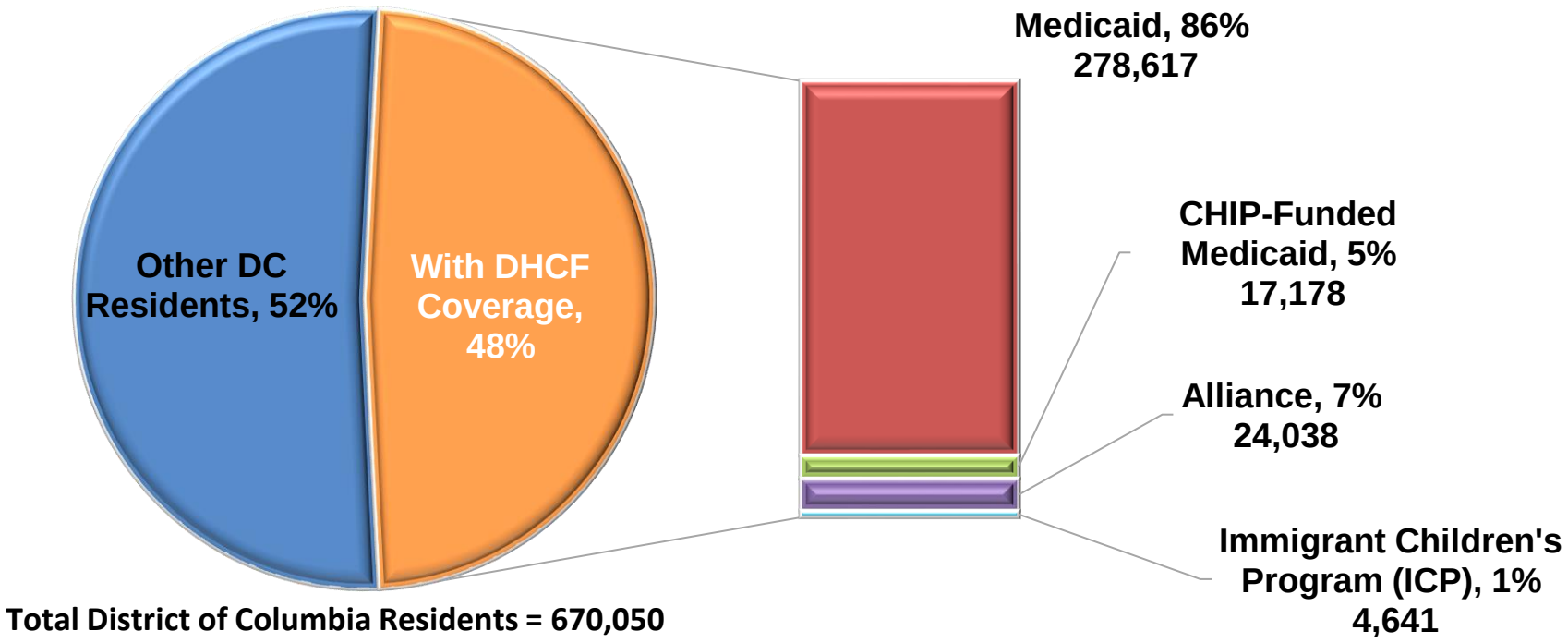
Medicaid Enrollment Growth Has Varied Over Time



Source: Data for FYs 2000-2009 extracted by Xerox from tape back-ups in January 2010. Data for FYs 2010-2022 from DHCF's Medicaid Management Information System as of March 2023. Figures are average monthly.

Nearly Half of District Residents Rely on DHCF-Funded Health Care Coverage – Most in Medicaid

Proportion of DC Residents with DHCF-Funded Coverage, FY 2022

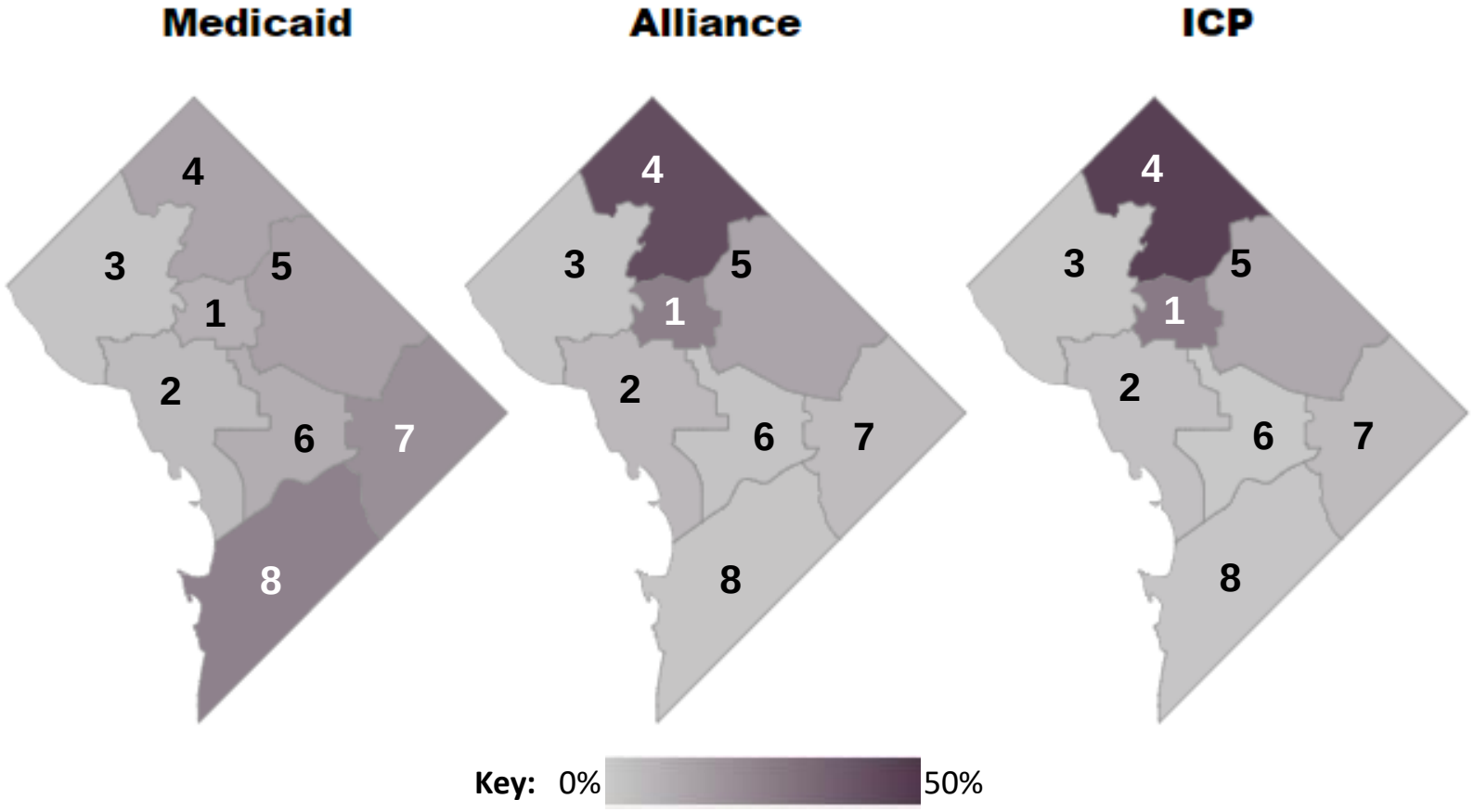


Total District of Columbia Residents = 670,050

Source: District population estimate reflects the U.S. Census Bureau's 2021 ACS 1-Year Data Tables. Medicaid, Alliance, and ICP data reflect FY 2022 average monthly enrollment as of 3/14/2023 from DHCF's Medicaid Management Information System.
Note: Sum of components may not equal total due to rounding.

Most Medicaid Beneficiaries Live in Wards 7 and 8, While Most Alliance and ICP Beneficiaries Live in Wards 1 and 4

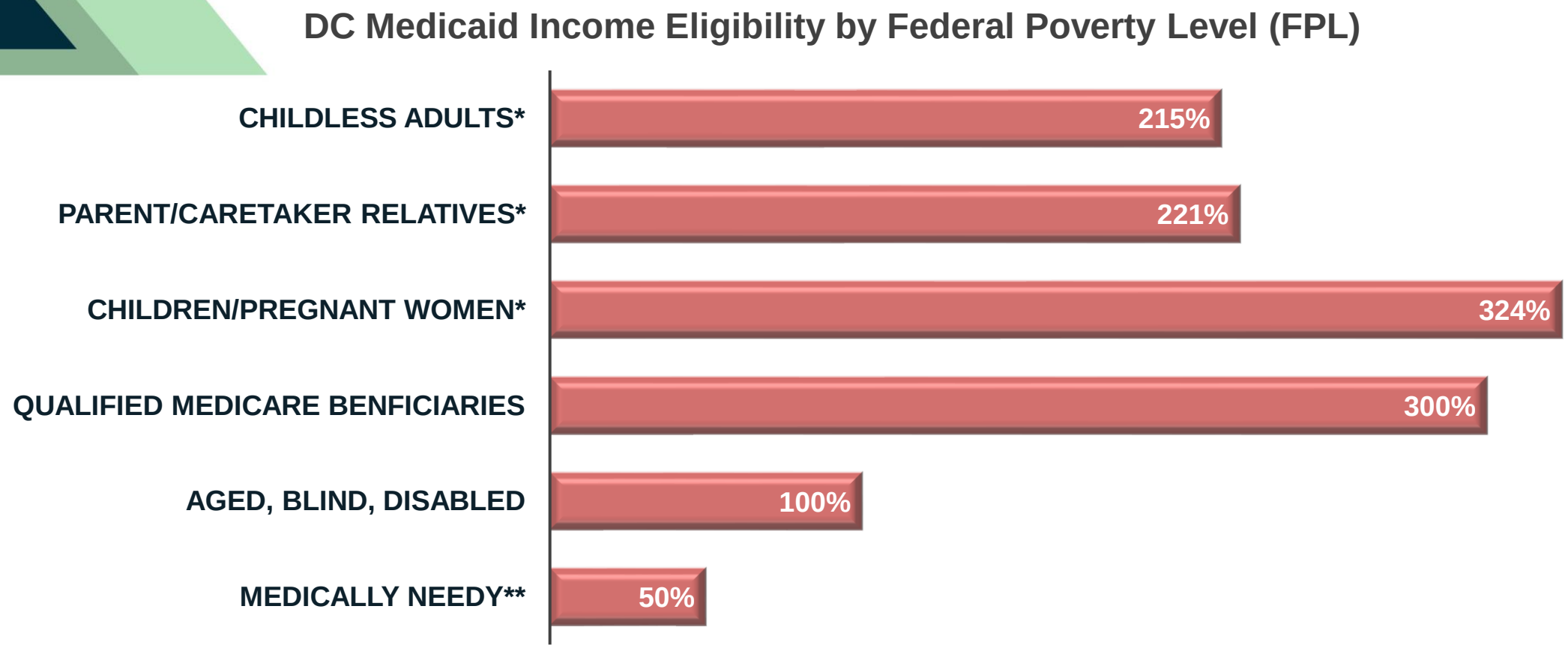
Ward Distribution by Program Type, FY 2022



Ward	Medicaid	Alliance	ICP
1	8%	24%	25%
2	4%	6%	3%
3	2%	2%	2%
4	11%	37%	41%
5	13%	13%	13%
6	9%	3%	2%
7	18%	5%	5%
8	22%	2%	2%
Other*	13%	8%	7%

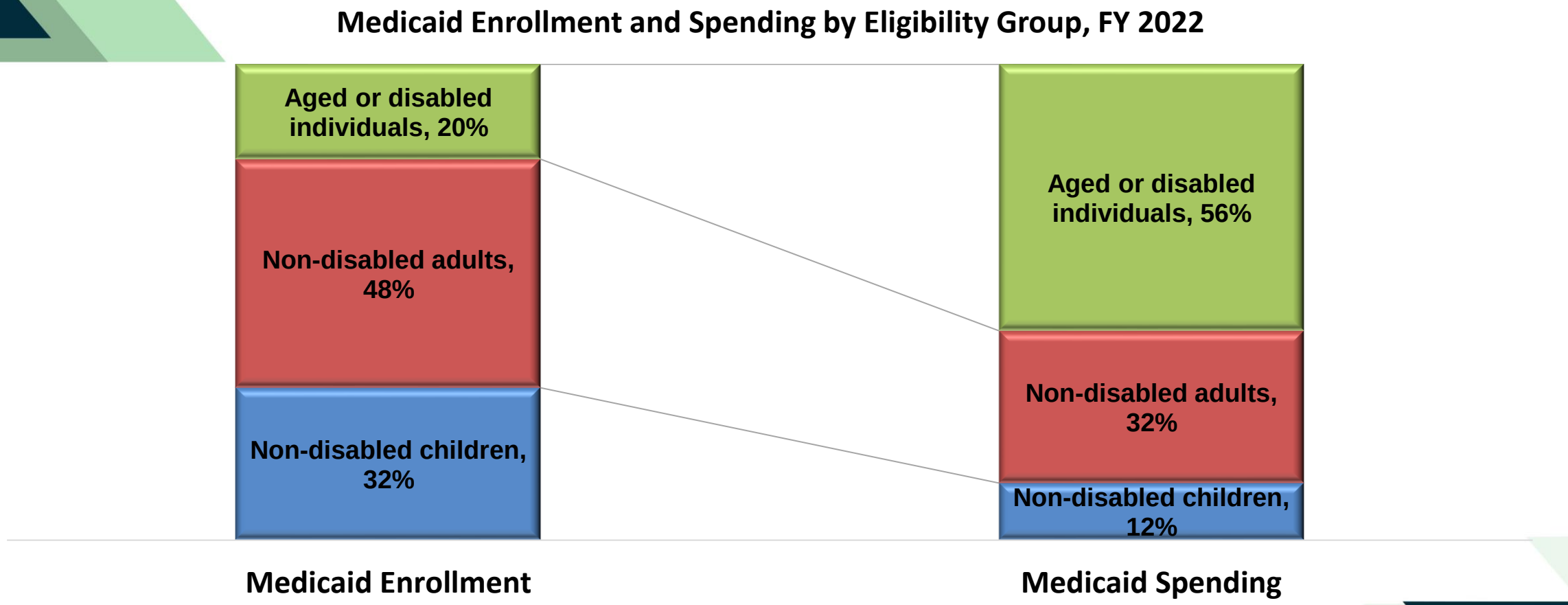
Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Based on average monthly enrollment. ICP = Immigrant Children's Program. Sum of components may not equal total due to rounding. *Other includes cases where a mapping is not readily available (e.g., due to a non-standard address format).

In the District, Most Low-Income Non-Elderly Adults Are Medicaid-Eligible



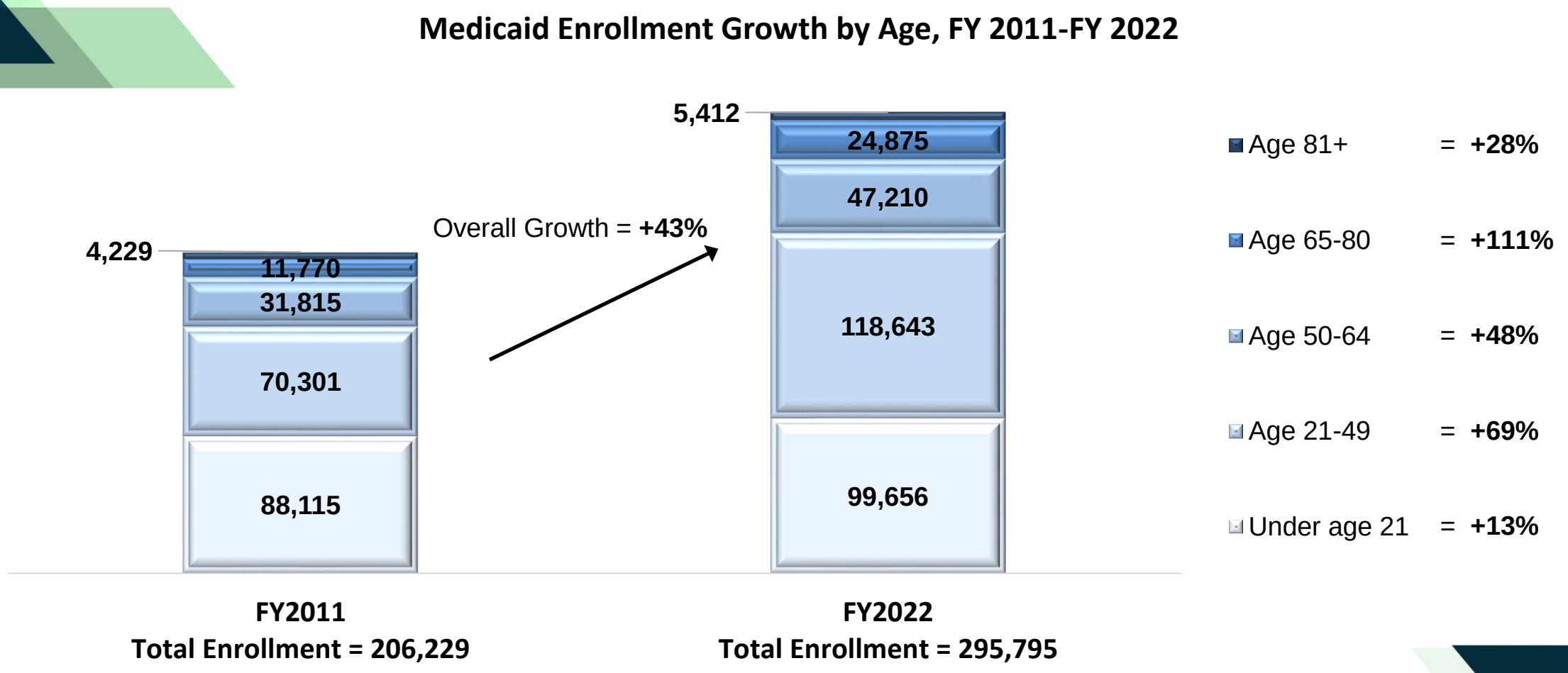
Note: Low-income is 200% FPL, which is $29,160 for an individual or $60,000 for a family of four in 2023.
* Includes a 5% income disregard.
** The Medically Needy Income Level (MNIL) in 2022 is 50% of the FPL for a household of 2 or more and 64% of the FPL for a household of 1.

Aged and Disabled Beneficiaries Account for About 20% of Enrollment, But Nearly 60% of Spending



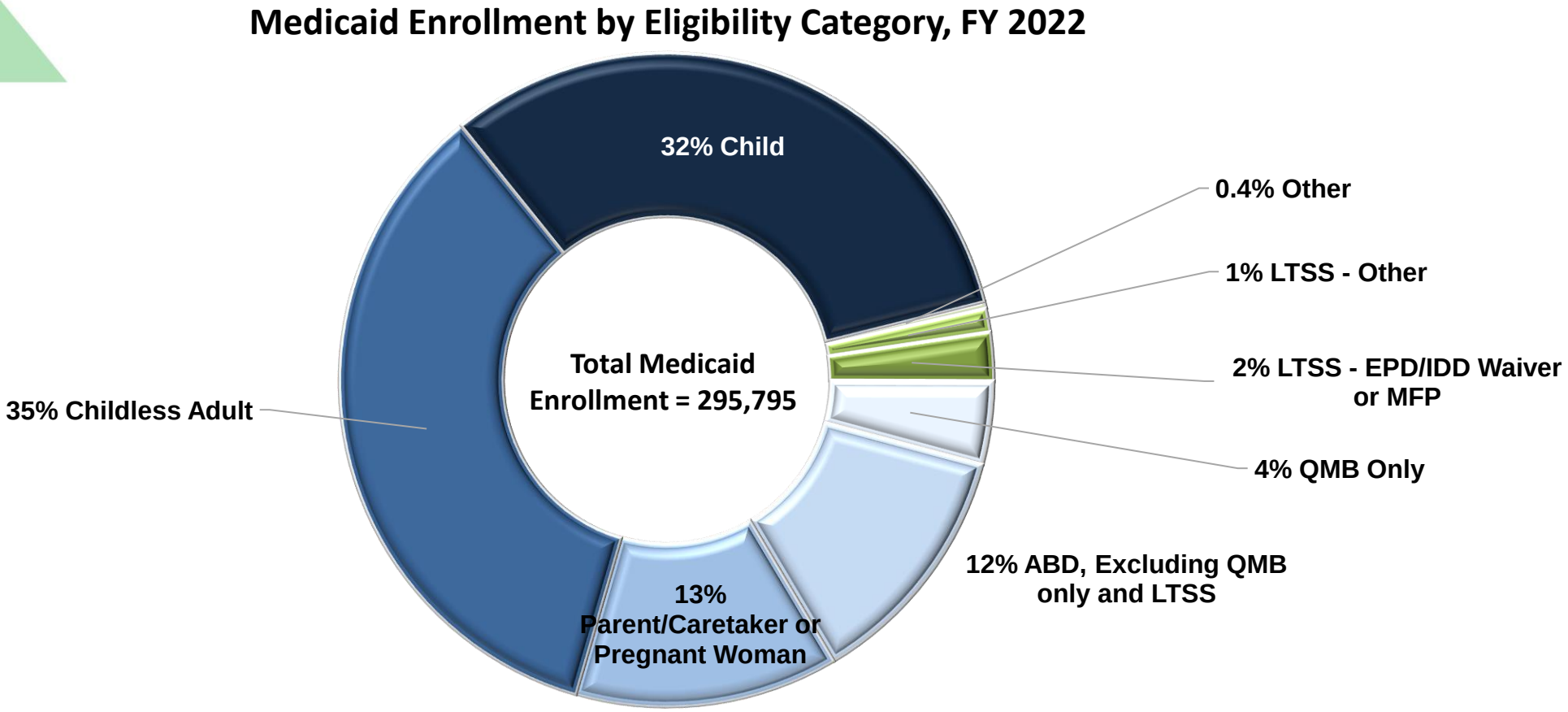
Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023 for eligibility in FY 2022 and claims with dates of service in FY 2022.
Note: Reflects eligibility group at the time of payment. Disabled includes individuals eligible for long-term services and supports an institutional level of care. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Adults Account for Most Medicaid Enrollment Growth From FY 2011 to FY 2022



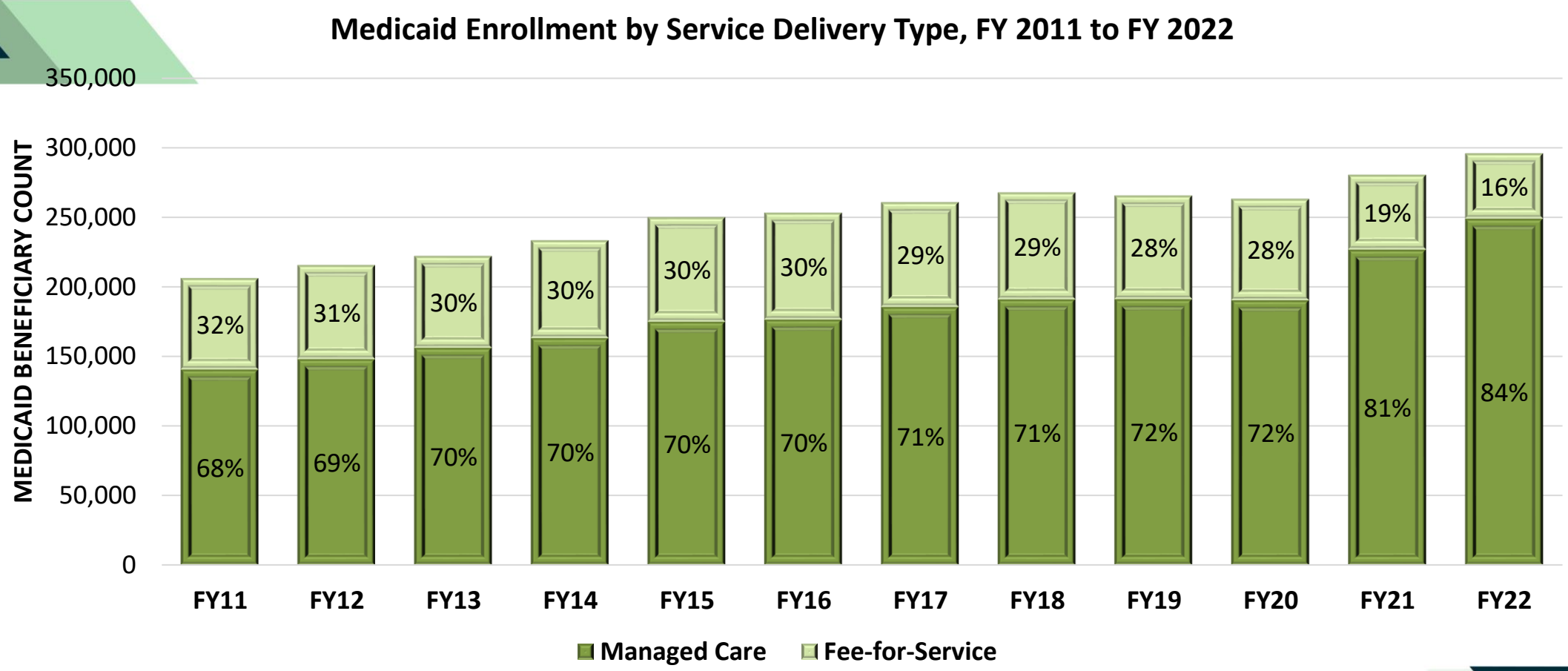
Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Enrollment reflects average monthly.

Childless Adults and Children Each Represent About One-Third of Medicaid Enrollees



Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Enrollment reflects average monthly. ABD = aged, blind, or disabled; EPD = Elderly and Persons with Disability; ICF = intermediate care facility; IDD = Intellectual or Developmental Disability; LTSS = long-term services and supports; MFP = Money Follows the Person; NF = nursing facility; QMB = Qualified Medicare Beneficiary.

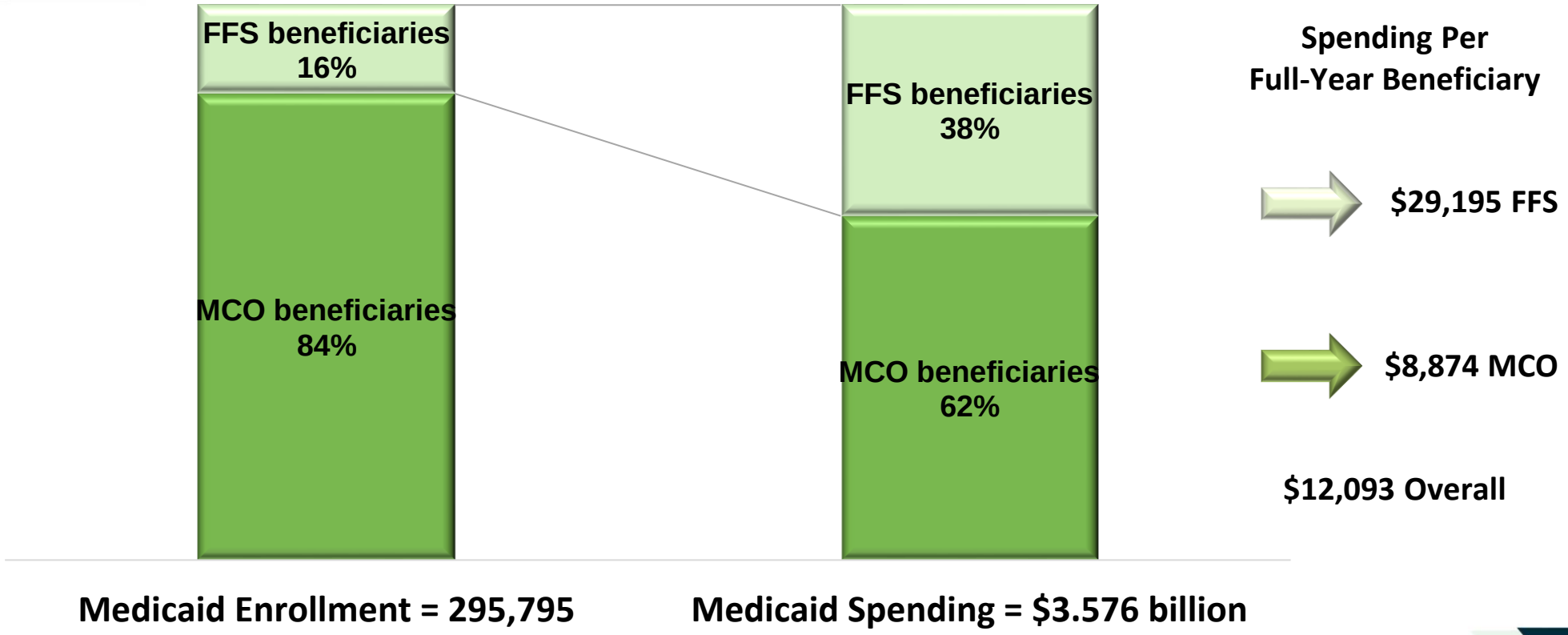
More Than 80% of the District's Medicaid Enrollees Are in Managed Care



Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Enrollment reflects average monthly.

Most Beneficiaries Are in Managed Care But Spending Is Substantial for Those Remaining Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2022



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023 for eligibility in FY 2022 and claims with dates of service in FY 2022.
Note: Enrollment is average monthly and spending per full-year beneficiary is the average cost over 12 months. Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Lower Incidence of Chronic Disease in Managed Care Compared to FFS

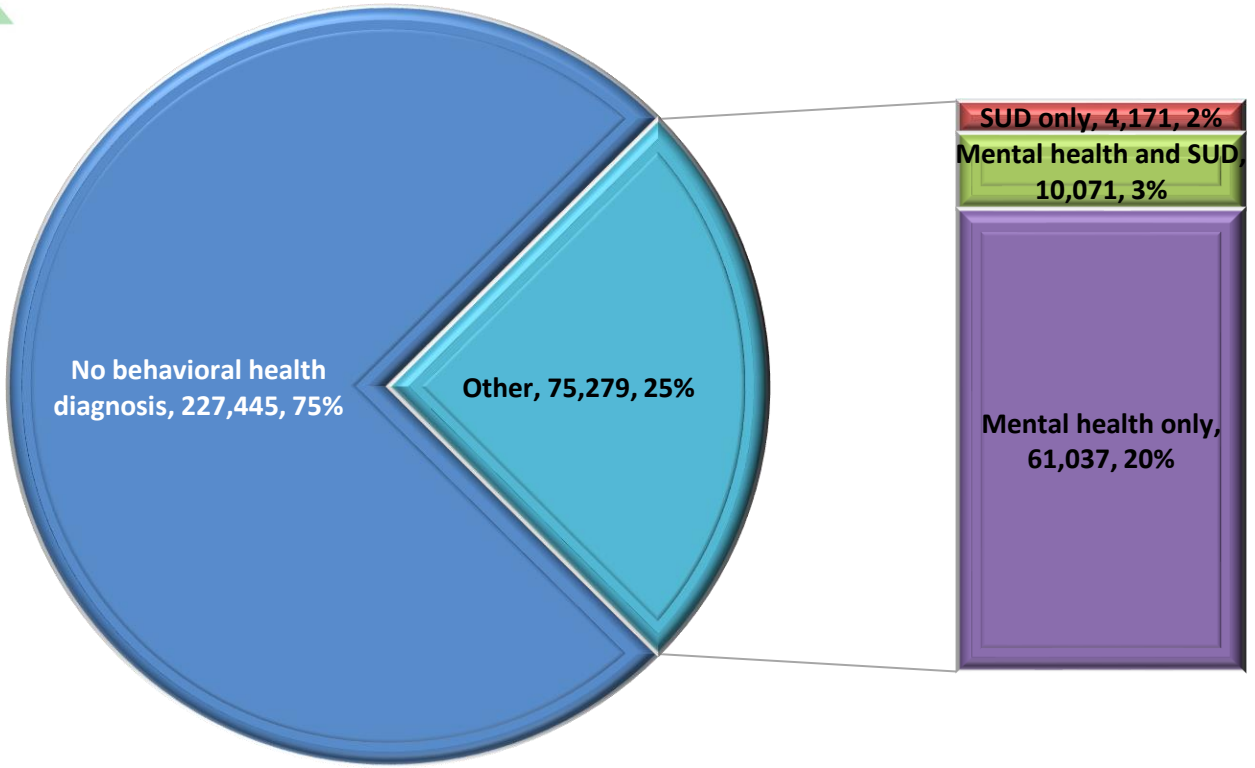
- **FFS Medicaid-enrolled adults were most likely to have the following chronic conditions:**
  - Hypertension (42%)
  - Hyperlipidemia (25%)
  - Diabetes (22%)
  - Rheumatoid Arthritis/Osteoarthritis (18%)
  - Chronic Kidney Disease (17%)
- **FFS Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (8%)
  - Depression (2%)
  - Anemia (2%)

- **MCO Medicaid-enrolled adults were most likely to have the following chronic conditions:**
  - Hypertension (22%)
  - Hyperlipidemia (13%)
  - Diabetes (10%)
  - Rheumatoid Arthritis/Osteoarthritis (8%)
  - Asthma (8%)
- **MCO Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (11%)
  - Depression (2%)
  - Anemia (2%)

Source: DC Medicaid Management Information System (MMIS) data extracted in March 2023.
Note: Beneficiaries identified were enrolled in Medicaid as of September 2022 and claims were examined for diagnoses in FY 2022. Children are defined as under age 21; adults are age 21 or older. Chronic conditions reflect 27 common categories identified using Chronic Conditions Data Warehouse (CCW) algorithms from the Centers for Medicare & Medicaid Services (CMS).

One-Quarter of Medicaid Beneficiaries Have a Behavioral Health Diagnosis

Distribution of Behavioral Health Diagnoses Among Medicaid Beneficiaries, FY 2022



Mental health and SUD
- SMI and SUD = 8,550
- Non-SMI and SUD = 1,521

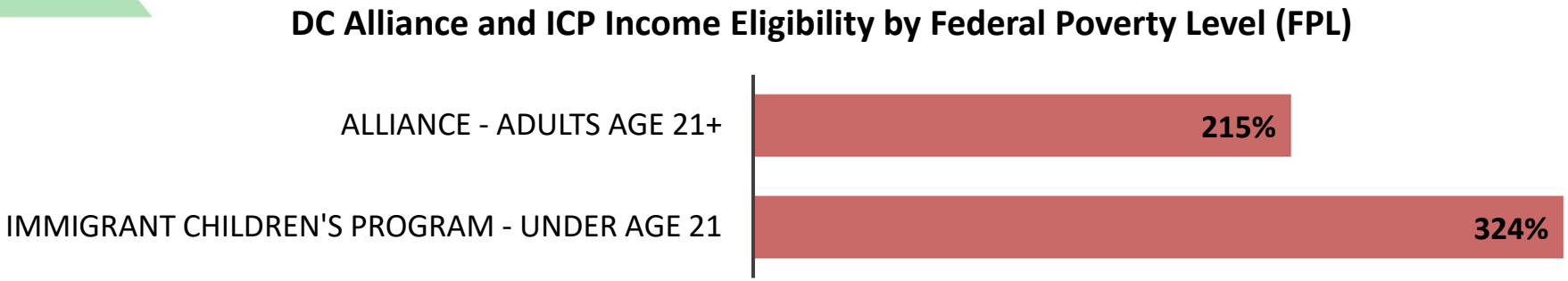
Mental health only
- SMI = 32,939
- Non-SMI only = 28,098

Medicaid beneficiaries = 302,724

Medicaid beneficiaries with BH diagnosis = 75,279

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023.
Note: Reflects FY 2022 diagnoses for Medicaid beneficiaries enrolled during FY 2022. Behavioral health diagnoses include substance use disorders (SUD) and mental health conditions. SUD diagnoses include alcohol, opioid and other drug use and dependence. Mental health diagnoses include serious mental illnesses (SMI), such as schizophrenia and bipolar disorder, and non-SMIs, such as anxiety.

DC Healthcare Alliance and the Immigrant Children's Program Use Local Funds to Cover Low-Income District Residents Who Are Ineligible For Medicaid



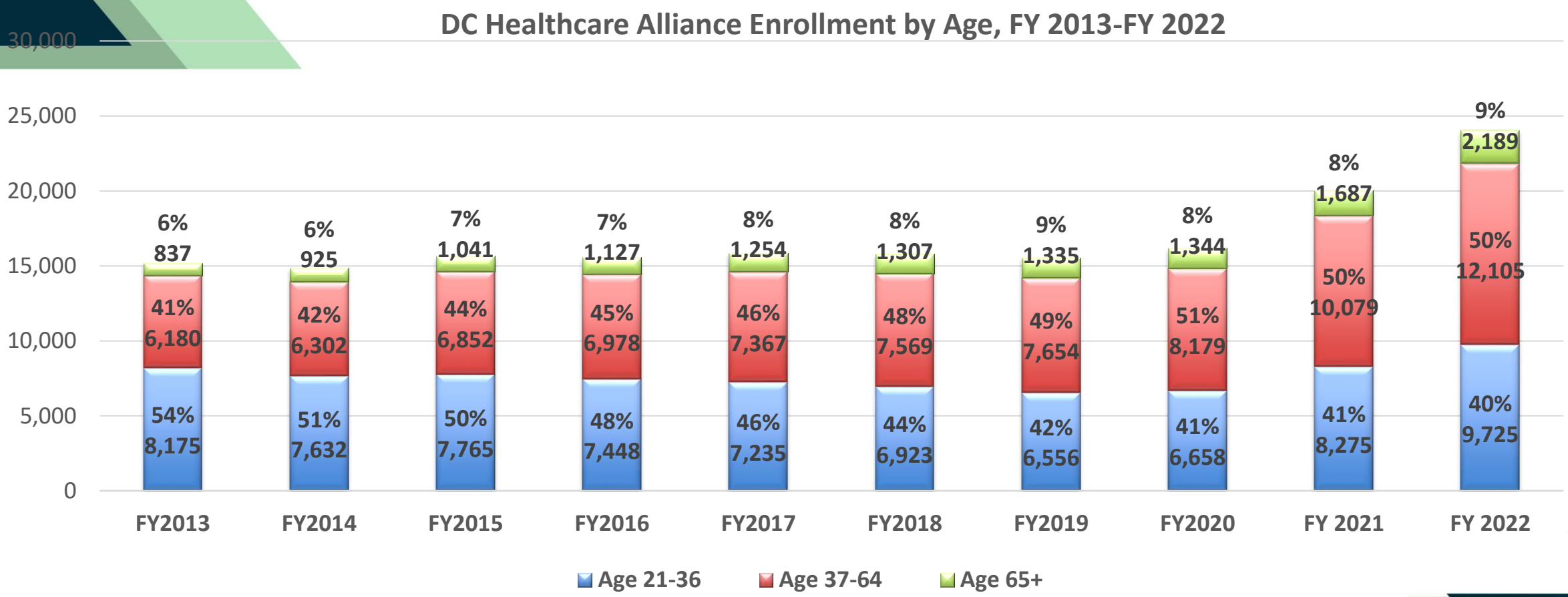
Key facts about Alliance/ICP:

- Alliance beneficiaries accounted for 7% of DHCF program enrollment in FY 2022; ICP beneficiaries accounted for about 1%
- Most Alliance and ICP beneficiaries live in Wards 1 and 4, compared to Wards 7 and 8 for Medicaid beneficiaries
- Noncitizens are more likely to be uninsured than citizens; however, the District's 2021 uninsured rate for noncitizens (11.8%) was substantially less than the national rate (31.1%)*

Note: Low-income is 200% FPL, which is $29,160 for an individual or $60,000 for a family of four in 2023.

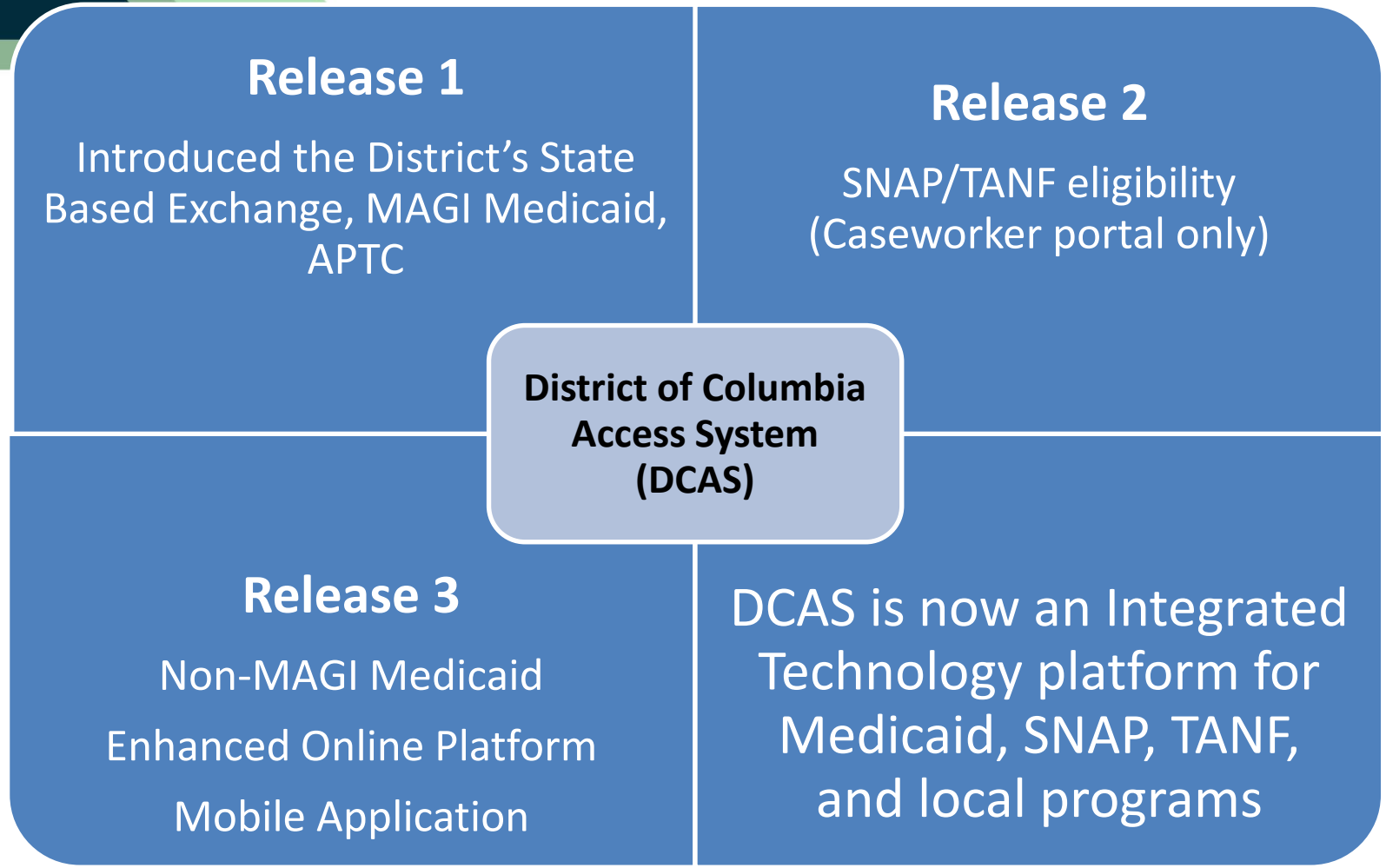
* Data extracted from U.S. Census Bureau, 2021 American Community Survey 1-year estimates. Rates reflect the civilian noninstitutionalized population.

During the PHE, Total Alliance Enrollment Increased Substantially But Age Distribution of the Population Remained Stable



Source: DHCF Medicaid Management Information System data extracted in March 2023.
Note: Enrollment reflects average monthly. Age 37 corresponds with a cutoff used to determine managed care rates.

Evolution of District Direct



As of November 2021, DCAS is a fully integrated eligibility system for the District's health and human service programs.

DCAS operates primarily in Operations and Maintenance (O&M) in FY23 & Beyond.

In FY23 & 24, DCAS continues a small DDI effort for new work and enhancements.

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  - Long Term Care
  - Behavioral Health

DHCF, DDS and DBH Have Worked Collaboratively To Enhance and Support HCBS Services Using HCBS ARPA Funding

HCBS ARPA Revenue Earnings

FY 2021 Revenue Reservation	$49,299,505
FY 2022 FFS Related Earnings	$43,615,790
FY 2022 MCO Related Earnings	$6,918,418
Total HCBS ARPA Revenue	**$99,833,713**

HCBS ARPA Key Factors

- Funds available for expenses incurred through March 2025
- Any unused revenue must be returned to CMS
- States must remain in accordance with the MOE requirements through March 2025
- All initiatives must be approved by CMS prior to implementation

Projects At-A-Glance

- Increase Provider Reimbursement
- Invest in the District's HCBS Workforce through bonuses, incentives & wage increases
- Increase Access to Services
- Support Transitions of Care
- Strengthen District Systems and Methodologies to support Providers more efficiently and effectively

HCBS Eligible Services

- Home Health
- EPD, IFS and DD waiver Providers
- BH Rehabilitation Services (MHRS & ASARS)
- Supported Employment (BH Waiver)
- Private Duty Nursing
- Adult Day Health
- Personal Care Aide

HCBS ARPA Direct Service Professional Bonus Grants

HCBS Providers were able to apply for a grant to incentives DSP workers in one or more of the below categories depending on the eligibility criteria.

Name of Grant	Retention	Recruitment and Conversion	Vaccine
Description	To Medicaid enrolled HCBS providers for disbursement of Retention bonus awards to DSPs.	To Medicaid enrolled HCBS providers for disbursement of Recruitment or Conversion bonus awards to DSPs.	To Medicaid enrolled HCBS providers for provision of a Vaccine incentive program to direct health care workers.
Total Amount of ARPA Funding	$17,700,000	$8,140,000	$2,860,000
Providers that Applied	63	48	38
Awards Issued	61	47	37
Funds Disbursed	**$16,331,590**	**$2,615,843**	**$450,664**

Over The Course of Three Years, DHCF will Use $48 million of HCBS ARPA Funding To Support Enhanced Wages for Direct Support Professions in HCBS – Total Cost $213M

CY2023

- Must pay DSP employees an aggregate of 110% of LW ($16.50 to $19.80)
- Payment supports wage, fringe, admin cost and vacancy factor of 5%
- Supplemental Payments Processed by End of February
- **Paid to Date $43.4 million to 286 HCBS Providers (total anticipated ($64.1M)**
- First report due July 2023 for period January 1-June 30, 2023 (will determine if additional funds are needed for CY23)
- 2nd Report due January 31, 2024

CY2024

- Must pay DSP employees an aggregate of 117.6% of LW (~$17.60 to $23.80)
- Payment supports wage, fringe, admin cost and vacancy factor of 5%
- Partial supplemental Payment paid by December 30, 2023 & Balance paid after report is reconciled
- **Estimated cost $73 mil**
- First report due July 2024 for period January 1-June 30, 2024
- 2nd Report due January 31, 2025

CY2025

- Must pay DSP employees an aggregate of 117.6% of LW
- Payment supports wage, fringe, admin cost and vacancy factor of 5%
- Enhanced wage becomes a part of the rate methodology effective January 1, 2025
- **Estimated cost $76M**
- After reconciliation of FY24 final report, any funds not used to pay salary, fringe and corresponding admin will be recouped by DHCF

The District of Columbia Pays Higher Wages For DSP's Than the Surrounding States and Pays Providers Higher Rates to Provide Personal Care Aide Service for Long Term Care

Enhanced Wage Above Living Wage For DSP's

Purpose and Goal

- Parity across Provider and Industries
- Encourage Employment with our providers
- Establishes Career ladder positions
- Bonus payments to support current employees but the enhanced wage to incentives new employees

DC Pays Highest Rates for HCBS Non-Skilled Care (i.e. PCA):
DC- $24 p/hr (OT- $36.04 p/hr)
NoVa- $21.79 p/hr
MD- $23 p/hr

DHCF will achieve an average of 117.6% one year earlier than anticipated utilizing HCBS ARPA funds

Medicaid's Enhanced Wages Provide a More Competitive Salary in the DMV

The average DSP Worker providing care in a Home and Community Based settings in DC will make:

- 15% more than NOVA and MoCo in FY23
- 21% more than PG County in FY23

Improper Billing and Denials Reduce The Amount of Revenue Providers Are Able to Recognize

Even though there has been a continuous request for DHCF to increase the reimbursement rates, improper billing by providers could be costing them millions of dollars.

FY 2022 Claims Denied by Provider Group				
Provider Group	Billed Amount	Paid Amount	Denied Amount	Percentage of Denied to billed
Adult Day Health 1915(i)	$ 6,402,817.94	$ 5,792,546.65	$ 610,271.29	9.53%
EPD Waiver	$ 100,880,706.41	$ 79,497,125.44	$ 21,383,580.97	21.20%
Home Health Agency	$ 278,988,318.06	$ 216,802,638.93	$ 62,185,679.13	22.29%
IDD Waiver	$ 348,304,171.03	$ 305,722,977.37	$ 42,581,193.66	12.23%
MHRS	$ 74,215,537.81	$ 64,242,309.27	$ 9,973,228.54	13.44%

EPD & HHA providers account for the majority claims billed but were denied. The data shows providers difficulty in billing correctly can result in loss of revenue.

If providers are able to become more efficient in billing, intake assessment and quality assurance processes; they would be able to increase revenue with allowable reimbursement

Practice Transformation Collaborative and Technical Assistance Efforts Strengthen Provider Readiness

The Practice Transformation Collaborative (PTC) aims to develop and disseminate various tools and resources that providers and staff members can use to achieve excellence in the areas of operations, clinical quality, finances, and staff and patient satisfaction. Providers and their staff will now have the infrastructure, workforce capabilities, and sustainable business models to deliver quality person-centered care across the care continuum. These competencies will be needed as the District transitions to value-based care to better improve patient outcomes and promote health equity using new payment methods to drive the change.

TA Program	Program Description	Provider Focus	Funding Source
Integrated Care DC 9/21 - 9/22 + 4 option years	Community and individualized (15-25 providers per year) competency-based training on **population health**, delivering **integrated person-centered care**, and **engaging leadership in VBP strategies**.	**Priority provider types:** Health Homes (HH), Federally Qualified Health Centers (FQHC), Department of Behavioral Health (DBH) certified providers, Free Standing Mental Health Clinics (FSMHC), Specialty Providers, Long Term Services and Supports (LTSS) and Medication-Assisted Treatment (MAT)	FY21 and partial FY22 (SUD Provider Capacity Grant) FY22-FY25 Recurring Contract
Business Transformation 3/23 - 9/23 + 2 option years	Design and deliver targeted **legal**, **financial**, and **business** technical assistance resources that enhance the formation of new value-based care arrangements and partnerships to support whole person care	Design and deliver targeted TA to improve capacity for integrated whole-person care by enhancing provider's ability to collaborate across entities and participate in value-based arrangements	FY22-FY24 (Mayor's ARPA Funding for Practice Transformation)
HCBS Digital Health **7/22 + 2 option years**	Supports provider implementation of **Health IT systems** and seeks to connect more service deliverers to the **DC Health Information Exchange (HIE)** and **telehealth**.	Eligible HCBS providers include long-term services and supports, behavioral health rehabilitative services (MHRS, ASARS), IDD/IFS waiver services, and housing supportive services	FY22-FY24 (HCBS ARPA)

DC HIE: Strategic Investments Have Supported Increased Demand and Use Among Providers

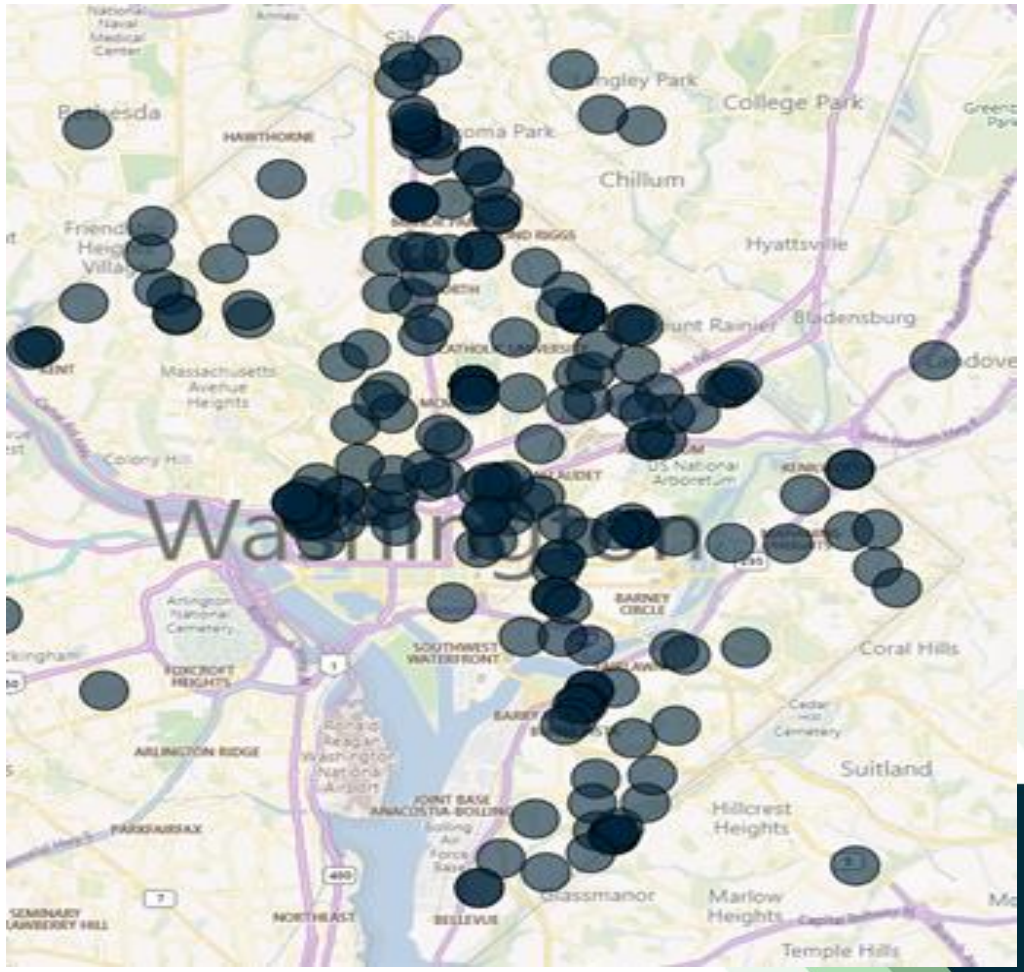
Major Providers and Health Systems Connected

- 1000+ participating organizations
- 8 Acute Care Hospitals (all)
- 36 Long-Term Care Facilities, including 15 Nursing Facilities
- 20 Home Health Providers
- 8 Federally Qualified Health Centers (all)
- 30 Behavioral Health Providers
- 7 Community-Based Organizations; 20 programs in areas of food, housing, workforce development, and cancer support available for closed-loop referrals

HIE Use at a Glance

Metric	February 2023	Year-to-Year Change *(Feb. 2022 to Feb. 2023)*
CRISP DC Users	14,744	12%
Patient Care Snapshot User Lookups	1,321	14%
Organizations with Encounter Notification Services access	705	14%
Organizations sharing admit, discharge, transfer (ADT) data	334	14%
Organizations sharing clinical care documentation	273	21%

DC HIE Connectivity: DC and Beyond Its Borders



The DC HIE is a Scalable Health Data Utility with 6 Reliable Core Capabilities for Providers

Critical Infrastructure (e.g. Encounters and Alerts) Lookup)

- ADT Alerts
- Health Records
- Patient Snapshot
- Image Exchange

Consent

- eConsent Solution

-SUD (42 CFR Part 2) Data Consent

-HIPAA Consent

-Telehealth Consent

Registries

- Care Management Registry
- Advance Care Planning

-Advance Directives

-eMOST

Directory and Secure Messaging

- Provider Directory
- Community Resource Inventory

Screening and Referral (e.g., SDOH)

- eReferral Screening

-Social needs screening for housing and food insecurity

-eReferral

Advanced Analytics for Population Health Management

- CRISP DC Reporting Services

Performance Dashboards

- Vaccine Tracker

DHCF Is Utilizing HCBS ARPA To Funds To Complete Policy and Rate Studies To Enhance Program Design and Payment Structure To Support Providers and Beneficiaries

Assisted Living Facility (ALF)- The ALF Rate Study started in January and it is anticipated to be completed by the end of the calendar year

- Assess the District's existing policy authority and reimbursement methodology for Medicaid-covered ALF services (under the EPD Waiver), including reviewing and evaluating its waiver and regulatory framework, ALR costs, and the context outside the Medicaid program in which ALRs operate, such as housing finance, ALR licensure, and the health care workforce.
- Compile data from across the District's program and nationwide, including stakeholder perspectives within the District and models for covering and paying for Medicaid ALF services in other jurisdictions
- Yield recommendations for policy and reimbursement modifications the District may undertake to improve, expand, or enhance the program, including a different Medicaid policy authority, a new reimbursement model, and more

Home Health Rate Study (HHA)- The Bidders Conference is being held the Week of the 27th of March

- Assess the utilization and needs of District residents to provide a recommendation to DHCF on the compliment of services provided that will encourage person centered care and better health outcomes for services in a Home and Community Based setting to support both physical and mental health needs, care coordination; as well as other habilitative services. Services include assistance with ADL's, skilled care, community engagement and other home support services
- Establish a payment methodology that will establish sustainability for providers to successful support the services provided; as well as allow flexibility in the staffing complement to provide care accordingly
- Ensure better alignment across Payors to reduce provider administrative burden and encourage more home health providers to participate in multiple payor services and provide recommendation on acuity based methodologies

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Total Hospital Payments Increased in FY2022 as a Result of Higher Outpatient Spend; However, the Hospital Spending Distribution Between Hospitals Remains Fundamentally The Same

Managed Care And Fee-For Service Hospital Payments, FY2021 and FY2022

	FY2021						FY2022					
	Inpatient	Outpatient	DSH	Total	% Total	% MCO	Inpatient	Outpatient	DSH	Total	% Total	% MCO
Children's National Medical Center	83,848,591	59,300,317		143,148,908	18%	85%	80,995,486	86,474,800		167,470,286	18%	90%
George Washington Univ Hosp	110,020,640	39,235,839		149,256,480	19%	81%	102,678,130	43,287,319		145,965,449	16%	83%
Georgetown Univ Hosp	37,452,121	19,132,943		56,585,064	7%	78%	40,490,240	32,354,248		72,844,488	8%	80%
Howard University Hospital	67,326,496	25,413,290	52,066,163	144,805,949	12%	71%	64,035,941	35,949,346	64,840,598	164,825,885	11%	76%
Sibley Mem Hosp	8,372,819	7,780,416		16,153,235	2%	84%	9,919,624	13,314,320		23,233,945	3%	88%
United Medical Ctr	24,044,937	12,180,661	19,954,295	56,179,894	5%	80%	19,076,943	15,732,517	8,817,812	43,627,272	4%	85%
Washington Hospital Ctr	141,581,025	66,864,755		208,445,780	26%	74%	157,039,974	107,430,994		264,470,968	29%	80%
HSC Pedicatric Center	2,023,274	884,067	718,633	3,625,974	0%	86%	817,481	984,542	2,353,383	4,155,406	0%	92%
Natl Rehabiliation Hosp	7,034,349	800,776		7,835,125	1%	66%	9,360,361	1,013,951		10,374,312	1%	77%
Psychiatric Inst of Washington	15,600,517	98,972	74,857	15,774,346	2%	72%	19,102,785	100,975	0	19,203,760	2%	67%
Saint Elizabeth Hosp	20,628	0	2,729,100	2,749,728	0%	0%	4,115	0	2,729,100	2,733,215	0%	0%
Capitol Hill	5,458,877	0		5,458,877	1%	26%	4,665,341	0		4,665,341	1%	62%
Hadley	2,344,355	12,082		2,356,437	0%	14%	1,725,827	9,275		1,735,102	0%	27%
Other In-District	1,542,338	1,138,091		2,680,428	0%	100%	2,911,463	2,638,284		5,549,747	1%	100%
Out-of-District	37,964,748	18,986,707		56,951,455	7%	80%	35,513,009	20,922,269		56,435,278	6%	82%
Total Payments	**544,635,716**	**251,828,916**	**75,543,048**	**872,007,680**			**548,336,721**	**360,212,839**	**78,740,893**	**987,290,453**		

Note: FFS amounts reflect Medicaid allowed while MCO amounts come from paid encounters.
FY2021 Data is paid through February 2022 to show similar run-out.

Hospital Costs Remain a Significant Portion of DHCF's Overall Budget

Provider Payment Category	FY2022 Expenditures	FY2023 Approved Budget	FY2023 Proposed Expenditures (1st Qrt Forecast)	FY2024 Proposed Budget*
EMERGENCY HOSPITAL SERVICES	4,336,216	4,964,929	5,071,074	4,868,022
GME PAYMENTS	25,456,416	20,653,655	28,256,762	16,330,209
DSH PAYMENTS	107,751,876	64,408,185	76,011,793	76,011,793
INPATIENT IN-STATE HOSPITAL	103,803,096	95,626,754	109,057,780	101,027,016
OUTPATIENT HOSPITAL	18,444,774	22,106,218	19,029,376	17,580,955
Total	**259,792,378**	**207,759,741**	**237,426,785**	**215,817,995**

Provider Payment Category	FY2022 Expenditures	FY2023 Approved Budget	FY2023 Proposed Expenditures (1st Qrt Forecast)	FY2024 Proposed Budget*
Medicaid MCO	1,723,431,324	1,440,443,110	2,106,910,715	1,894,462,647
Alliance MCO	157,084,195	127,276,202	98,964,546	117,199,057
Total	**1,880,515,519**	**1,567,719,311**	**2,205,875,261**	**2,011,661,704**

Total Medicaid Provider Payment Budget	**3,850,357,887**	**3,544,020,340**	**4,357,124,256**	**4,108,425,551**

- **Hospital costs referenced in the table do not include Emergency Medicaid or Hospital care provided to the Childless Adult population**
- **MCO Cost do not include Dual Choice MCO**

Key Factors

- Hospital budget has remained relatively steady at 10% - 11% of the Fee-For-Service budget in FY23 and FY24
- In FY24, FFS hospital spending within Emergency Medicaid makes up $35.4 million (in excess of the amounts shown in the table).
- Childless Adults in the FFS program make up $23.4M in FY24 hospital spending (in excess of the amounts shown in the table)
- The MCO budget represents roughly 49% of Medicaid and Alliance provider spending
- Hospital payments represent 36.1% of the MCO capitation rate assumptions prior to the establishment of the ceiling language
- Hospital payment represent 34.7% of the MCO capitation rate assumptions with the implementation

Medicaid Hospital Provider Reimbursement Act of 2023

- This subtitle would require DHCF to fund Medicaid managed care rates at a level that ensures:
  - Outpatient hospital reimbursement at a **minimum** of 100% of costs and a **maximum** of 110% of the fee-for-service outpatient methodology set forth in the Medicaid State Plan
  - Inpatient hospital reimbursement at a **minimum** of 98% of costs and a **maximum** equal to the negotiated rates in place as of March 31, 2023.

- DHCF is also required to submit 42 CFR 438.6(c) directed payment proposals to CMS to support implementation of the subtitle

- The subtitle would also require DHCF to report to the Mayor on all-payor hospital costs in the District of Columbia annually by December 31

Hospital Rate Range For MCO Population Between 100% and 110% of FFS Rate Methodology For Outpatient Cost

In FY2024, DHCF will establish BSA language to ensure that assumptions for hospital spending for the MCO population is aligned to a reasonable range of actual

FACTS:

- ✓ **The FFS Outpatient Rate Methodology is based on 100% of cost since FY2022; in FY2021 it was 77% of cost**
- ✓ **The Directed Payment for MCO Outpatient rates were set at a floor of 100% of FFS rate methodology in FY2022; in FY2021 it was 130% because the FFS rate was 77%**
- ✓ **FFS Outpatient per member cost is historically more expensive than MCO per member cost since the transition**
- ✓ **In FY2022, although the FFS rate methodology increased to 100%, hospital rates continued to be negotiated at the 130% of the FFS rate**

Result: In FY2022/23; hospitals are being paid well over their cost experience

The BSA will also establish a ceiling for Inpatient rates as well, aligning the rate to a maximum of the negotiated rate percentage established as of March 31, 2023 between the hospitals and MCO's
The ceiling is a hard cap that will be implemented through a Directed Payment to MCO's and will be re-evaluated each budget cycle after review of hospital cost

Hospital: FFS vs MCO Retrospective

FFS Hospital rate setting has implicitly skewed MCO reimbursement relative to cost

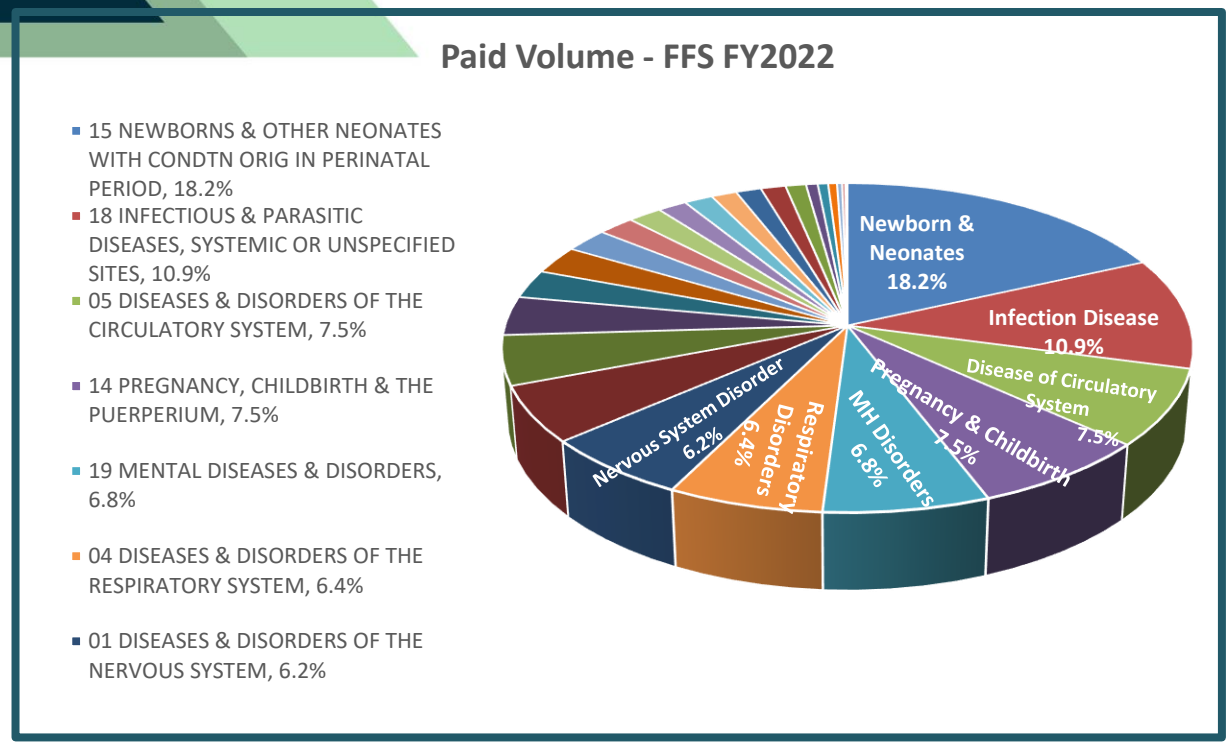
	FY23 Projected Acute Inpatient				FY23 Projected Outpatient			
Population	Cost	Allowed	Allowed to Cost Ratio	Case Mix	Cost	Allowed	Allowed to Cost Ratio	Service Mix*
FFS	**154,554,543**	**150,972,409**	**97.7%**	**1.139**	**27,350,896**	**27,350,888**	**100.0%**	**0.683**
MCO Medicaid	316,975,379	334,237,844	105.4%	0.935	203,530,056	223,401,252	109.8%	0.646
MCO CASSIP	20,131,530	21,154,491	105.1%	1.029	11,438,225	9,460,015	82.7%	0.489
MCO Alliance	9,235,915	9,141,835	99.0%	1.335	15,310,520	21,005,938	137.2%	0.802
Total MCO	**346,342,825**	**364,534,170**	**105.3%**	**0.946**	**230,278,802**	**253,867,205**	**110.2%**	**0.649**

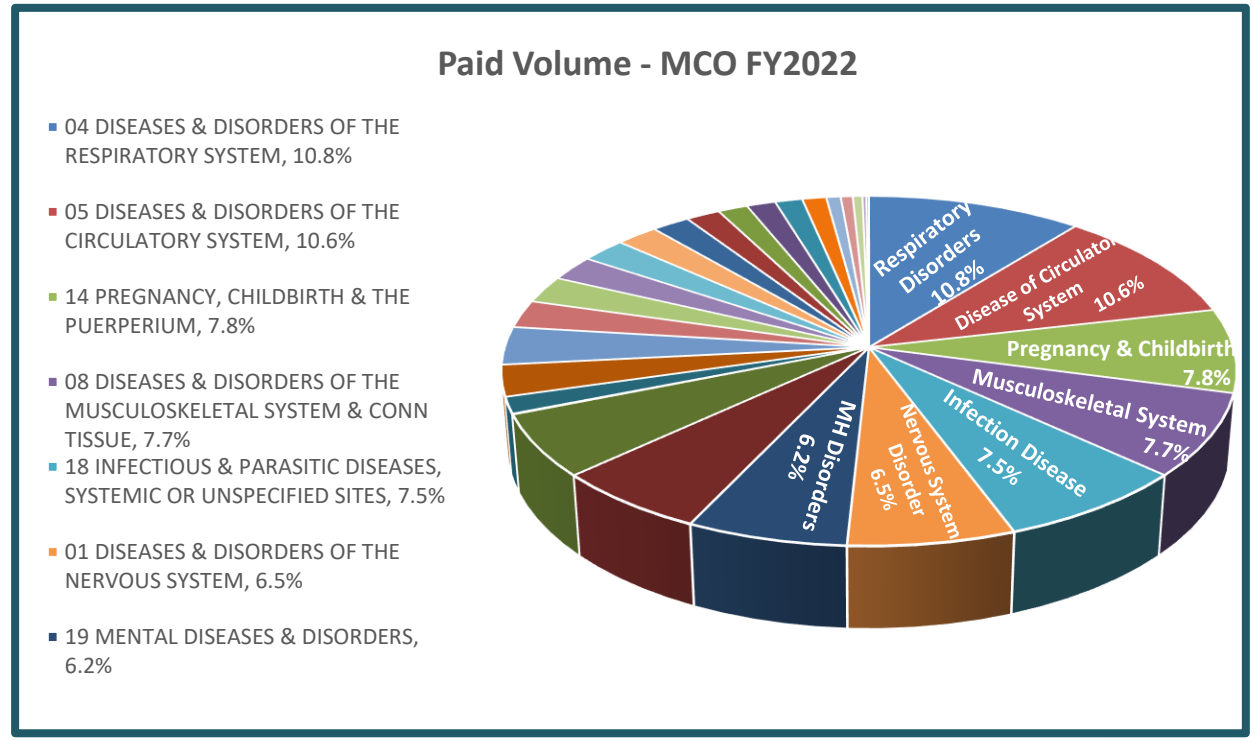
** MCO Service Mix estimated using v3.15 weights and assuming similar trend from v3.15 to v3.17 observed for FFS at each hospital*

Since MCO's and hospitals use FFS rates as a floor for contract negotiations, MCO hospital costs are not being properly reflected.

FFS beneficiaries are not representative of aggregate MCO experience as acuity is higher for FFS population and FFS includes services that are carved out from MCO contracts, i.e. transplants

In FY22, Fee-For-Service Inpatient Hospital DRG Utilization Was Mainly Attributed to Newborns and Neonates; While Respiratory Care Was The Highest Utilization For MCO's





- Almost 20% of FFS volume is attributable to treating newborns after delivery while another 7.5% is related to childbirth; in comparison to only 6% of the total MCO experience with a similar percentage related to childbirth.
- Meanwhile, MCO volume sees DRGs related to the respiratory and circulatory at the top; likely attributable to be a result of the impact of COVID.

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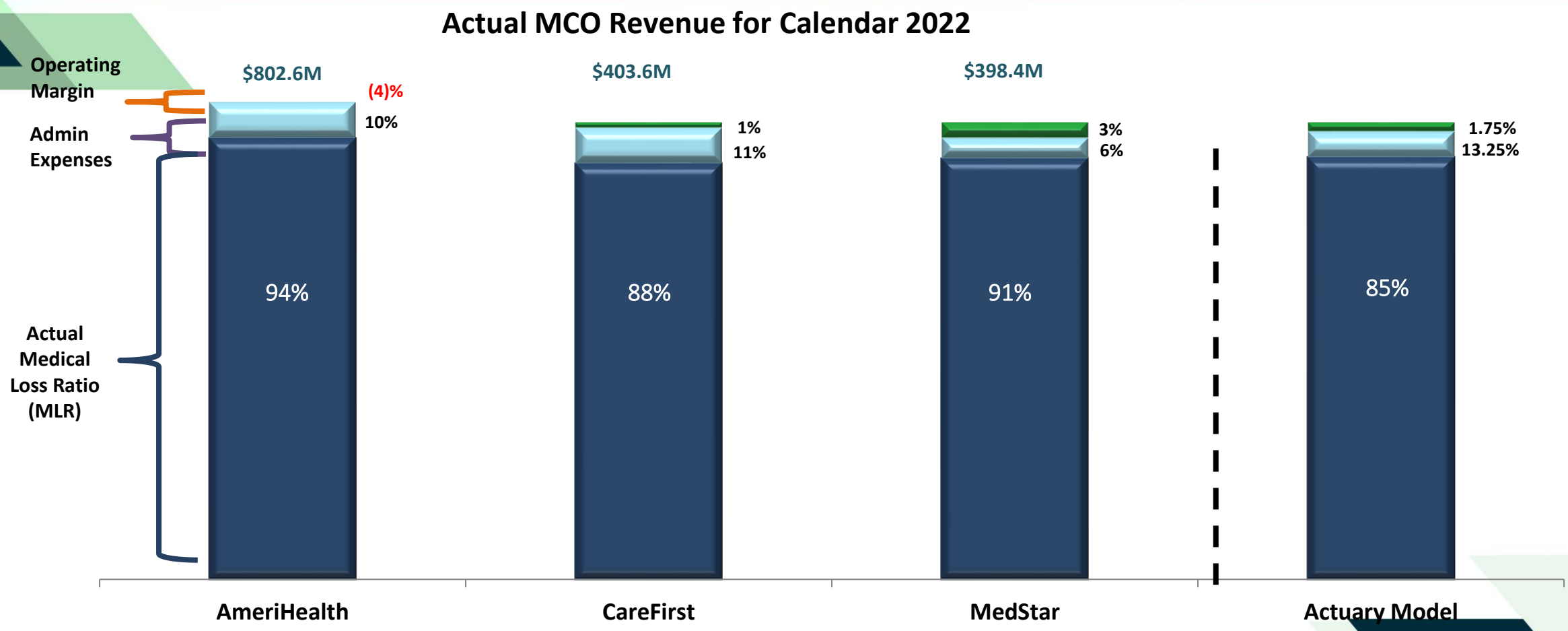
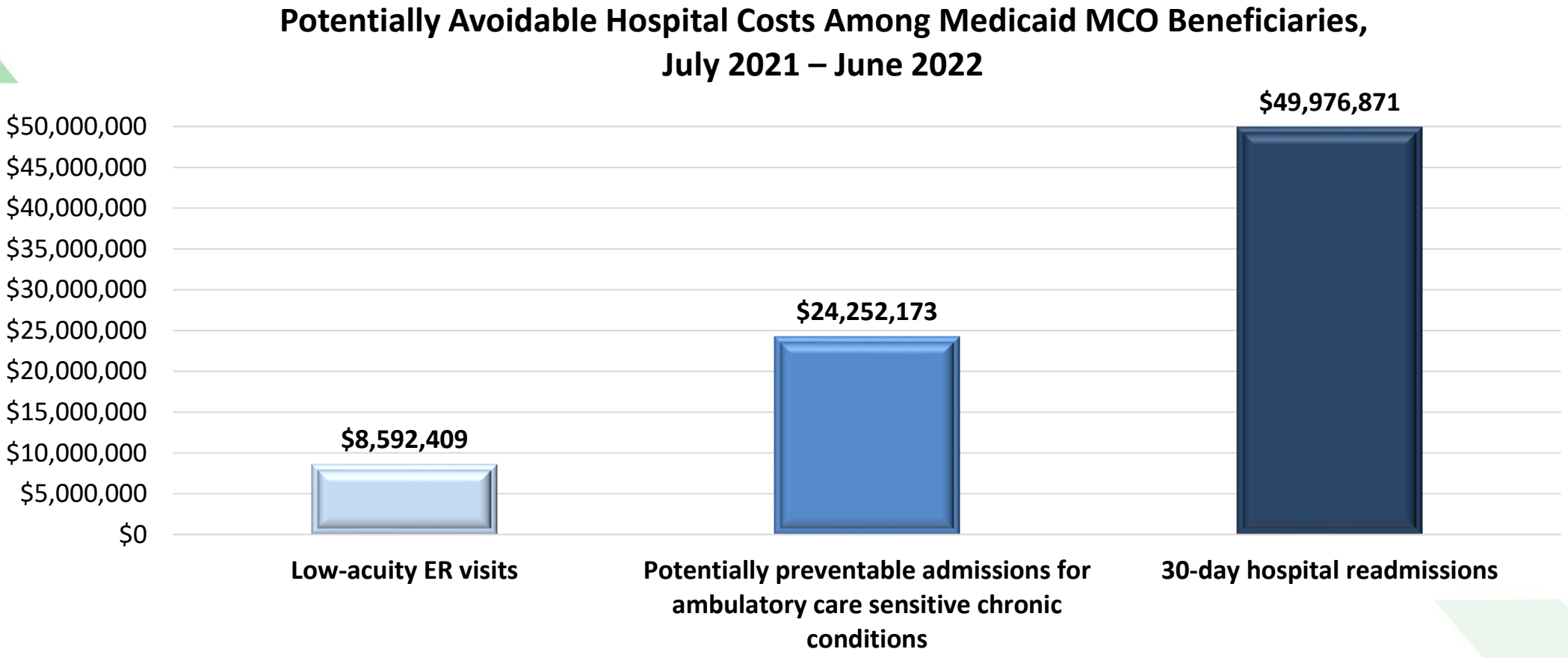
One Of Three Full Risk MCO's Spent At Least 93.25% of Revenue on Enrollee Medical Expenses Per The CMS Actuarial Model



Source: MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the DCHFP and Alliance MCOs that operated during 2022. MedStar's results are shown annualized as of 9/30/2022 as this is the most recent financial statements available

Note: MCO revenue does not include investment income, or DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. MLR numerator is medical expenses – i.e., total annual incurred claims (including incurred but not reported (IBNR)) and cost containment expenses as of December 31, 2022 (September 30, 2022 for MedStar), net of reinsurance recoveries. DHCF requires through its managed care contracts that all full-risk MCOs maintain a minimum MLR of 85%. *MCO reported reserve estimates included in DISB filings impact reported medical expenses and MLR amounts, and actual claims expense may differ from estimated reserves. Health Care Quality Improvement (HCQI) are included in the Administrative

The Impact OF the Public Health Emergency Was A Driver in the Increase In Hospital Readmissions, While ER Services Declined



Number of Medicaid MCO beneficiaries in population analyzed = 236,000

Source: DC Medicaid Management Information System (MMIS) data extracted in September 2022 for Medicaid MCO encounters with July 2021 – June 2022 dates of service.
Note: Figures are limited to enrollment in DC Healthy Families Program (DCHFP) plans. Other Medicaid managed care plans (CASSIP and D-SNP) are excluded. Low-acuity non-emergent (LANE) amount reflects a subset of total LANE visits, adjusted for duration of enrollment and credibility factors based on professional medical judgment.

New and Evolving Drug Treatments Affect Pharmacy Costs for DHCF Beneficiaries

Drugs in the pipeline that may have a fiscal impact on FY24 includes treatment for Cancer, Infectious Diseases, Behavioral Health and Autoimmune Disorders.

FFS	FY 2020	FY 2021	FY 2022
Pharmacy total	$226,527,602	$165,745,862	$172,355,029

FFS Pharmacy

- Amount paid doesn't include rebates
- Drugs that have impacted pharmacy costs are treatment for HIV/AIDS, Antipsychotics, COVID tests, Anticonvulsants and Multiple Sclerosis Agents.

MCO population	Draft Annual Pharmacy PMPM trend in FY 2024 rate development
Medicaid children	+4.5%
Medicaid adults	+5.0%
Alliance adults	+7.0%

MCO pharmacy

- Pharmacy per member per month (PMPM) trend is driven by unit cost and utilization increases
- Higher PMPM growth is driven by drugs for treatment of rheumatoid arthritis, oncology, and enzyme deficiencies.

Medicaid Dental Fee Schedule Increase

DHCF proposes a 10% increase to the Medicaid Dental Fee Schedule. The dental rates were decreased previously; however, dental providers have increased office expenses due to COVID. In FY22, DHCF reimbursed dental providers $6,695,307.21. A 10% increase will have a potential budgetary impact of $669,531

FY24 - Potential Ten Percent Increase of Dental Rates		
Dental Provider Type	**Amount Paid FY22**	**10% Increase FY24**
Clinic, Dental	$1,976.60	$197.66
Dentist	$2,761,567.82	$276,156.78
Dentist, Group Practice	$3,535,979.99	$353,598.00
Dentist, Waiver	$395,782.80	$39,578.28
Grand Total	**$6,695,307.21**	**$669,530.72**

Source: DHCF MMIS data extracted via MDW Cube, 3/15/2023.
Notes: Reflects paid, final FFS claims with a first date of service in FY 2022.
Payment amount is taken from any claim line containing a procedure code beginning with the letter D (see Table 2 for codes).
Excludes a small amount of payments (less than $20k) for D code billing on claim types other than dental (e.g., outpatient hospital and practitioner/physician claim types).

Long-Term Care: Focus in FY24

For the past three years, DHCF's focus for long-term services and supports in the Medicaid program has been around three key areas:

- Maintain and support the LTSS system, its providers, and residents served throughout the COVID-19 Public Health Emergency
- Develop, implement and support programs focusing on integrating Medicare and Medicaid benefits for dual eligibles, particularly LTSS users
- Expand, enhance, and strengthen home- and community-based LTSS to promote safe aging in place for District residents through ARPA-financed initiatives

DHCF has successfully met a variety of goals in the above areas:

- Served nearly 28,000 unique beneficiaries since the outset of the PHE through institutional and community-based LTSS, provided across nursing facilities, ICFs, three HCBS waiver programs, and additional community-based Medicaid programs
- Launched both a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) through the Dual Choice expansion, providing integrated Medicare and Medicaid benefits to now more than 14,000 enrollees, and the District's long-awaited Program of All-Inclusive Care for the Elderly (PACE) east of the river
- Leveraged ARPA funding to support investment in LTSS system workforce, quality, and infrastructure to lay the foundation for an even more effective LTSS system of the future

In FY24, DHCF will continue to pursue its primary areas of focus, with special emphasis on

- Unwinding LTSS-specific PHE policies, including eligibility and service changes, payment enhancements, and major process changes
- Continuing and launching new ARPA initiatives in the key areas of focus in DHCF's approved spending plan

Long-term Care: HCBS Utilization

Utilization of HCBS is at record levels as shown in the table at right, which reflects only Medicaid fee-for-service

- Continuous Medicaid eligibility ensured that enrollment in most LTSS programs continues to trend upward
- Combined with coverage under Dual Choice, which launched Medicaid operations partway through FY22, close to 6,000 unique beneficiaries used EPD Waiver benefits and more than 5,000 used state plan PCA during FY22

FY22 observed increased utilization of key services

- In the last month of FY21, 47 individuals had paid claims for EPD Waiver Assisted Living services, but served more than three times that number (156) over the course of FY22
- The system's ADHP program has sustained its expansion initiated in 2020-2021, serving a monthly average of 214 people in FY22; in the last six months of FY20, the program served an average of just over half that (123)
- DHCF continues to enjoy continued growth and maturation of its self-directed benefit in the EPD Waiver program, Services My Way. During FY22, a total of 1,655 unique beneficiaries used Services My Way, including more than 500 accessing this benefit through the Dual Choice program

Service	Total Number of Recipients*
Institutional Total*	**3,991**
Nursing Facility	3,733
ICF/IID	262
HCBS Total*	**8,348**
State Plan PCA	4,334
EPD Waiver	5,359
IDD Waiver	1,796
Institutional and HCBS Total*	**11,854**

Note: Numbers reflect individuals ever receiving a given service during FY 2022. Excludes services paid under managed care, including the District's Dual Choice program that began operating in February 2022.
ICF = intermediate care facility; IDD = Intellectual and Developmental Disabilities; HCBS = home and community-based services; LTSS = long-term services and supports; PCA = personal care assistance; EPD = Elderly and Persons with Physical Disabilities.

The sum of recipients across services exceeds these unduplicated totals because some individuals receive more than one of the service types shown.

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023 for fee-for-service claims with FY 2022 dates of service.

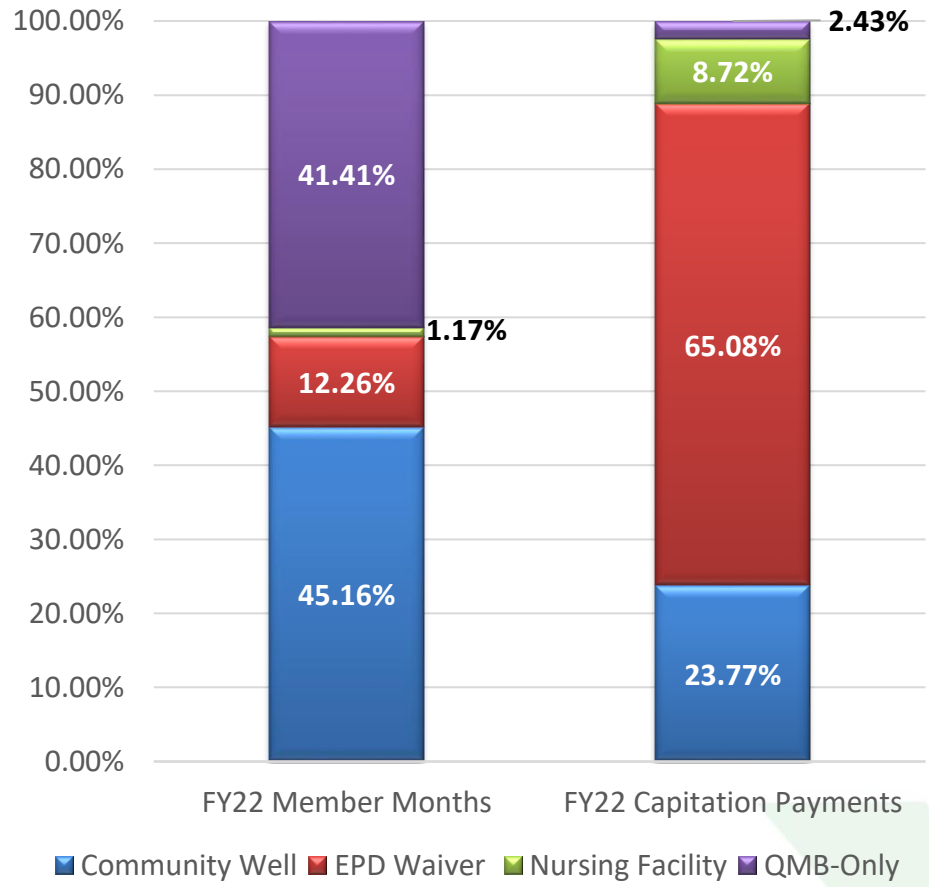
Long-term Care: Dual Choice Utilization

The Dual Choice program includes a diverse array of duals

- A small proportion of enrollment includes individuals using EPD Waiver and NF services (13.4% of member months in FY22)
- A larger share of enrollment is comprised of "QMB-only" beneficiaries, who are not eligible for full Medicaid benefits but access cost-sharing support through Medicaid (41.4% of member months in FY22) and "Community Well" beneficiaries, who are full-benefit duals not enrolled in the Waiver or living in a nursing facility (45.2% of member months in FY22)

Medicaid costs for duals – for whom Medicare is the primary payer for most services – are predominantly driven by long-term care, cost-sharing for acute care, and behavioral health

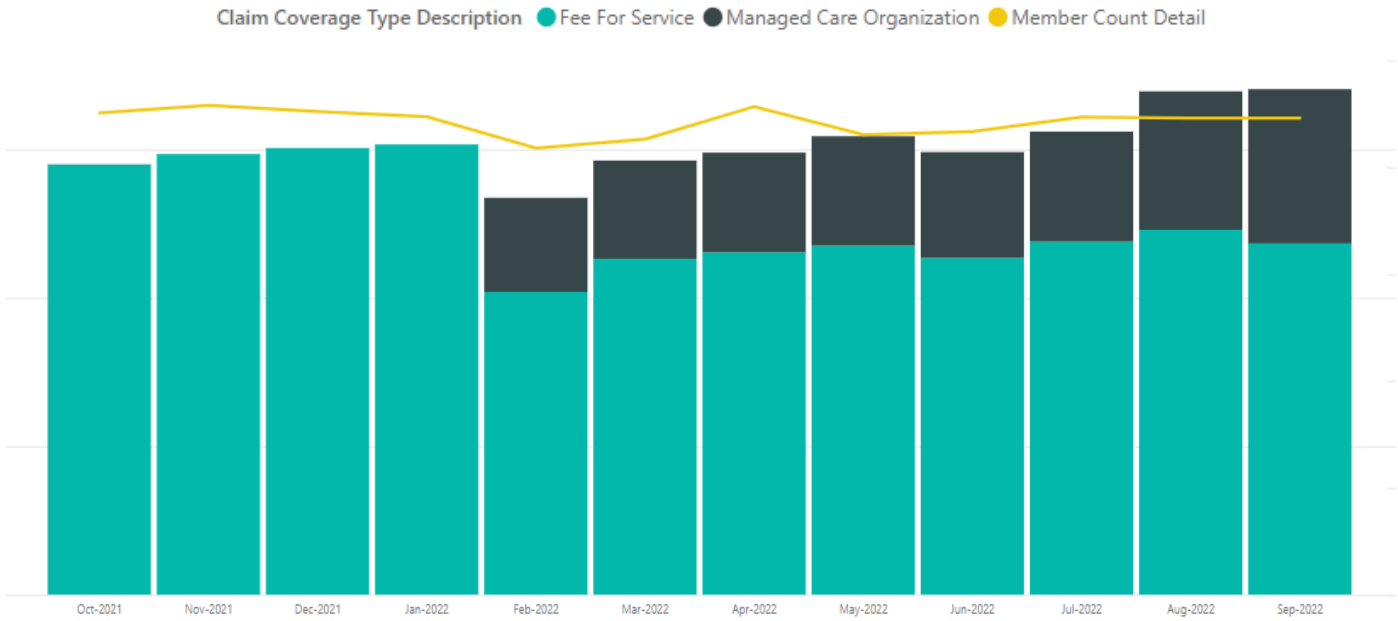
- Accordingly, 73.8% of capitation payments for Dual Choice in FY22 were paid for LTC populations; just 2.4% of capitation spending in the program was for the QMB-only population and 23.8% for the Community Well group
- Encounter data from the program shows robust use of LTSS among Medicaid-covered populations: encounter data includes Medicaid-covered nursing facility utilization for 752 unique beneficiaries and EPD Waiver utilization for 1,742 unique beneficiaries



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023 for D-SNP capitation payments for February 2022 through September 2022.

Long-term Care: Shifts from Fee-for-Service to Dual Choice

- Dual Choice is designed to promote enhanced, integrated care management across Medicare and Medicaid, but offers the same benefit package as fee-for-service for DC duals, including access to EPD Waiver services for those who qualify
- As a result, individuals enrolled in Dual Choice access the same services, generally from the same providers. DHCF's costs for these beneficiaries generally trends in parallel to fee-for-service, although beneficiaries access benefits differently
- As demonstrated in the snapshot below, monthly EPD Waiver utilization over FY22 generally trended upward slowly in aggregate, even after the launch of Dual Choice (grey columns beginning in February 2022)



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2023 for EPD Waiver claims and encounters from October 2021 through September 2022.

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Behavioral Health Rate Study Service Review

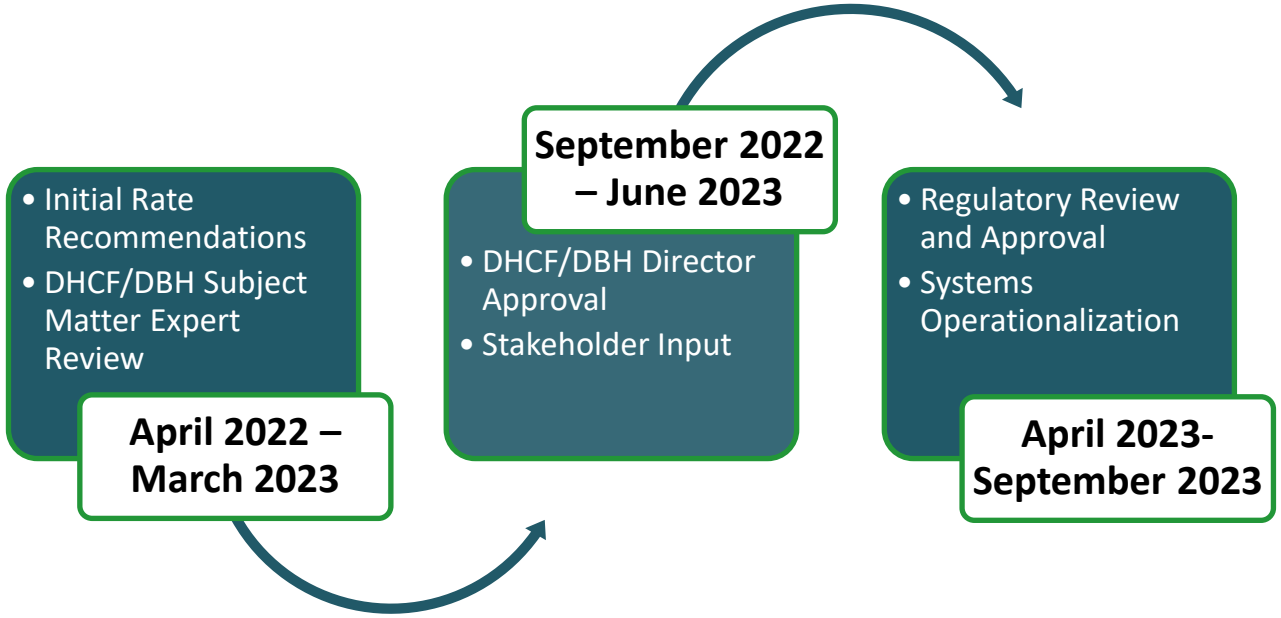
- DHCF and DBH are collaborating to conduct a comprehensive review of the District's behavioral health services. We're working to develop rate models for 53 District behavioral health services, ensuring rate reimbursement levels appropriately reflect the cost of providing services at fidelity.

- Additionally, DHCF and DBH are collaborating to consider adding new services to the continuum of Community-Based Behavioral Health to address current gaps in service. New services include:
  - Attachment and Biobehavioral Catchup (ABC)
  - Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET-CBT)
  - Dialectical Behavioral Therapy (DBT)
  - Transition to Independence (TIP)
  - Collaborative Care Services (CoCM)
  - Partial Hospitalization (fee-for-service)
  - Parent- Child Interaction Therapy (PCIT)
  - Peer Support

- The District is also considering seeking authorization from CMS to receive Medicaid reimbursement for the following existing services, expanding access and increasing reimbursement:
  - Intensive Care Coordination (Modeled after the High-Fidelity Wraparound Model)
  - Psychiatric Consult with Physician (formerly DCMAP)

Behavioral Health Rate Study Implementation and Timeline

Goal: to establish rate methodologies that will support the behavioral health provider network's ability to achieve the goals and expectations set forth by DBH and ensure qualifying District residents have access to quality behavioral health care.



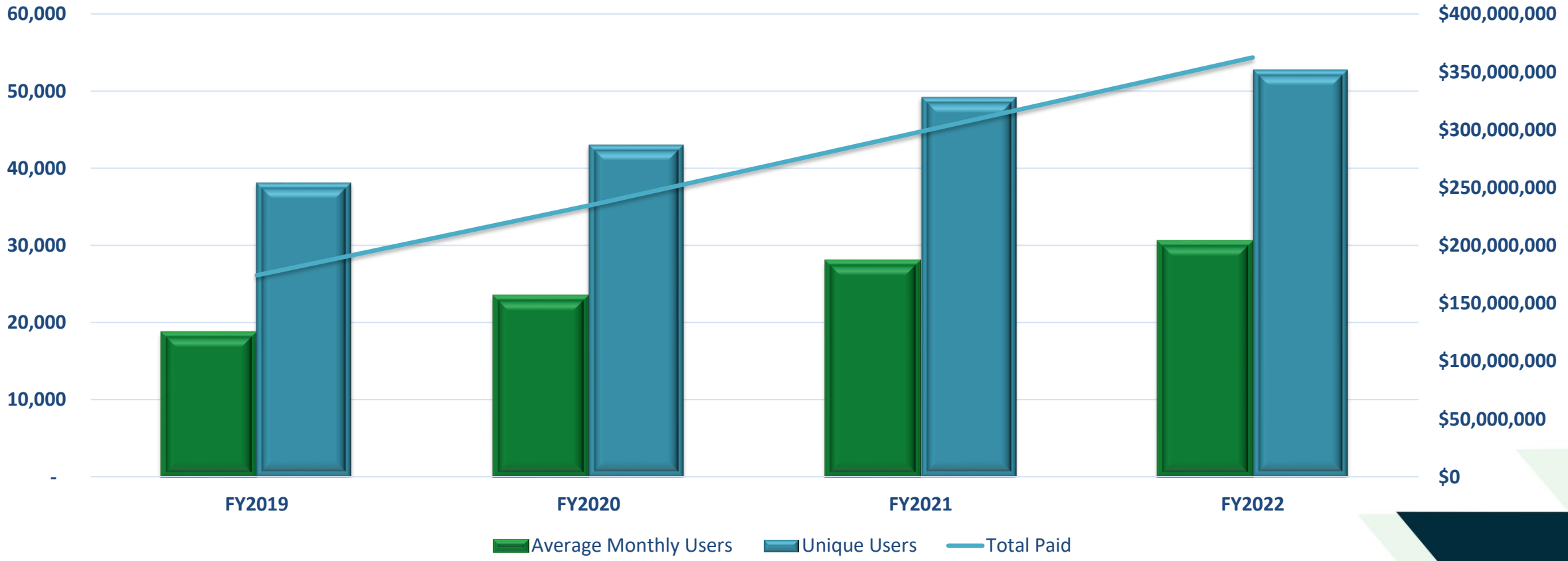
Key Implementation Dates:

- July 1, 2023: Proposed FFS-only Implementation of Rate Model Changes to Assertive Community Treatment (ACT) services.

- October 1, 2023: Proposed carve-in of community-based behavioral health services into the Medicaid MCO contracts.

Behavioral Health Cost Drivers: Medicaid Behavioral Health Services Users

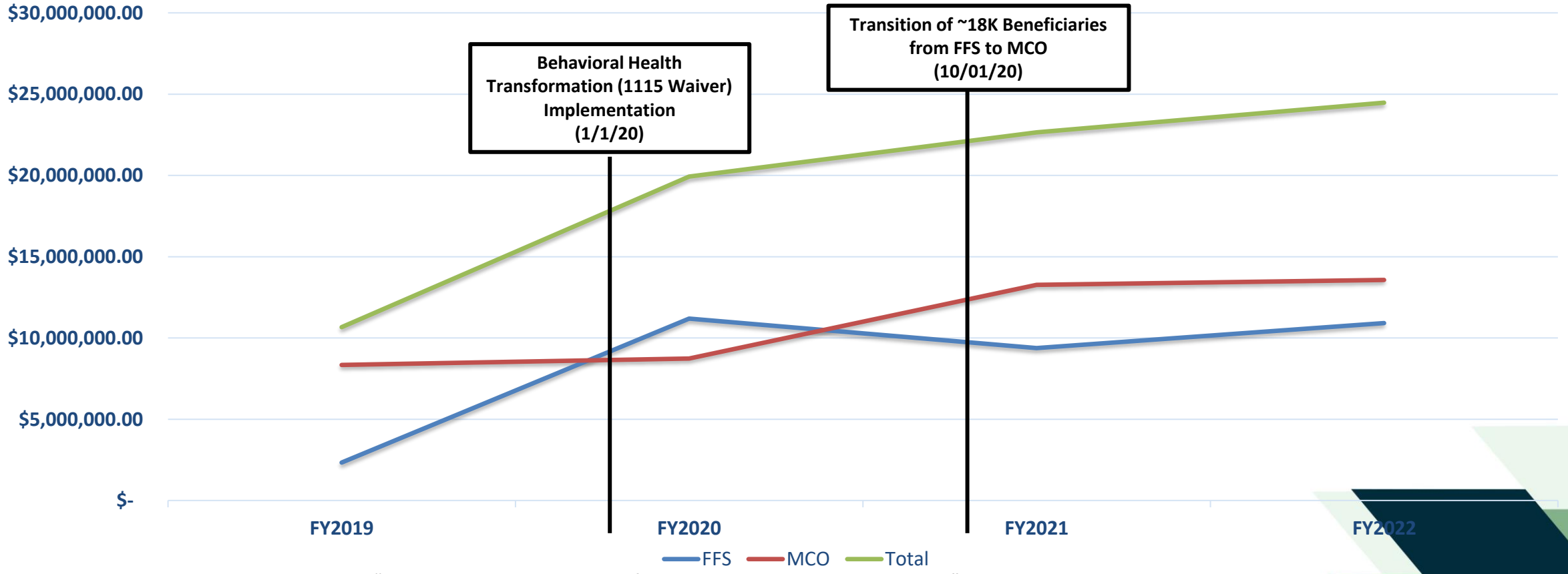
Number of Users from FY2019 to FY2022 Drove Expenditures



Source: Medicaid Datawarehouse Dashboard titled "DHCF Spending and Utilization for Selected Behavioral Health Services"
Notes: Dates represent date of service. Services include MHRS, ASARS, FQHC BH, OLP, and Inpatient Behavioral Health Spending.

Behavioral Health Cost Drivers: Psychiatric Hospital Spend

Psychiatric Hospital and Inpatient Detox Spending FY19-FY22



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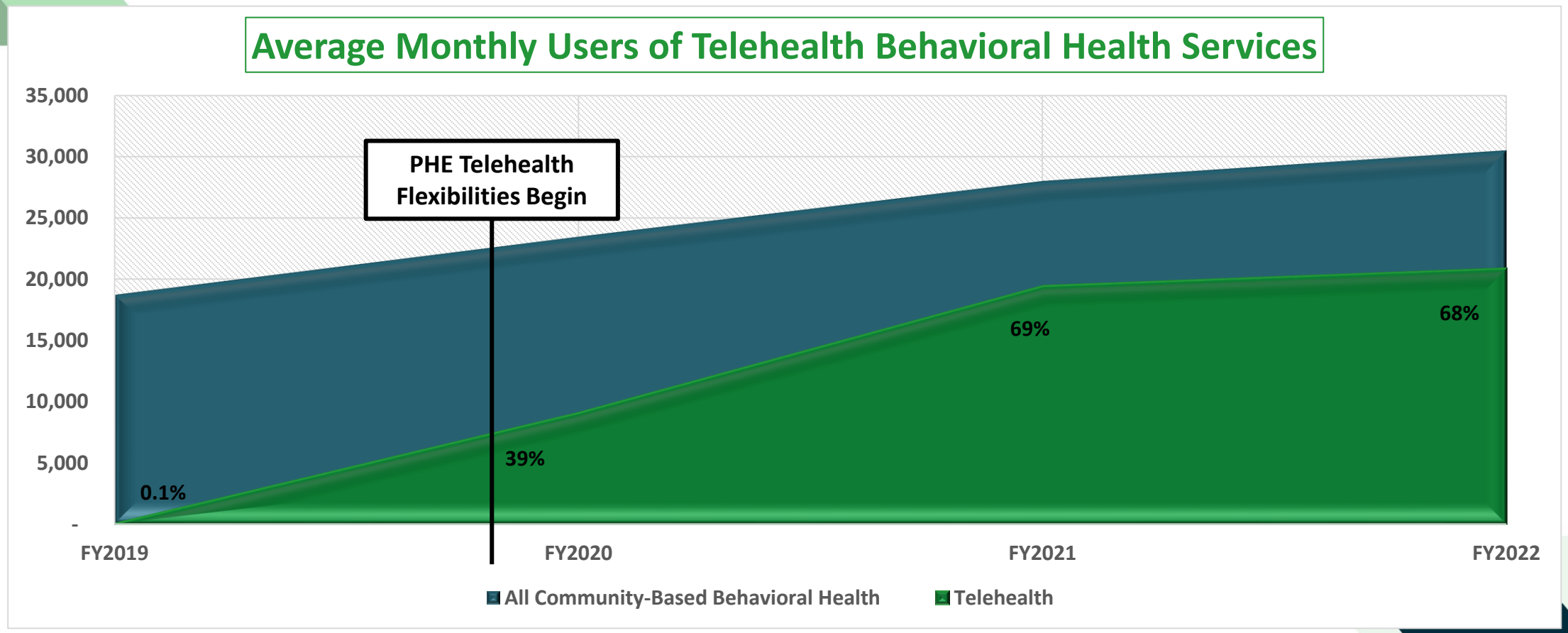
Behavioral Health Cost Drivers: Telehealth



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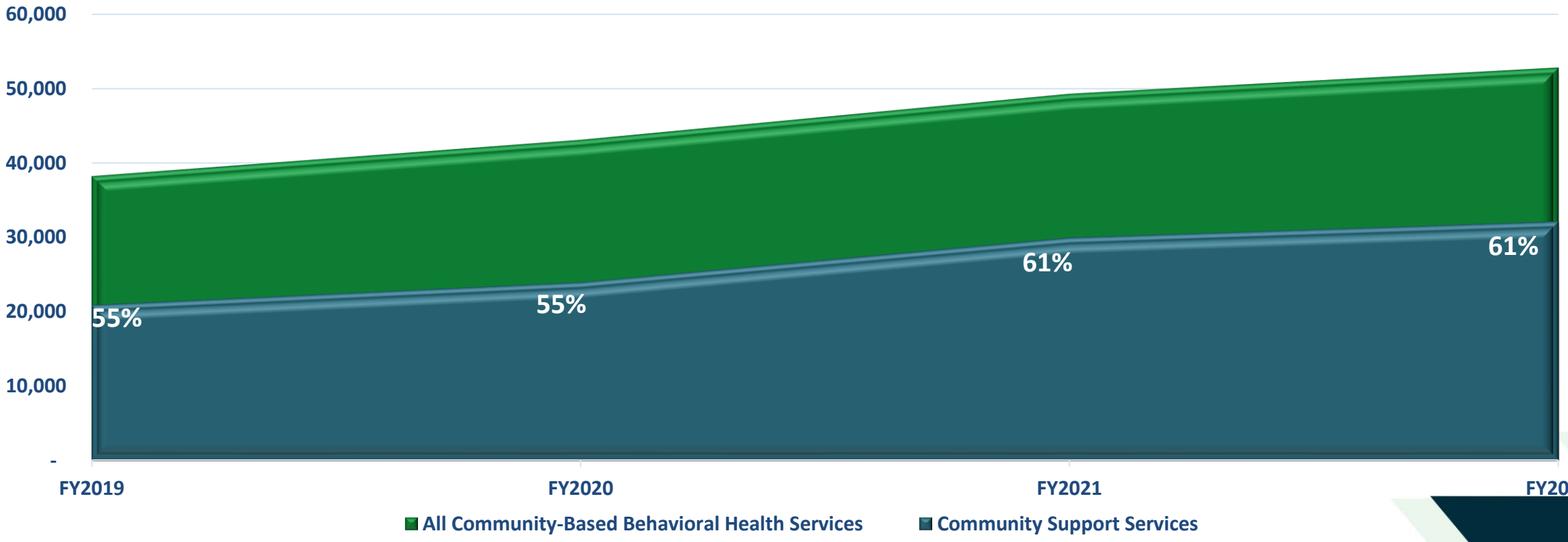
Notes: Dates represent date of service. Services include MHRS, ASARS, FQHC BH, OLP, and Inpatient Behavioral Health Spending.

Behavioral Health Cost Drivers: Community Support

Unique Community Support Beneficiaries as a Percentage of All Behavioral Health Beneficiaries



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Notes: Dates represent date of service. Services include MHRS, ASARS, FQHC BH, OLP, and Inpatient Behavioral Health Spending.

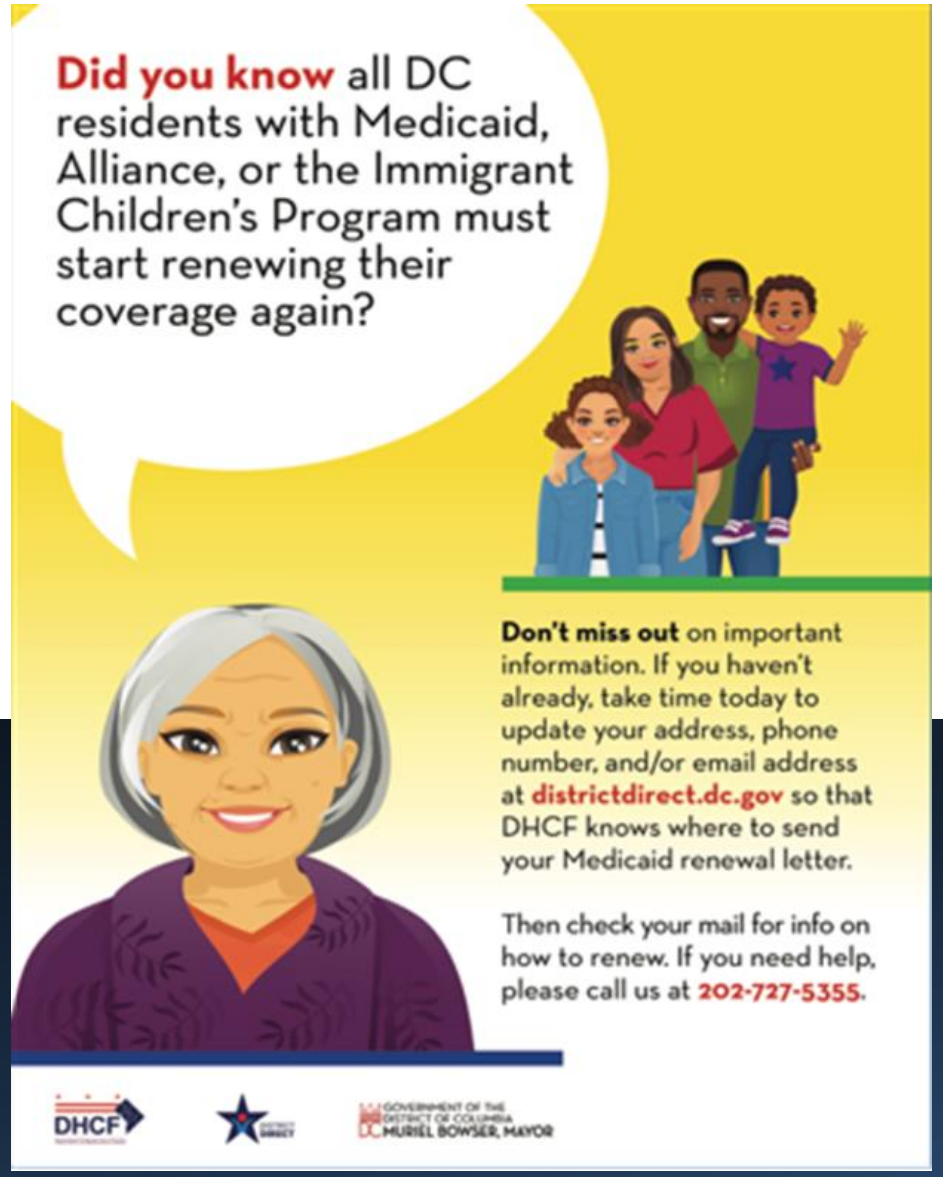
FY24 Proposed DHCF Initiatives Are Core to Building a Resilient Health Care System

FY24 Budget seeks to stabilize providers to ensure their ability to serve Medicaid beneficiaries is

We do this through:

- Maximizing multi-payer revenue sources,
- Setting competitive rates,
- Ensuring payment and rate methodologies align with reasonable cost experience to ensure sustainability
- Increasing interoperability through incentives and HIE
- Integrating behavioral health services into MCO contracts

Don’t Wait to Update!




Q&A

DHCF and DBH Continues to Invest in the Delivery of High Quality Behavioral Health Services

Consolidated	DHCF Local	DHCF ARPA	DBH Local	Medicaid	Total
MHRS	$4,300,000.00	$2,759,677.31	$51,534,869.02	$140,060,081.06	$198,654,627.38
ASARS	$0.00	$14,085.40	$992,648.82	$2,391,204.79	$3,397,939.01
YSATS	$0.00	$0.00	$1,247.25	$2,962.18	$4,209.43
BHT Waiver	$0.00	$0.00	$8,336,187.18	$19,805,389.95	$28,141,577.12
Health Homes I	$0.00	$0.00	$136,013.50	$322,962.24	$458,975.74
Total	**$4,300,000.00**	**$2,773,762.72**	**$61,000,965.77**	**$162,582,600.21**	**$230,657,328.70**

- The figures above reflect the impact of the behavioral health rate study, new programs, inflation and the conclusion of the PHE
- Local cost of new programs as well as MHRS and ASARS inflation funded with ARPA
- DHCF continues to invest local funds in MHRS