DEPARTMENT OF HEALTH CARE FINANCE (HT0)

A Fair Shot

WE ARE WASHINGTON
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Presentation Overview

- ☑ **Overview Of District's Budget For FY2023**
- ☐ **Overview of Deputy Mayor, Human Support Services Cluster Priorities**
- ☐ **Cedar Hill Regional Medical Center Progress**
- ☐ **DHCF Program Overview**
- ☐ **DHCF Budget Development and Rates**
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- ☐ **Alliance**
- ☐ **Conclusion**

The District's Economy Is Rebounding

	Pre-COVID	Early COVID	Mid-COVID	Today
DISTRICT REVENUES	$8.7B	$7.9B	$8.5B	$9.4B
UNEMPLOYMENT RATE	5.0%	11.1%	7.2%	5.8%
RESIDENTIAL VACANCY (Multi-Family)	7.7%	11.4%	12.7%	9.0%
COMMERCIAL VACANCY	11.1%	11.9%	12.5%	14.3%
DC RESIDENTS VACCINATED	-	0%	49%	72%
CONSUMER SPENDING	-	-41%	-17%	+7.3%
RESTAURANT SPENDING	-	-49%	-26%	-20%
PUBLIC HEALTH RESTRICTIONS	NONE	MANY	SOME	FEW

This budget will…

Invest $19.5 billion in helping us emerge from the pandemic stronger and more ready to thrive than ever

The Operating Budget is Funded With More Than $12 Billion

OPERATING BUDGET

- **$12 billion** general funds budget
- **$10.7 billion** Local Funds budget
- Local Funds increase of **$1.3 billion** or 14% over FY 2022 Approved Budget
  - ❖ This growth includes significant **one-time investments**, such as $409 million for HPTF.
  - ❖ Growth is **~6%** when one-time investments are excluded.

Key Investments

- ➢ **Schools**
- ➢ **Affordable Housing**
- ➢ **Human Support Services, and**
- ➢ **Facilities Maintenance, plus Debt Service to support planned capital investments**

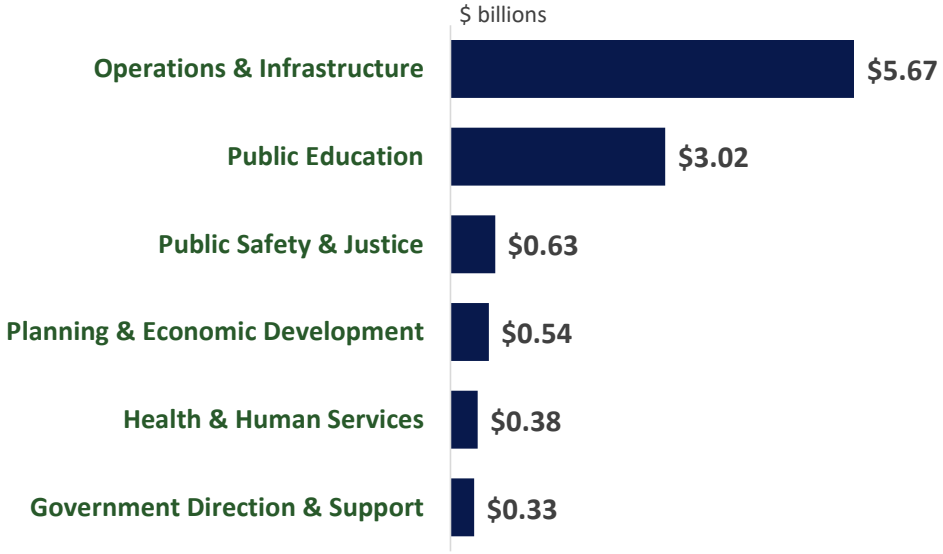
Federal Relief of $2.2 Trillion Greatly Aided District Budgeting Throughout Pandemic

$millions	FY 2021 Actual	FY 2022	FY 2023	FY 2024	TOTAL
Alternative 911 Response	$0.1	$7.0	$6.6	$6.6	**$20.2**
Build and Preserve Affordable Housing	$158.3	$306.4	$38.5	$31.1	**$534.3**
COVID-19 Response	$22.5	$63.9	$0.0	$0.0	**$86.5**
Economic Recovery for Residents and Businesses	$83.3	$403.7	$252.7	$105.3	**$844.9**
Gun Violence Prevention	$2.2	$41.8	$44.1	$45.3	**$133.3**
Learning Acceleration	$5.5	$87.6	$112.1	$30.6	**$235.8**
Oversight, Accountability and Efficiency	$0.1	$18.2	$4.8	$5.5	**$28.6**
Reduction of Healthcare Disparities	$22.1	$43.3	$4.5	$3.7	**$73.6**
Youth Safety	$0.1	$15.0	$12.7	$15.4	**$43.1**
Other	$7.0	$54.3	$172.3	$10.4	**$244.1**
TOTAL	$301.1	$1,041.3	$648.3	$253.8	**$2,244.4**

Funding includes state and local fiscal recovery funds. Total is not inclusive of other grants the District received through ARPA. "Other" includes Infrastructure, Revenue Replacement for Government Services, and Other categories.

$10.8 Billion In Major Capital Investments Across Six-Year Spending Plan

PROPOSED FY 2023-FY 2028 CAPITAL SPENDING



CAPITAL IMPROVEMENTS PLAN (CIP)

- **$10.8 billion** total six-year capital budget
- **Increase of $1.78 billion** or 20% over FY 2022-FY 2027 Approved CIP

MOST SIGNIFICANT INCREASED INVESTMENT

DCPS	+$866 million
DDOT	+$465 million
DOC	+$243 million
DMPED	+$143 million

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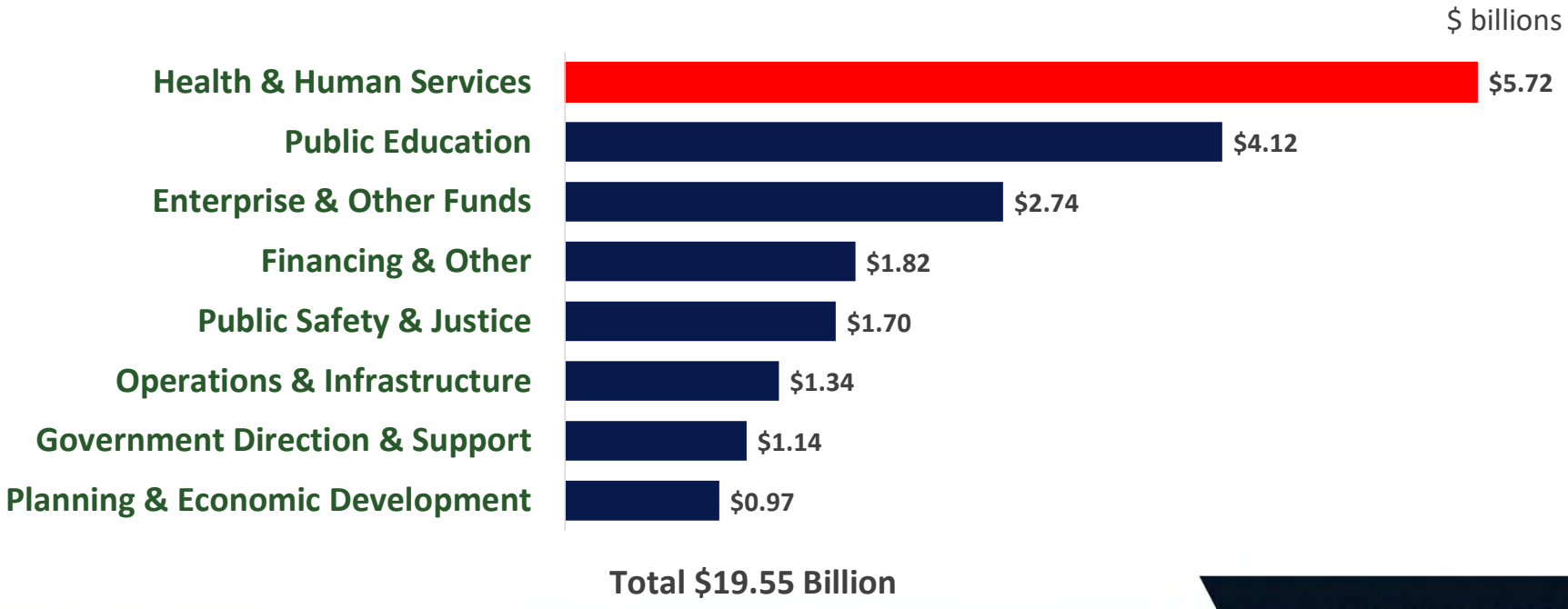
Health and Human Services Accounts For Largest Portion Of Mayor Bowser's FY 2023 Budget

PROPOSED FY 2023 Operating Budget



Total $19.55 Billion

Health & Human Services

- **$927** million to fund the local match for the $3 billion Medicaid program and to support base funding for Alliance
  - Includes **$11.5M** to retain direct support professionals—who care for our most vulnerable residents—by raising wages over a three-year period
  - Includes **$4.2M** to extend Alliance enrollment to 12 months and end the required in-person 6-month re-certification for District residents
- **$4.5M** to expand school nursing services at additional school health services programs in public and public charter schools
- **$114.6M** across two years for modernizations and renovations of permanent and temporary supportive housing and shelter services
- **$2.8M** to enhance programs and services at the new 801 East Men's Shelter
- **$2.6M** to continue operating the DC animal shelter
- **$750K** to enforce a new ban on flavored tobacco sales
- **$500K** to expand eligibility for individuals with developmental disabilities to provide the same services as individuals with intellectual disabilities

FOR SENIORS, THIS BUDGET WILL DELIVER…

- Free **dental services** ($500K)
- Greater community connection and wellness through technology by distributing **personal tablets** ($2.6M)
- Expanded city-wide mobility through increasing the **Connector Card program** ($1M)
- Increased nutrition support through **grocery card distribution** for eligible seniors ($750K)

ENDING CHRONIC HOMELESSNESS

$31M to invest in Homeward DC that will add **permanent supportive housing vouchers** for 500 more individuals, 260 more families, and 10 more youth as well as other critical outreach and prevention services so that the District can end chronic homelessness.

In FY2022, DHCF Continued to Provide Enhanced Payments to Ensure Financial Sustainability for District Health Care Entities Providing Care To Medicaid & Alliance Beneficiaries

Hospital Support

- $15 Million Granted to District Hospitals to address continued nurse staffing shortage and other pandemic related cost resulting from PHE FY22
- $8 Million Hospital Support grant focused on impact of DSH rule change FY22-FY23

American Rescue Plan Act of 2021 Initiatives

- $1M for Business Practice Transformation Grant FY22-FY23
- $3M for HCBS Provider Digital Technical Assistance Grant FY22-FY23
- $225K for a Remote Patient Monitoring Pilot Grant FY22
- $1M for the Produce Prescription Program Grant FY22-FY23

PHE Rate Enhancements During the PHE

- Nursing Facilities – 20% base rate enhancement
- Intermediate Care Facilities – 20% base rate enhancement
- Personal Care Aides and Skilled Nursing (RN/LPN) – enhanced quarantine and overtime pay
- Adult Day Health Program (ADHP) – remote services and retainer payment flexibilities
- Adult Substance Abuse Rehabilitative Services (ASARS) – 20% rate enhancement
- Federally Qualified Health Center (FQHC) – payment methodology shift to per-person, per-month payments
- All Providers – Telehealth Flexibilities

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CEDAR HILL REGIONAL MEDICAL CENTER GW HEALTH

COMMITTEE ON HEALTH – FY23 BUDGET UPDATE, MARCH 28, 2022

STATUS UPDATE MARCH 2022

https://newhospitals.dc.gov/

CEDAR HILL
REGIONAL MEDICAL CENTER

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

GW Medical Faculty Associates

Children's National

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

For More Info Contact Nelsie.smith@dc.gov or visit the Hospital Website at https://newhospitals.dc.gov

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Mayor's Budget Includes $15 Million Allocation For Increased Cost For The New Hospital in Ward 8

- Hospital construction cost have increased due to three factors –

  1. The hospital was designed and budgeted for before COVID-19, in late 2019. The partners incorporated lessons learned during COVID into the design – for example the use of 100% outdoor air HVAC systems.
  2. Inflation, global and national supply chain shortages, and market conditions have increased the cost of non-residential construction and new health construction by 12% from October 2020 to 2021 – with no expected end in sight.
  3. The hospital partners made a strategic decision to build a larger diagnostic and treatment area to accommodate future growth and potential health emergencies.

- Universal Health Services will contribute $5.5 million to assist with the additional costs associated with the larger diagnostic and treatment center.

- Workforce training and project management funds are also included in the budget.

  - $250,000 for the District to establish voluntary training courses for any United Medical Center staff who are interested in working at the new hospital and need to upskill or reskill to meet the new hospital's hiring requirements. This is a requirement of the Council passed legislation and associated agreements.
  - $240,000 to support the project's overall implementation, specifically these funds would be used for a 3rd party construction project manager to be overseen by DHCF.

Work on the new hospital has begun…

- Removal of former 801 East Men's Shelter
- Removal of former steam tunnels

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FY 2023 PROPOSED B

Cedar Hill Memorial Health Center Will Be A Full-Service Community Hospital with Verified Trauma Center

- 136 inpatient beds (can expand to 196 in the future)
- Verified Trauma Center
- ICU, Surgery and Operating Rooms
- Newborn Delivery and Women's Services w/ Level II Neonatal Intensive Care Unit
- Behavioral Health
- Adult and Children's Emergency Department
- The solar panels on the garage will provide energy assistance to over 200 households in the adjacent community.
- The hospital must comply with the District's CBE, First Source and Project Labor Agreement Requirements.
- Staffed by the George Washington Medical Faculty Associates, George Washington School of Medicine and Health Sciences and by Children's National
- Helipad if FAA Approves

What is a Full-Service Community Hospital with a Trauma Center?

- As a full-service community hospital **with a trauma center**, the new Hospital will look, feel, and function similar to Johns Hopkins Sibley Memorial Hospital.
- **Trauma centers** can provide **more acute emergency services** than a traditional emergency department.
- The **new hospital will be able to treat nearly 90% of all trauma incidents that occur in Wards 7 and 8**.
- The new hospital will also have a helipad if approved by the FAA.

A Trauma Center includes:

- **Dedicated Trauma Director and Trauma Program Manager**
- **Injury Prevention Specialist**
- **24/7 General Surgery Availability**
- **24/7 Orthopedic and Neurosurgery Availability**
- **Dedicated Orthopedic Surgeon**

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DHCF Budget Development: Unwinding From the Public Health Emergency

DHCF

Department of Health Care Finance

FY23 DHCF Total Budget $3.7B
FY23 Local Budget $927.2M

DHCF Transforms Health Care Delivery System

Building on Reform Efforts to Improve Health Outcomes and Preparing for Return to Normal Operations Post-Public Health Emergency

The Goal: Improve health outcomes so that District residents can live their best lives while ensuring program and health system stability

The Path to Improve Outcomes:

- More value over volume: increase expectations for value-based purchasing through managed care
- Increased access to care: require universal contracting with MCOs for key providers (acute care hospitals and FQHCs)
- More coordinated care: transition FFS Medicaid population to managed care

FY2021 First Transition to Managed Care:

- Adults receiving social security income (SSI)
- Adults who opt-out of MCO enrollment

FY2022 Expanding Medicaid Medicare Integration

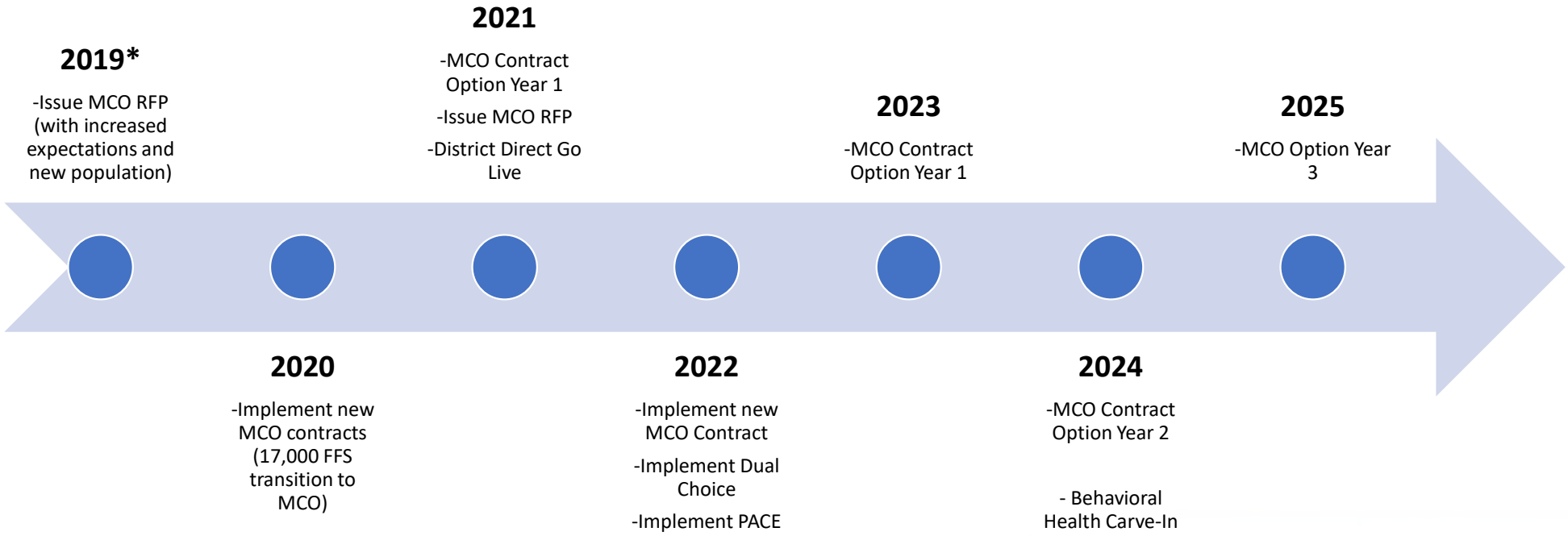
- Implement PACE program
- Implement Dual Choice program
- Implement HCBS ARPA Initiatives

FY2023 New Managed Care Program Contracts and Post-PHE

- Increase value-based purchasing requirements
- Planning for carve-in of behavioral health services
- “Un-wind” from the PHE, e.g. restart eligibility recertifications; program flexibilities and enhanced rates end (pending end of federal PHE)

DHCF Transforms Health Care Delivery System

DC Medicaid Reform Milestones Revised to Reflect New MCO Procurement



HCBS ARPA Initiatives (FY2022 – FY2024)

DHCF has received conditional approval to implement HCBS enhancement activities that fall under four main categories:

Category 1: Provider Reimbursement and Workforce Recruitment, Retention, and Development

- Direct Support Professional (DSP) recruitment and retention bonuses; vaccine incentive; transportation benefit training initiatives;
- DD Direct Support Professional bonus payment;
- HCBS Provider rate increases to support increase in DSP Wages; achieving a DSP living wage of an average of 117.6% by FY25
- BH rate increase in FY22 and FY24
- Potentially subsidizing a permanent rate increase for qualifying HCBS providers (including HHA, DD Waiver and BH providers) to support increased living wage rates for DSP's.

Category 2: Expanding Services and Increasing Access to Services

- Certified Medication Aides (C-MAs) and Services; DME services to prevent functional decline; Remote patient monitoring pilot;
- Assisted Living Facility rate study and Home Health rate study

Category 3: Quality Oversight, Infrastructure, and Provider Capacity Building

- Support for provider implementation and use of electronic health records;
- Support for provider connectivity to the health information exchange;
- ASARS provider capacity building grants;
- Expansion of assessment and care coordination IT infrastructure

Category 4: Beneficiary Education, Support, and Transitions of Care

- Case Management Support for beneficiaries transitioning to D-SNP & PACE;
- Housing Coordination services for DDS community;
- Beneficiary/Provider Health Literacy Program;
- DDS Covid-19 Impact Study;
- LTSS Referral Management System

DHCF Programs Provide Health Care Coverage to 47% of District Residents – Supporting Near Universal Coverage in DC

Near universal coverage

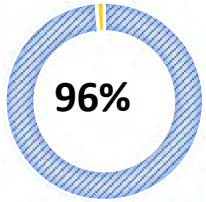
DC has the second lowest uninsured rate

DHCF covers more than 300,000 people

On average during FY 2021:
- more than **279,000** were in **Medicaid**;
- **20,000** in the **DC Healthcare Alliance** and
- **4,000** in the **Immigrant Children's Program**

More than 4 out of 10 District residents

7 out of 10 children



Of all eligible DC children are enrolled in Medicaid

Health challenges remain despite coverage

12th in the nation — For 911 call-volume

10% of residents — Report delaying care due to not being able to get an appointment soon enough

Source: Population and demographic estimates are from the U.S. Census Bureau (2021 state population totals and 2020 ACS 1-Year Experimental Data Tables); DHCF Medicaid Management Information System (MMIS) data extracted in March 2022; Haley et al., "Insurance Rose Among Children and Parents in 2019," Urban Institute, July 2021.

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DHCF FY2023 Local Budget Snapshot

In millions

FY22 Recurring Budget	**814,646,705**
Adjustments Made During MARC Formulation	52,826,742
2% Reduction	(16,480,565)
FY2023 Revised Baseline	**850,992,882**
Budget Adjustments:	
Restoration of Agency Budget Reductions to Meet MARC	37,773,425
Additional Vacancy Savings	(930,581)
Total Restored of Proposed Budget Savings Initiatives	**36,842,844**
Mayor's Enhancements:	39,343,141
Final FY2023 Local DHCF Budget	**927,178,867**

Note: Local Budget Snapshot does not include $480k in ARPA Revenue Replacement

DHCF's FY2023 Year Over Year Comparison

Appropriated Fund		FY 2022 Approved Budget	FY 2023 Proposed Budget	YoY Budget Change	% Change
0100	Local	847,228,958	927,658,867	80,429,909	9.5%
0110	Dedicated Taxes	103,219,385	105,105,077	1,885,692	1.8%
0150	Federal Payments	2,000,000	2,000,000	-	0.0%
0200	Federal Grants	3,206,819	5,174,115	1,967,296	61.3%
0250	Federal Medicaid Payments	2,553,572,305	2,663,283,088	109,710,783	4.3%
0400	Private Grants	-	365,701	365,701	100.0%
0600	SPR Revenue (Type)	6,434,236	5,643,542	(790,694)	-12.3%
0700	Intra Districts	141,368,841	-	(141,368,841)	-100.0%
Grand Total		**3,657,030,545**	**3,709,230,390**	**52,199,846**	**1.4%**

Variance Explanations

- **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
- **Federal Payments:** District ARPA funding will be utilized to support three initiatives to improve health care for District residents by strengthening the health care network.
- **Federal Grants:** the Money Follows the Person grant has been extended to cover home and community-based services capacity building including apprenticeship opportunities and other workforce development activities intended to strengthen the direct support workforce for long term services and supports. There is an emphasis on activities that rebalance long term services and supports from institutional care to home and community-based care.
- **Federal Medicaid:** FY22 allotment will be increased to reflect extension of the EFMAP from December 2021 to June 2022 and FY23 budget reflects anticipated Medicaid participation post the PHE at the normal match rates
- **Private:** New grant to support cost in the transition of residents who decide to move to the Dual Choice program from their current Medicaid program
- **OType**: Alignment of budget to revenue, reflecting a decrease in anticipated revenue from 3rd party Collections. Established budget in a new fund to support assistance to eligible residents through the application and redetermination process to maintain their healthcare.
- **IntraDistrict**: Change in accounting process for interagency agreements. Funding now remains in the agency paying for the cost or service

Highlights of DHCF's FY2023 General Fund Budget Allocation

In millions

Local- $927.7M*

Budget Adjustments: $81.3M

($1.4M): 9.2% in Vacancy Savings

(3.9M): Efficiencies in maximizing participation

$48.8M: Restore local funding due to the end of the enhanced federal match available in FY22, Fund Postpartum Bill, elimination of face-to-face recertification for Alliance and other changes

$37.8M Restoration of budget adjustments to meet the agency MARC

Enhancements $39.3M:

$490k: One Time funding for Cedar Hill Medical Center planning support including a PMO and training for potential hospital staff

$26.7M: One Time funding to support increase in utilization related to the continued extension of the PHE and continued coverage

$4.2M: Support cost associated with extending the recertification process for Alliance beneficiaries from 6-months to 12-months

Continuation of ARPA Funding $480K

$480k to support non-emergency transportation cost for Alliance beneficiaries to attend medical visits

*** Local budget is $927.1M plus Revenue replacement ARPA funds $480k Totals $927.7**

Federal Payments- $2M

Continuation of District ARPA Funding:

$1.5M to support Practice Transformation to ensure an adequate provider network exists to support whole person care by establishing value-based care systems

$500k to support Produce Rx initiatives that give health care providers nutritional tools to better manage and coordinate care for Medicaid residents with chronic illnesses

Dedicated Taxes- $105M

Continuation of support for Provider Payments, Administrative cost and Quality. Budget based on anticipated revenue collection

$17.7M 0110- Nursing Home Quality of Care Fund

$66.9M 0111- Healthy DC Fund (MCO)

$6.5M 0112- Stevie Sellow's Fund (ICF)

$8.5M 0114- Hospital Assessment Tax (Inpatient)

$5.5M 0115- Hospital Provider Fee (Outpatient)

O Type Revenue- $5.6M

Continuation of support for Provider Payments and Administrative cost. Budget based on anticipated revenue collection

$2.5M 0631- Third Party Liability- Medicaid Collections

$2.5M 0632- Health Care Bill of Rights

$600K 0635- Indiv. Insurance Mkt Affordable and Stability*

* New fund that will support navigation and assistance to qualified District residents to complete the application process to maintain health care coverage

DHCF Continues Initiatives Started in FY22 and Continues to Support Initiatives to Improve Outcomes for District Residents and Ensure Access to Great Health Care

Initiatives Started in FY22 Budget:

- Establishment of Neurobehavioral health services
- Extension of Postpartum Care
- Dual Choice and PACE
- Permanent Supportive Housing Services (collaboration with DHS)
- Scheduled rate updates based on audited cost reports for FQHC's, Nursing Facilities, Hospitals and Intermediate Care Facilities (ICF)
- Behavioral Health rate study
- Outpatient payment methodology set at 100% of cost (up from 77% of cost in FY21)
- Practice Transformation
- Produce Rx
- Doula service development
- Inclusion of Non-Emergency transportation for Alliance beneficiaries to eligible services

Initiatives Included in FY23 Mayor's Budget:

- Doula Service implementation
- Expansion of allowable services for Pharmacist to expand access to preventative care
  - ❑ Tele pharmacy and Point of Care testing for certain viruses
  - ❑ Expansion of Medication Therapy Management services
- DHCF will support cost associated with increasing Direct Service Professionals wages to an average of 117.6% of Living Wage or Minimum Wage (whichever is higher) beginning in FY23 to achieve full compliance by FY25. DHCF will utilize HCBS ARPA funding to support this increase in FY23 and FY24
- Initiatives in Home and Community Based settings through the HCBS ARPA funding that will enhance and improve services and monitoring of services provided to District residents receiving care through qualifying services
- Expansion of recertification period for Alliance beneficiaries from every 6 months to annually and no longer requires a face-to-face visit
- Funding to support outreach to ensure qualifying District residents have assistance in applying for Medicaid and Alliance
- Behavioral Health rate increases
- First year of new MCO contracts; including risk corridors and value-based purchasing requirements

DHCF Will Utilize HCBS ARPA Funds to Support Providers in Paying Direct Support Professionals An Average of 117.6% of Living Wage/Minimum Wage By FY2025

In response to the recent workforce shortage in Direct Support Professional (DSP) Workforce, DHCF will use HCBS ARPA funding in FY2023 and March 2024 and the District will support with local funds for fiscal years forward.

Mayor's Proposal

- Support HCBS providers, through the Medicaid rate; the ability to pay DSP's a wage above the living and minimum wages (whichever is greater). The current proposal aligns the concept of the original Bill (B23-214) to pay DSP's an average of 117.6% of LW or MW but expands it to cover the following DSP's: PCA's, Participant Direct Care Workers (PDW's in Services My Way an EPD Waiver service), DD DSP's, DSP's working in a MHRS- Mental Health Rehab Services and ASARS- Adult Substance Abuse Residential Services setting that provide services to Medicaid participants in home and community-based settings. Provider will determine the rates they pay their DSP workers; however, they are required to pay an average of 117.6% of the LW/MW.
- This concept establishes a career ladder and promotes longevity by offering a range of pay from living wage (entry level) to $4 more for a tenured DSP

How Will Funds Be Allocated?

- DHCF will allot funds in FY2023 and FY2024 in a lump sum allotment to each Provider based on DSP data provide- due October 1st including Schedule of DSP's, salaries, date of hire and vacancy rate
- The allotment will be issued in December and the requirement for Providers to pay qualifying DSP's new rate will be aligned with regular living wage adjustments on January 1st
- DHCF will complete a reconciliation at the end of the period to determine the increase in DSP wages over the year and the impact it had on the vacancy rate
- In FY2025, DHCF will amend the State Plan and Waivers to increase the rate methodology for the respective provider to support the impact of achieving the average of 117.6% for the DSP workforce

What Will the Allotment Cover?

- The increase will cover the cost of paying an average of 117.6% of living/minimum wage (whichever is greater)
- Fringe
- Administrative rate

Example: The example assumes that living wage continues to increase annually

	Living Wage	Mid Level	Higher Level
FY2023	$16.10	$18.93	$22.37
FY2024	$16.45	$19.35	$23.20
FY2025	$16.82	$19.78	$24.05

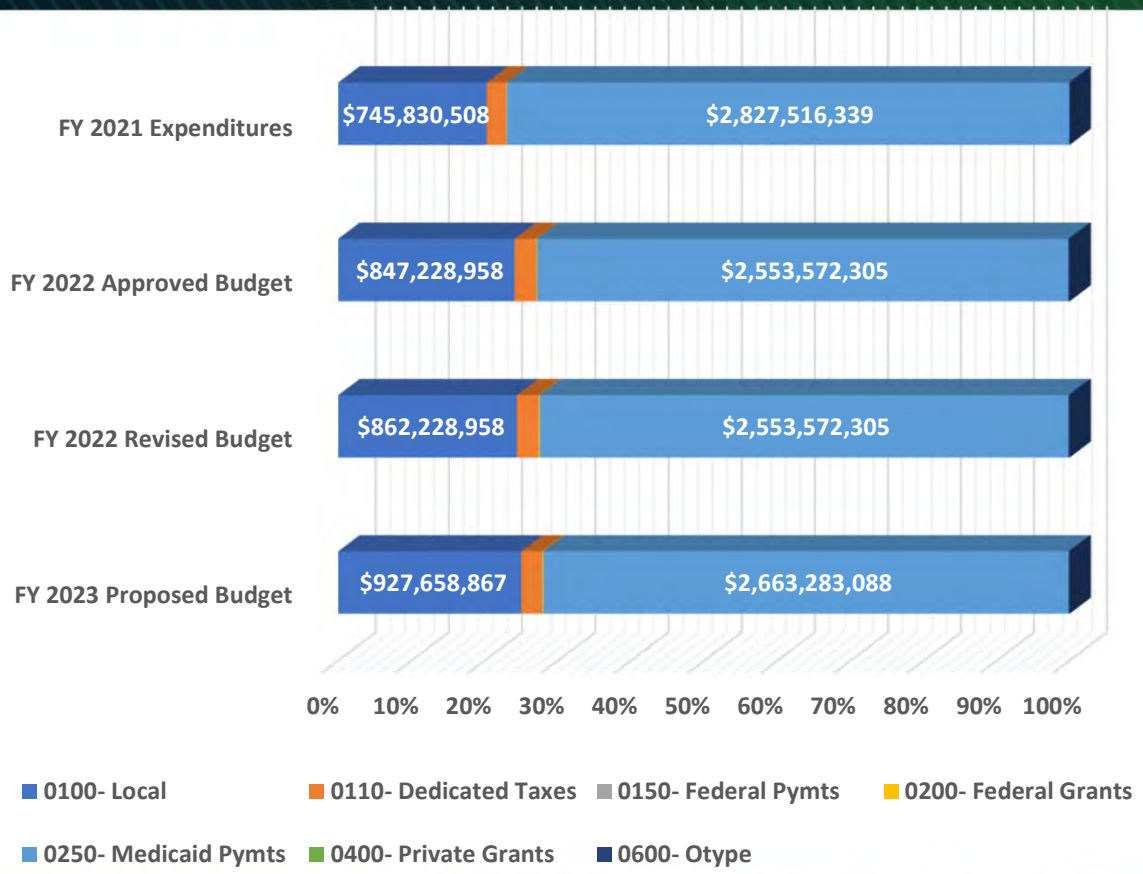
DHCF FY2023 Budget Snapshot by Fund

Fund	Fund Title	FY23 Proposed Budget	FY23 FTE's
0100	LOCAL FUNDS	927,178,867	168
1135	ARPA - LOCAL REVENUE REPLACEMENT	480,000	0
8158	ARPA - MUNICIPAL	2,000,000	0
0110	NURSING HOMES QUALITY OF CARE FUND	17,654,971	1
0111	HEALTHY DC FUND	66,927,696	4
0112	STEVIE SELLOW'S	6,524,194	1
0114	HOSPITAL ASSESSMENT TAX	8,454,038	0
0115	DC PROVIDER FEE	5,544,178	0
8200	FEDERAL GRANTS	5,174,115	2
8250	FEDERAL MEDICIAD PAYMENTS	2,663,283,088	179
8400	PRIVATE GRANT FUND	365,701	0
0631	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	2,519,000	3
0632	BILL OF RIGHTS-(GRIEVANCE & APPEALS)	2,524,542	13
0635	INDIVIDUAL INSUR MKT AFFORD & STABILITY	600,000	0
	Total by Appropriated Fund	**3,709,230,390**	**372**

Highlights In FY23 Funding

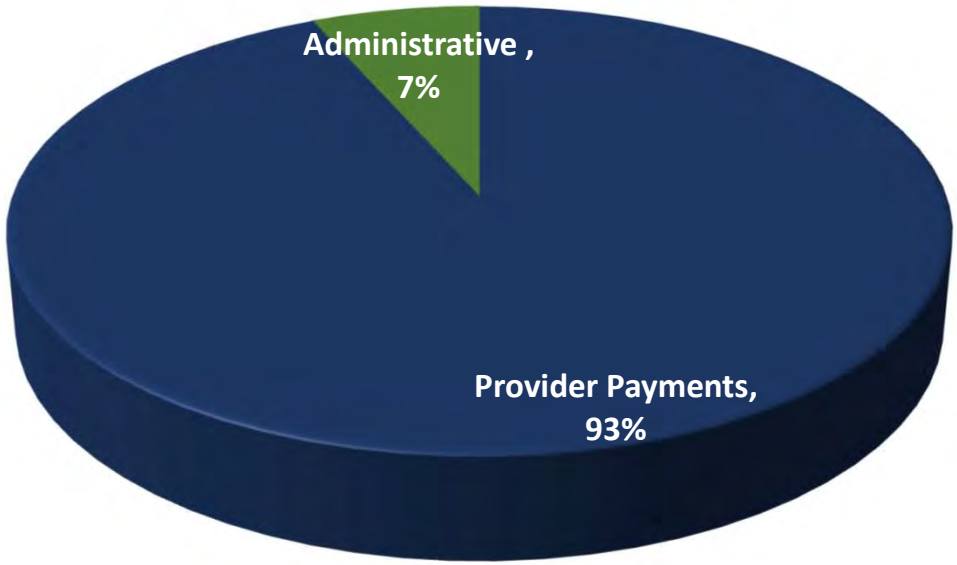
- **Fund 1135:** Supports cost related to providing non-emergency transportation to Alliance beneficiaries to medical appointments
- **Fund 8158:** Supports the continuation of the Practice Transformation Initiative and the Produce Rx
- **Fund 8400:** Assist with the oversight and review of the transition to the new Dual Choice program for residents that are eligible for Medicare and Medicaid
- **Fund 0635:** Funds will be utilized to support outreach and enrollment assistance to residents receiving healthcare through Medicaid and Alliance

Federal Medicaid Payments Continues to Support Over 70% of DHCF's Budget and Local Appropriated Funds Support Over 20%, and Dedicated Taxes 3%



Total	Percent of Medicaid Coverage
➢ $3,674,720,378	➢ 77%: Includes 4 quarters with Enhanced FMAP
➢ $3,515,661,703	➢ 73%: Medicaid budget will be increased to assume 3-qtrs of Enhanced FMAP. Current budget only assumes 1-qrt of Enhanced FMAP
➢ $3,532,866,637	
➢ $3,709,230,390	➢ 72%: The FY23 budget assumes the enhanced FMAP ends in FY22 and resumes to transitional match amounts

93% of the FY23 DHCF Budget Continues to Support Services to District Residents Receiving Health Care through Public Insurance



Spending Category	FY23 Proposed Budget
Provider Payments	$3,461,460,569
Administrative	247,769,821
Total Agency Budget	**$3,709,230,390**

Spending Category	FY23 Proposed Budget
Personal Services	$49,559,496
Supplies	426,945
Fixed Cost	2,691,226
Training and Other Services	2,275,598
Contractual Services	180,346,487
Equipment	12,470,069
Total Administrative budget	**$247,769,821**

DHCF's FY2023 Budget Increase of $52.2 M Over FY2022 is Mainly Attributed to Provider Payments

Spending Category	FY 2023 Proposed Budget	FY 2022 Approved Budget	Variance	FY 2021 Expenditures	FY 2023 Proposed FTEs	FY 2022 Approved FTEs
0011-REGULAR PAY - CONT FULL TIME	39,285,719	34,263,485	5,022,234	28,639,292	354.01	329.99
0012-REGULAR PAY - OTHER	1,416,805	1,549,495	(132,690)	1,375,515	18.20	21.04
0013-ADDITIONAL GROSS PAY	-	-	-	287,845	-	-
0014-FRINGE BENEFITS - CURR PERSONNEL	8,856,972	7,909,963	947,009	6,232,609	-	-
0015-OVERTIME PAY	-	-	-	17,108	-	-
Personal Services	**49,559,496**	**43,722,943**	**5,836,552**	**36,552,369**	**372**	**351**
0020-SUPPLIES AND MATERIALS	426,945	200,953	225,993	50,721	-	-
0030-ENERGY, COMM. AND BLDG RENTALS	487,135	408,722	78,413	358,723	-	-
0031-TELECOMMUNICATIONS	338,507	388,939	(50,433)	345,548	-	-
0032-RENTALS - LAND AND STRUCTURES	1,305,902	1,453,414	(147,511)	1,365,085	-	-
0034-SECURITY SERVICES	129,181	309,203	(180,022)	127,764	-	-
0035-OCCUPANCY FIXED COSTS	430,500	434,858	(4,358)	421,588	-	-
0040-OTHER SERVICES AND CHARGES	2,275,598	2,179,178	96,420	800,922	-	-
0041-CONTRACTUAL SERVICES - OTHER	180,346,487	183,630,114	(3,283,627)	128,146,868	-	-
0050-SUBSIDIES AND TRANSFERS	**3,461,460,569**	**3,411,181,086**	**50,279,483**	**3,570,850,106**	**-**	**-**
0070-EQUIPMENT & EQUIPMENT RENTAL	12,470,069	13,121,134	(651,065)	15,291,894	-	-
Non-Personal Services	**3,659,670,895**	**3,613,307,602**	**46,363,293**	**3,717,759,219**	**-**	**-**
Grand Total	**3,709,230,390**	**3,657,030,545**	**52,199,846**	**3,754,311,588**	**372**	**351**

In FY23 DHCF Will Continue to Focus on Community Outreach and Provider Payments to Ensure Efficient and Effective Health Care

	DHCF Programs	FY22 Revised Budget	FY22 Approved Budget	FY23 Proposed Budget	Variance	FY23 Proposed FTEs	FY22 Approved FTEs	Variance
1000	AGENCY MANAGEMENT (AMP)	53,707,784	38,707,784	47,708,113	**9,000,329**	152.35	124.99	27.36
100F	AGENCY FINANCIAL OPERATIONS (AFO)	6,786,406	6,786,406	6,136,935	**(649,471)**	17.00	17.00	0.00
2000	HEALTHCARE DELIVERY MANAGEMENT (HCDMA)	29,032,940	29,032,940	27,674,432	**(1,358,508)**	37.00	34.02	2.98
200L	LONG TERM CARE PROGRAM (LTCA)	23,444,775	23,444,775	27,791,330	**4,346,555**	40.00	38.00	2.00
3000	HEALTHCARE POLICY AND PLANNING (HCPRA)	6,196,055	6,196,055	5,198,508	**(997,547)**	26.00	32.00	(6.00)
300A	DCAS MANAGEMENT ADMINISTRATION (DCAS)	82,925,589	82,925,589	73,133,587	**(9,792,002)**	58.86	68.02	(9.16)
5000	HEALTH CARE FINANCE (HCFA)	3,407,944,734	3,407,944,734	3,449,704,808	**41,760,074**	2.00	0.00	2.00
6000	HEALTH CARE OPERATIONS (HCOA)	54,248,979	54,248,979	55,939,073	**1,690,094**	27.00	27.00	0.00
8000	HEALTH CARE REFORM AND INNOVATION (HCRIA)	9,948,217	7,743,284	13,463,605	**5,720,321**	12.00	10.00	2.00
DCRP	DISTRICT RECOVERY PLAN	-	-	2,480,000	**2,480,000**	0.00	0.00	0.00
	Grand Total	**3,674,235,478**	**3,657,030,545**	**3,709,230,390**	**52,199,846**	**372.21**	**351.03**	**21.18**

Budget Variance Explanations by Program Administration:

- **AMP:** increase is attributed to shifting of DAPR from Policy to AMP, to support the continuation of IT software & maintenance and MDW new contracts (Medication Therapy Mgmt. & HealthEC) approved by CMS; **PS**: increase is due to 3 new FTE shifts from contracts to staff, 6 FTEs shifted from HCPRA and 6 new FTEs to support expansion of Data Analytics (DAPR) department and cost allocation shifts; increase in FTE's due to new interagency process for accounting purposes
- **AFO:** decrease in auditing cost and other services
- **HCDMA** slight decrease in contractual services. **PS**: increase is due to DOH-MOU new interagency process for accounting purposes
- **LTCA** increase in contractual services that aligned with contract option years along with some anticipated procurements in FY23. **PS**: increase in FTE and cost is due to MOU new interagency process for accounting purposes for the DCOA-MFP
- **HCPRA** decrease in contractual services due to shifting DAPR from Policy to AMP; **PS**: shifted DAPR's FTEs to AMP
- **DCAS** net decrease in contractual services is due to system being in more advanced stages of being fully operational. **PS**: reduction is due to MOU new interagency process for accounting purposes for the DHS-MOU
- **HCFA PS**: increase is due to MOU new interagency process for accounting purposes OTR-MOU. Net increase is attributed to enhanced FMAP ending in FY22; requiring additional local funds in FY23. FY23 enrollment projections assume all eligibility re-determinations will be completed within 12-months period post 60 days after the end of PHE (scheduled April-22ts option year renewal and extension
- **HCOA** increase in contractual services is to support various contracts.
- **Health Care Reform and Innovation** Net increase in contracts is to support the DC MES and the Core HIE grant not budgeted in FY22; **PS**: conversion of existing contract positions to Full-Time FTE in FY23
- **District Recovery Plan** Shift to compartmentalize the FY23 allotment of District ARPA funds into one project

The FY2023 Proposed Budget For Provider Payments Assumes a 1.2% Increase Over FY2022 With The Largest Increase In The Alliance Program at 8.4%

Medicaid Provider Payments

FY2023 $3,252,528,395

- 1% increase over FY2022
- Budget supports institutional and community health care cost for services received through the Fee For Service (FFS) Medicaid program

Medicaid Public Provider Payments

FY2023 $73,359,100

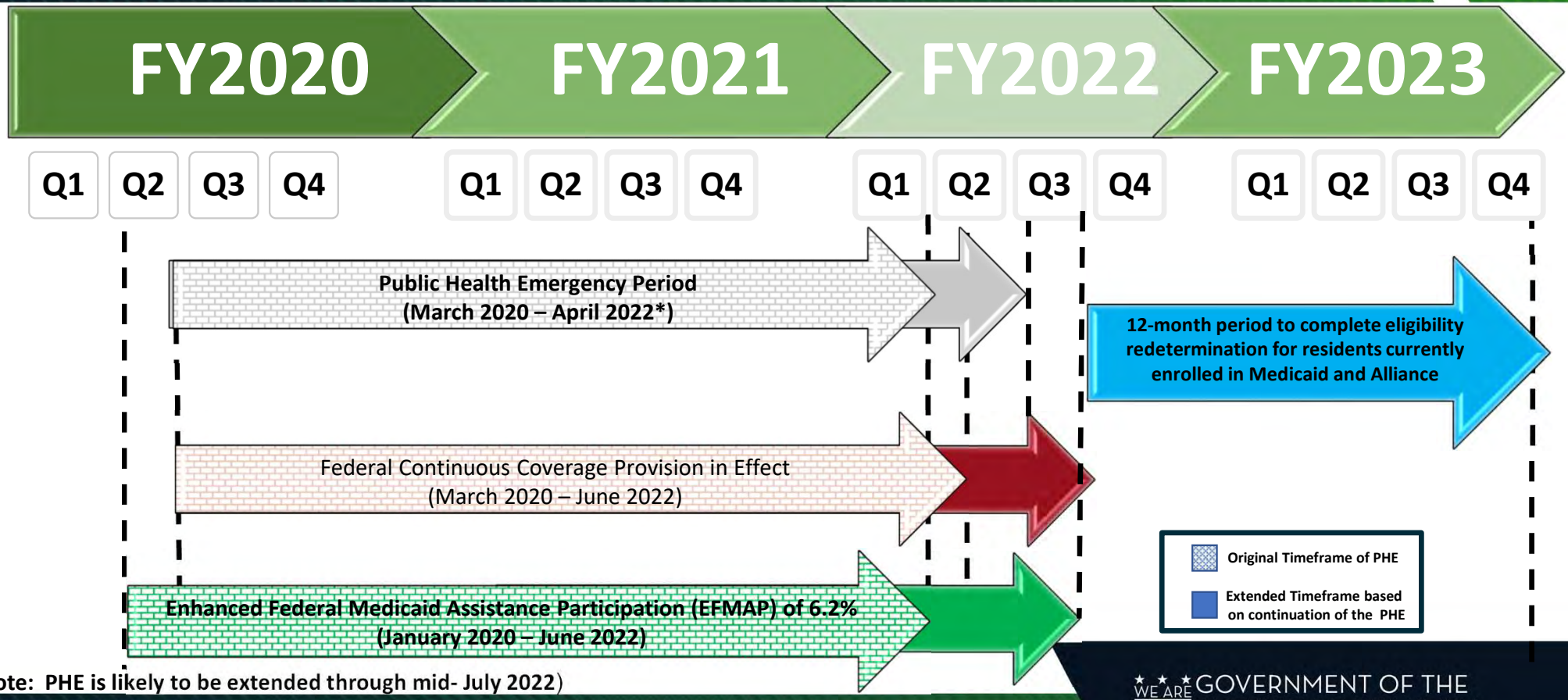
- .04% increase over FY2022
- Budget supports the federal share of cost for District agencies that provide care on behalf of the Medicaid and Alliance programs

Alliance Provider Payments

FY2023 $123,538,872

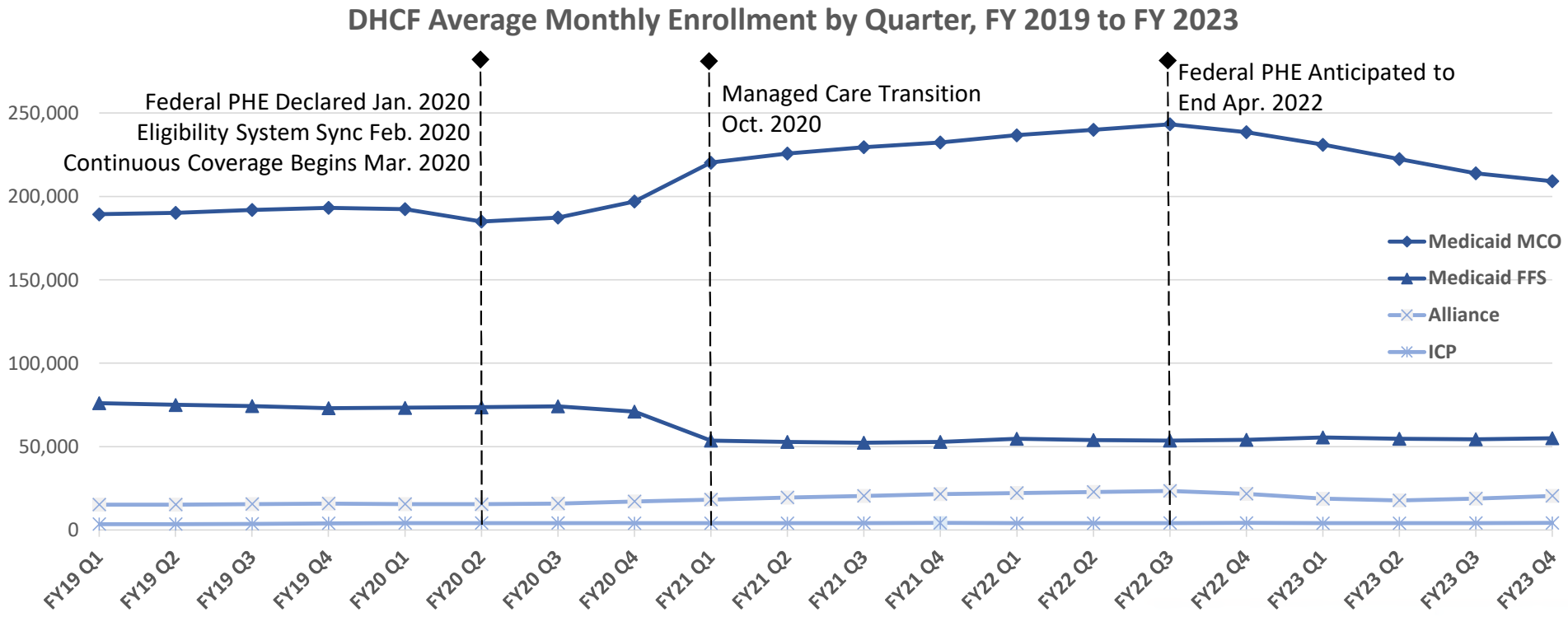
- 8.4% increase over FY2022
- Cost of care for the Alliance population has continued to increase year over year
- Budget supports the capitation payments made to MCO's to provide care for Alliance beneficiaries

The Public Health Emergency, Requirement for Continuous Coverage and the Enhanced Federal Participation is Expected to End in FY2022; However, It Will Take 12-Months to Redetermine All Beneficiaries Eligibility



Note: PHE is likely to be extended through mid- July 2022)

DHCF Enrollment Continues to Increase During the PHE; However Steep Enrollment Decline Anticipated Once the PHE Ends in FY22



FY 2023 Provider Payment Budget Assumptions

- The federal Public Health Emergency Will End as Currently Scheduled in April 2022
- COVID Provider Rate Relief Ends in FY 2022
- Spending Forecast Based on Actual Spending through September 2021 with Adjustments to Exclude Spending for Beneficiaries who Transitioned to MCOs October 1, 2020
- Historic Inflation / Cost Trends Included

- Living Wage & Minimum Wage Increases Included
- MCO Budgets Based on Estimated Actuarially Sound Rates
- Alliance Based on Elimination of the Face-to-Face Interview Requirement and Extension of Enrollment Period to 12 months
- FY 2022 New Initiatives Continue – Dual eligible Special Needs Plan (DSNP), PACE, and Housing Supportive Services

FY23 Provider Payment Budget is Based On Assumptions of Post PHE Utilization and Rates; As Well As Transition Population* Spending Trends Without PHE Rates Rate

Provider Payment Category	FY2021 Expenditures	FY2022 Approved Budget	FY2023 Proposed Budget*	YoY Variance		Variance Explanation
Hospital	253,726,006	191,495,044	220,699,190	29,204,146	15%	Alignment with anticipated utilization post pandemic in Inpatient and a decrease in DSH as a result of the cahnges in DSH requirements
Hospital Support Funding	9,900,000	8,000,000	8,000,000	-	0%	
ICF/IID	98,625,562	109,758,823	92,556,719	(17,202,104)	-16%	Based on anticipated enrollment (XXX), FY23 includes funding to pay increased DSP wages for FY21 and FY23 does not include enhanced rate but assumes rebasing
Skilled Nursing Facility	303,898,273	280,101,143	286,081,727	5,980,584	2%	
Primary Care (Physicians, Clinics and FQHC)	96,373,867	99,627,598	69,156,102	(30,471,496)	-31%	Assumes end of enhanced rates and "normal" utilization for FFS population post transition
Other (Medicare Part A, B, etc)	123,232,012	136,125,533	154,916,714	18,791,182	14%	
DME	15,289,893	18,155,075	24,990,621	6,835,546	38%	Includes assumptions in utilization and updates in Fee Schedule adjustments
Behavioral Health (Inc. BH Waiver)	152,854,816	165,838,412	158,235,140	(7,603,273)	-5%	
Skilled Care	25,941,841	20,449,326	29,432,902	8,983,576	44%	Alignment of Nursing Rates including inflation
LTCS (incl PCA and PACE)	181,910,430	166,808,814	87,793,560	(79,015,254)	-47%	Assumes end of enhanced rates for PCA and ADHP, and a full year of PACE
DSNP	-	-	123,215,268	123,215,268		
EPD Waiver	170,957,106	203,578,632	210,349,699	6,771,068	3%	
DD Waiver	308,558,556	294,924,043	313,866,978	18,942,935	6%	
IFS Waiver	1,548	4,114,601	5,975,703	1,861,102	45%	Assumes increase in enrollment in the waiver
Emergency Medicaid	30,027,240	34,995,382	31,855,709	(3,139,673)	-9%	
MCO	1,598,723,474	1,475,732,863	1,516,854,052	41,121,188	3%	
Permanent Supportive Housing	-	10,667,822	70,575,546	59,907,724	562%	FY23 assumes a full year of implementation and increased enrollment
Total	**3,370,020,624**	**3,220,373,110**	**3,404,555,630**	**184,182,519**		
Note: FY23 Budget includes funds interagency funding that supports the provider payment category						

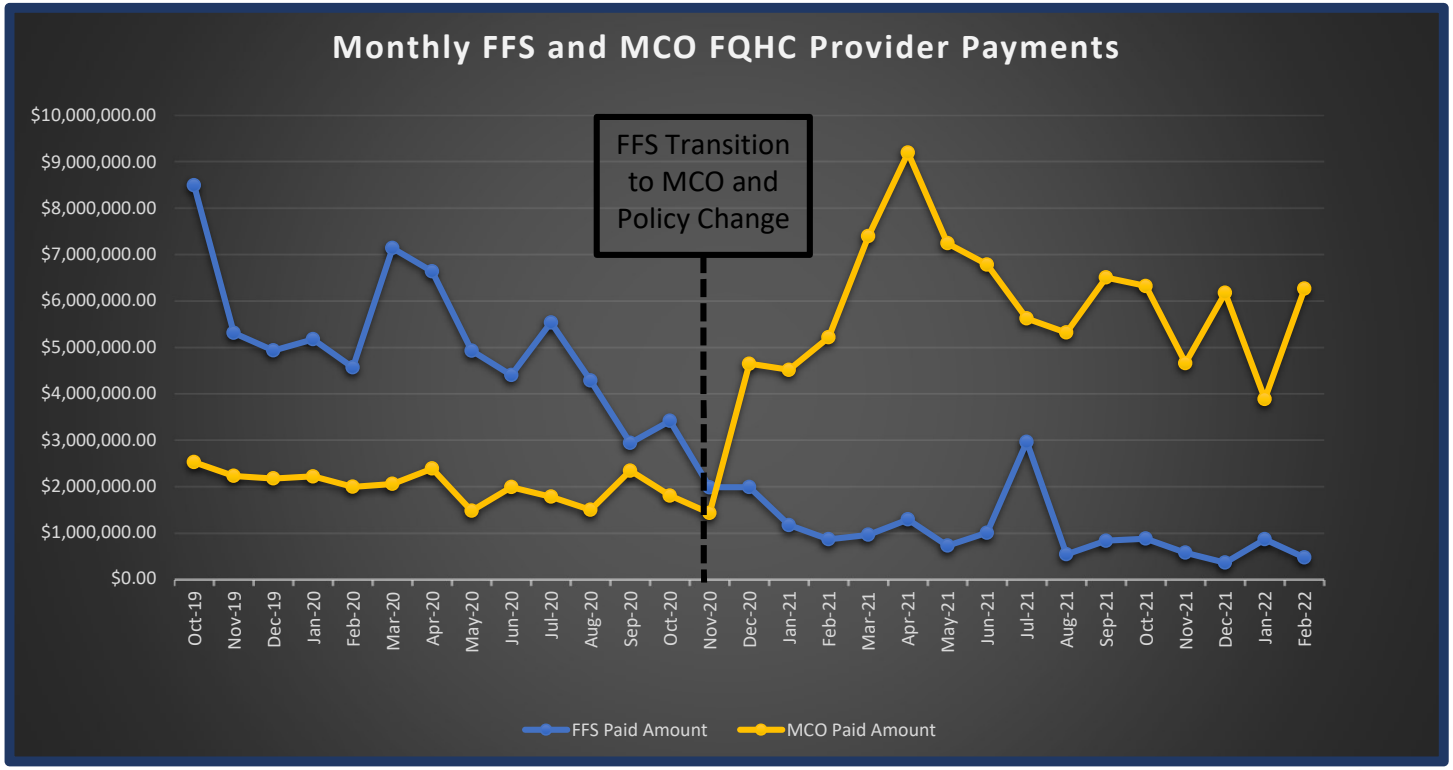
FY2021
- Full Year of PHE
- Enhanced Provider Rates
- First Year of FFS Transition

FY2022
- 1 Qtr. of PHE Enhanced Provider Rates

FY2023
- Post Enhanced Rates
- Return to Regular Provider Rates
- New Utilization Trends
- Adjusted Enrollment

* Transition Population represents the FFS Populations that shifted to MCO in FY21 (including SSI adults and Beneficiaries eligible for MCO but opted out).

The FQHC FFS Program Shrank After Transition of FFS Beneficiaries to Managed Care



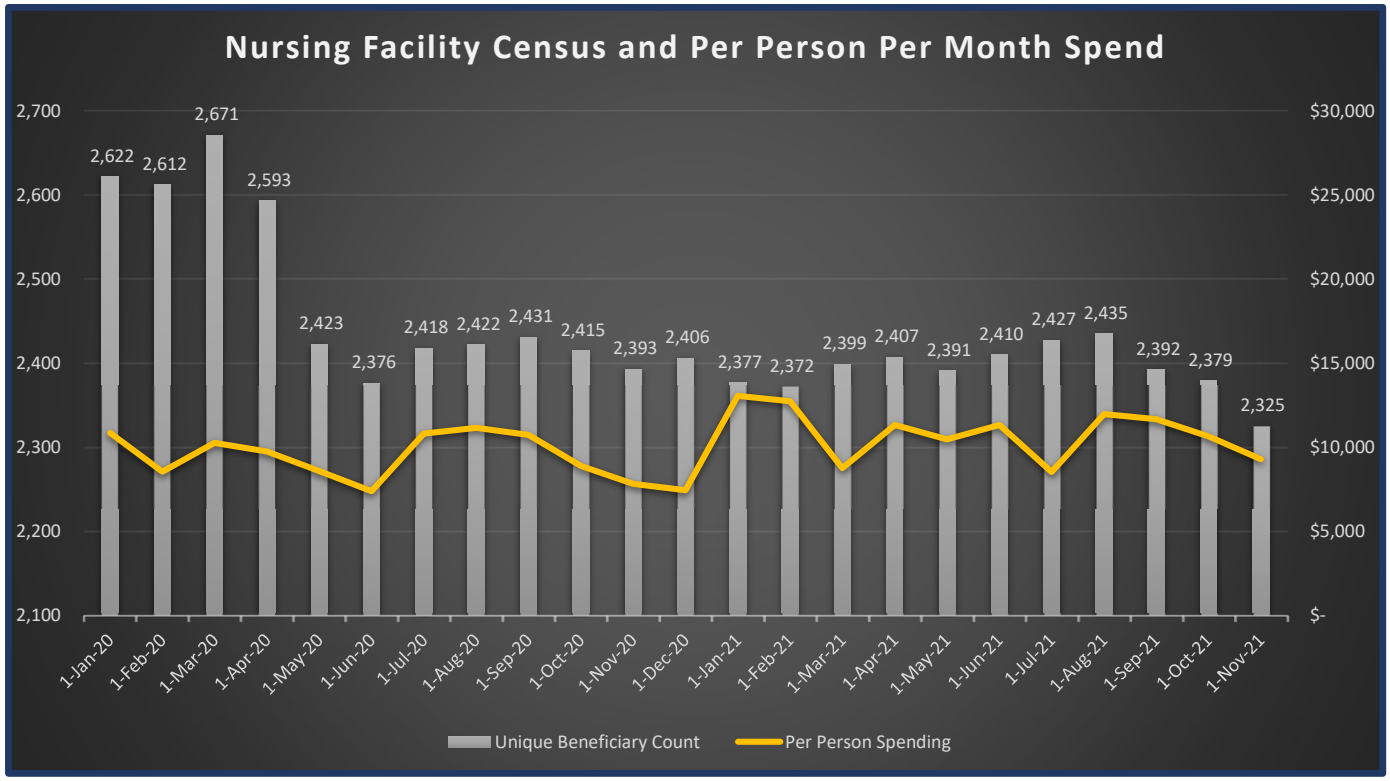
Key Factors

- FY20 Public Health Emergency
- FY21 Continuation of PHE and Transition of FFS to MCO
- March 2020- Current, FQHC's receive a FFS PMPM Payment during the period of the PHE
- FY21 reflects the policy change to end wrap payments and direct MCO's to at a minimum pay full FFS APM rates

Changes in FY23 Budget

- The FFS utilization of FQHC's decline as more people shift to MCO's (including the new Dual Choice program)
- In FY22, FQHC's rates have been rebased and include assumptions to support impacts of the ongoing impacts of cost related to COVID-19
- The FY23 assumes the decline in FFS utilization and increase in rates based on FY22 rate adjustments

Skilled Nursing Facility Census and Per-Person Spend Remain Steady



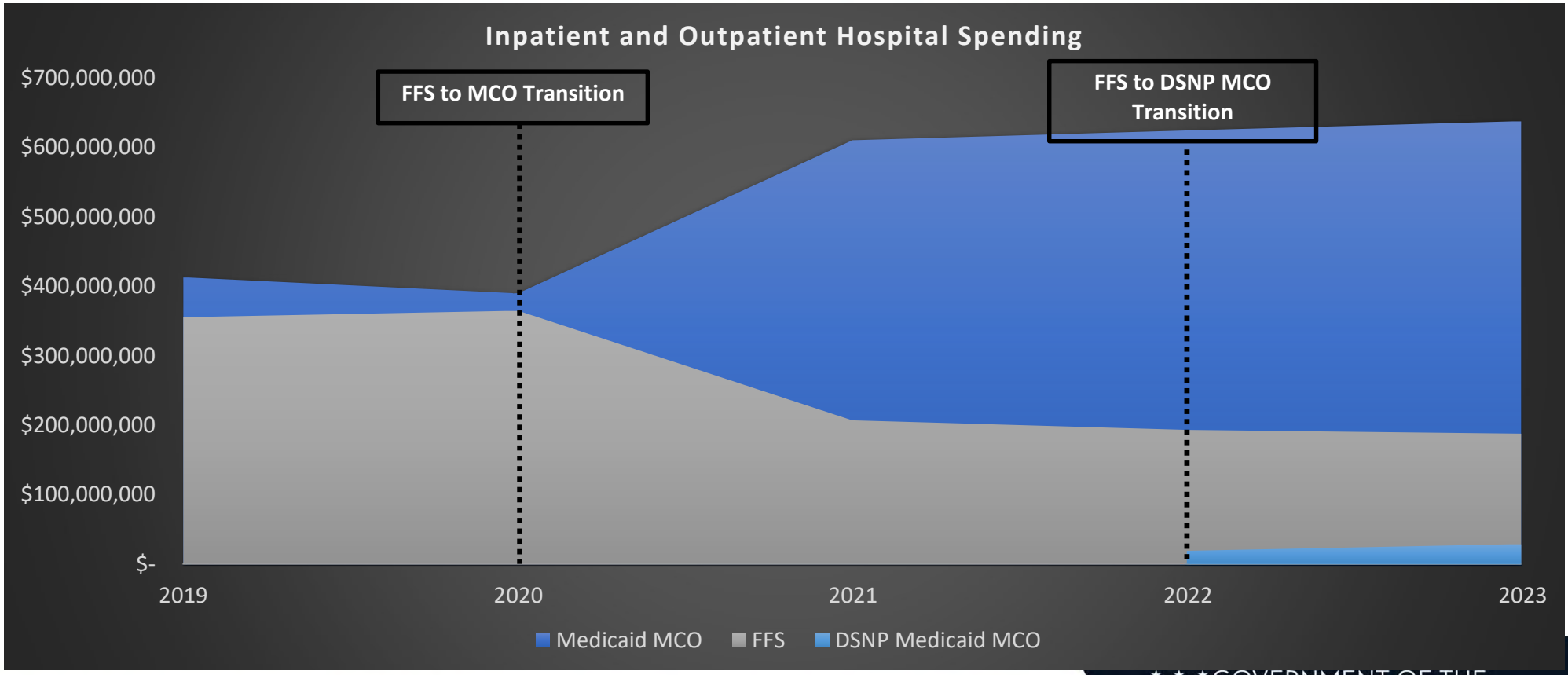
Key Factors

- Beginning in March 2020, Nursing Facility census declined dramatically as a result of COVID-19; including deaths and shifts to HCBS
- In FY20 SNF's received a rate increase to address CNA salary costs
- During the pandemic, SNF's are receiving a 20% increase in the base rate to support cost related to the pandemic

Changes in FY23 Budget

- In FY22, SNF rates have been rebased and include assumptions to support impacts of the ongoing impacts of cost related to COVID-19

As the District Moves Toward More Coordinated Care for District Medicaid and Alliance Beneficiaries, More Hospital Costs are Captured Under Managed Care



FY2023 FFS Program Rate Updates

- **Rebasing Rate Update –** In line with the relevant SPA requirements, the reimbursement rates for the following services will be updated in FY 2023 using the providers audited cost information. The rebasing of rates are typically conducted every 3-4 years.
- **Services**
  - ICF/IID
  - IDD Waiver
  - IFS Waiver
- **Effective Date**
  - January 1, 2023

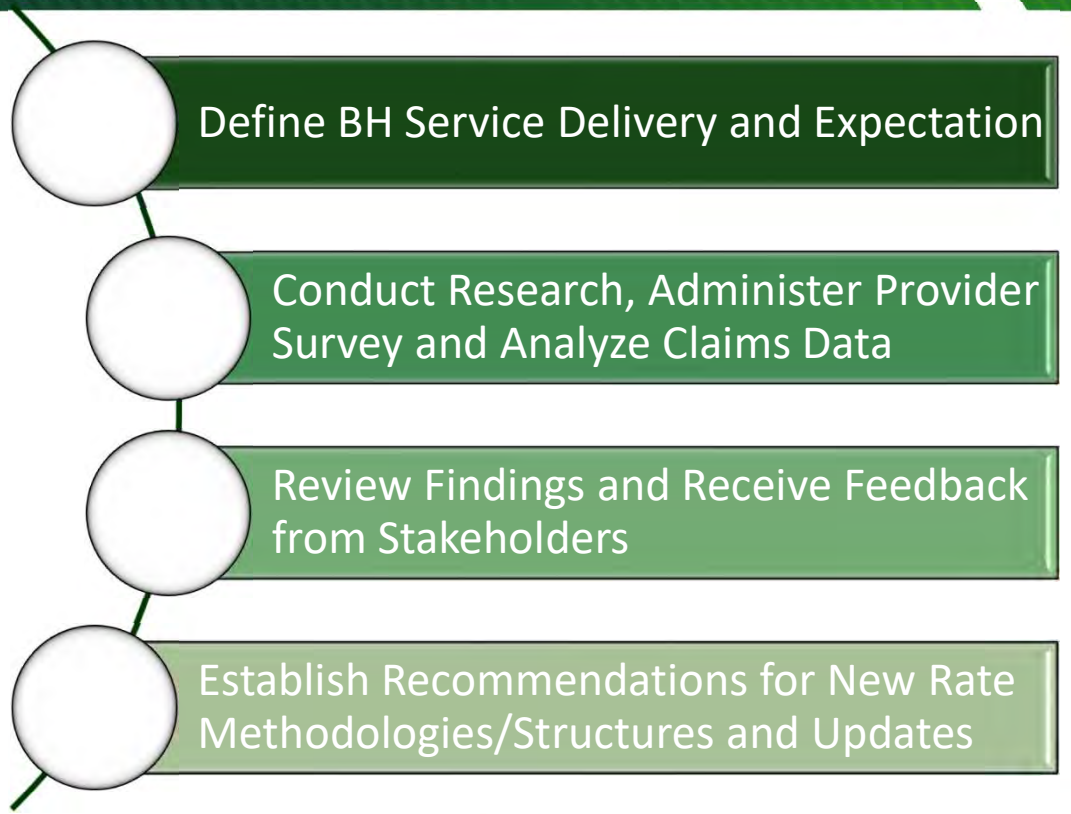
- **Periodic Rate Updates –** the following services are subject to the annual/ periodic adjustments based on either the District's living wage, the CMS market basket or CMS fee schedules.
- **Services**
  - Hospital
  - Direct Support Professionals (HHA, BH and DD Waiver providers)
  - Skilled Nursing and Private Duty Nursing
  - Fee Schedule – Physician, DME, Lab & Anesthesia
- **Effective Date**
  - Living Wage – Jan 1, 2023 (possibly July 1, 2023)
  - CMS Market Basket – October 1, 2022, or Jan 1, 2023
  - CMS Fee Schedule – Jan 1, 2023

DHCF is Collaborating with DBH on a Comprehensive Review of DC's Medicaid Behavioral Health Provider Reimbursement Rates

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.

Milestones: DHCF's contractor has completed a cost survey of District BH providers and has begun analyzing survey and claims data. Work will be completed in phases to allow for simultaneous District review and feedback.

Timeline: The contractor will finalize its recommendations by September 30, 2022. Implementation of new rates is scheduled for October 1, 2023.

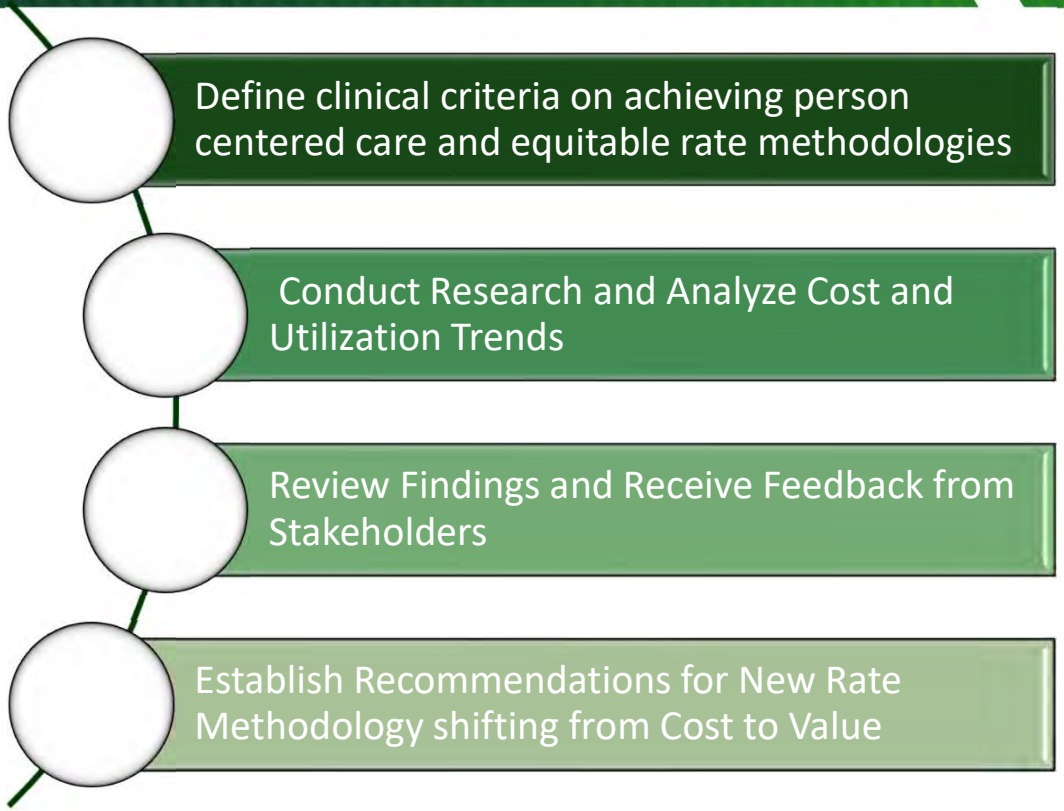


DHCF is Committed To Better Align the Home Health Rate Methodologies To Support Quality, Whole Person Care to Achieve Better Outcomes for Residents

Goal: to establish rate methodologies that will support Home Health Agencies to focus on improving beneficiary experience of care and appropriate services to obtain better outcomes for an individual

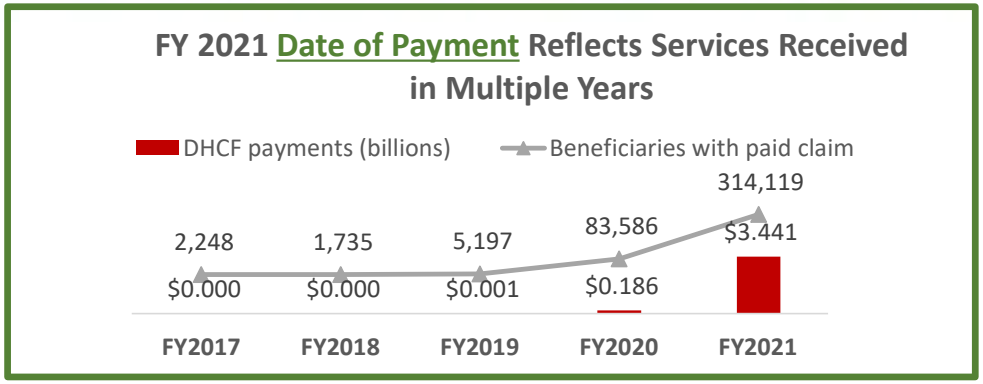
Milestones: DHCF will complete a Home Health Rate Study to determine a rate methodology that will promote person centered quality care; as well as ensure a sustainable rate to maintain access of care

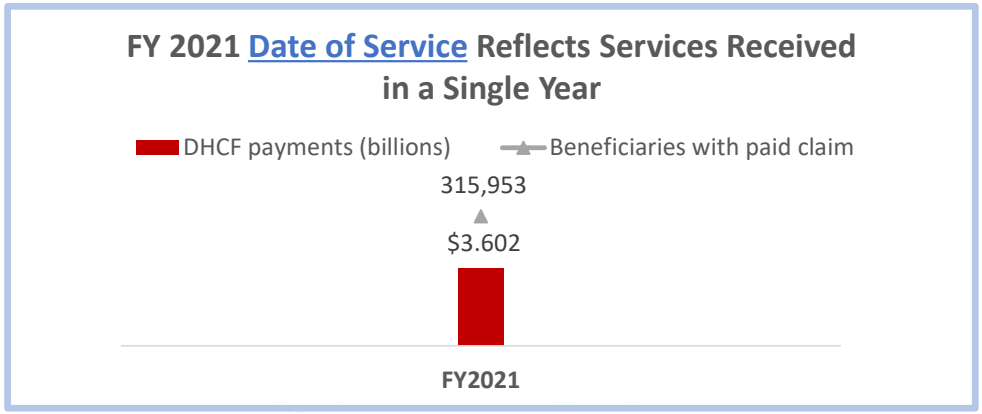
Timeline: The RFP for the study will be issued in Spring 2022 and will include community participation to ensure the anticipated goals are met to establish a proposed methodology change for FY24



Budget Figures Reflect Date of Payment While Most Beneficiary Population Analyses Reflect Date of Service

- **Date of payment** analyses reflect the amount paid based on when the claim was billed for a given period within the fiscal year
  - Claims submitted by providers in a given month will be allocated to the month the claim was paid (unless the claim is from a previous fiscal year, in which case the claim is posted against an accrual)
  - Used for budgeting and forecasting to determine the amount of funds needed to pay claims within the fiscal year; helps determine billing and spending trends
- **Date of service** analyses reflect a year or other period when services were received, regardless of paid date
  - Representative of enrolled population during period
  - Requires several months after the period ends for data to be reasonably complete, due to lag between service receipt and payment
  - Often used for beneficiary and population profiling





Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of payment or dates of service in FY 2021.
Note: Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Includes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Presentation Overview

- ❑ **Overview Of District's Budget For FY2023**
- ❑ **Overview of Deputy Mayor, Human Support Services Cluster Priorities**
- ❑ **Cedar Hill Regional Medical Center Progress**
- ❑ **DHCF Program Overview**
- ❑ **DHCF Budget Development and Rates**
- ☑ **Building Infrastructure to Support Program Value & Accountability**
  - **DC Access System Eligibility System**
  - **Health Information Exchange**
- ❑ **Medicaid Program Overview**
  - Eligibility
  - Enrollment
  - Utilization and Spending Trends
- ❑ **Medicaid Program Trends**
  - Medicaid Managed Care
  - Fee-For-Service
  - Pharmacy
  - Behavioral Health
  - Long-Term Care
- ❑ **Alliance**
- ❑ **Conclusion**

Strengthening Infrastructure: Evolution of District Direct

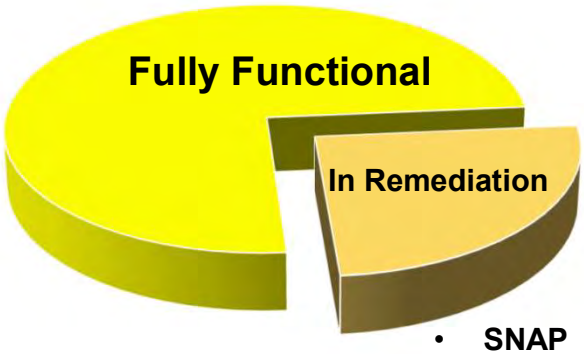
RELEASE 1

- APTC
- MAGI Medicaid

- Non-MAGI Medicaid
- Long Term Care
- TEFRA/Katie Beckett
- Breast and Cervical Cancer
- IDD, EPD, IFS Waivers
- Spend-Down
- Medicaid Case Audit
- Interfaces w/ DMV, BOE, OCFO, USPS,

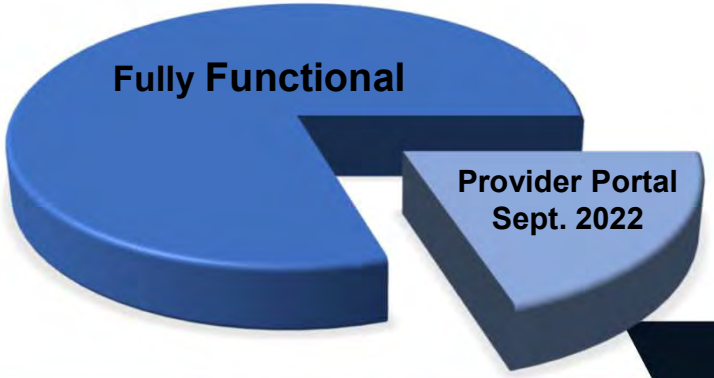
RELEASE 2

- Cash Eligibility
- SNAP Applications
- Fraud Management



- Enhanced Integrated Application
- SNAP Eligibility
- SNAP Notices
- Payment/EBT Processing

RELEASE 3



District Direct: How it Works

District Direct's Online and Mobile App are a one stop shop entry points that put power into the hands of our residents to apply for and manage their benefits at their convenience. When District Direct is live, customers will be able to do the following:

- **Connect to their existing accounts** to see active cases or in progress tasks, such as needing to submit verification documents or recertify
- **Submit applications** for food, cash, and medical benefits
- **Recertify** for the benefits
- Provide **changes of circumstances**, as needed
- View a **personalized dashboard** with required tasks, status, cases, and more available (must have a connected account)
- **Manage and view their benefits** (e.g., active cases, payment details, EBT card balances)
- View **electronic notices** (paper notices will still be sent)
- Review **frequently asked questions (FAQs)** and **contact details** for the agencies

Customer Technology Comparison

What is the difference between District Direct, DC Health Link, and the DHS Benefits Portal?

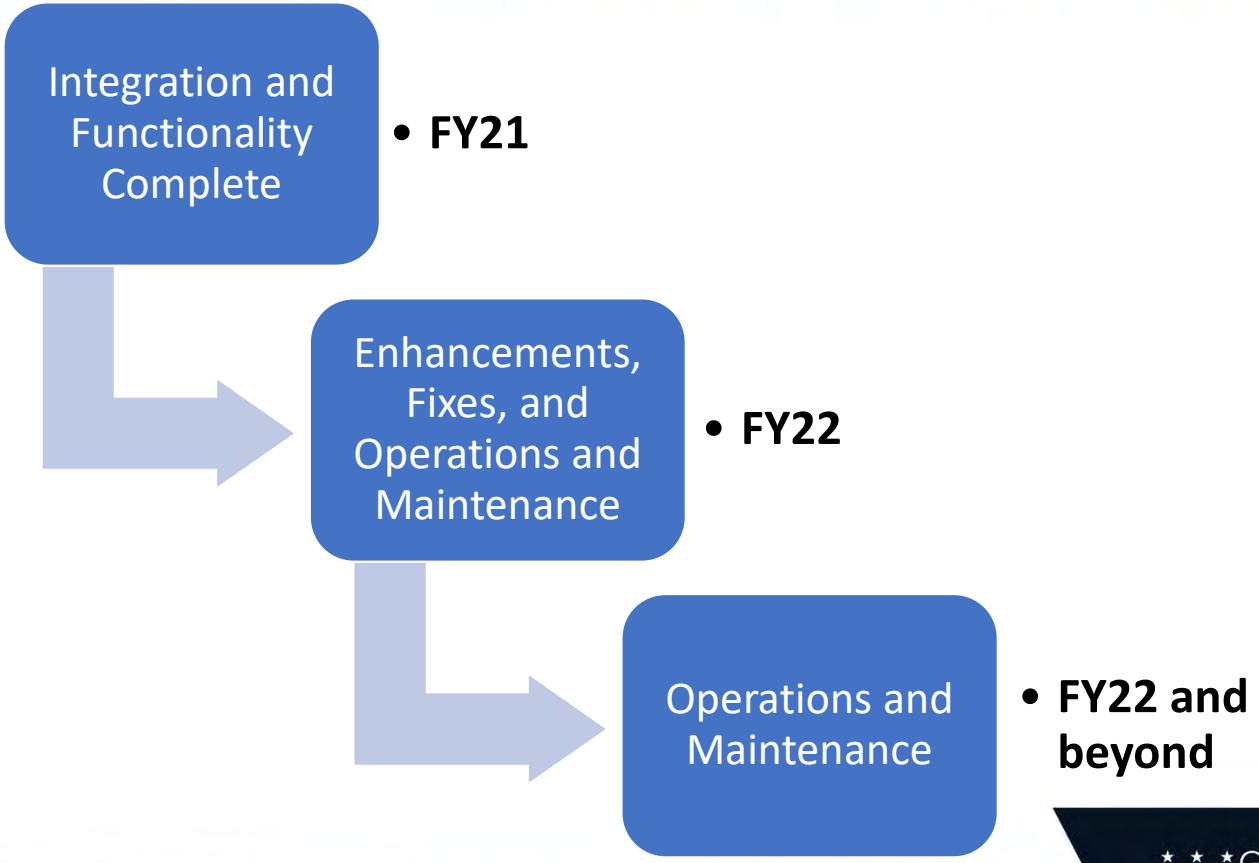
PRIOR STATE

DISTRICT DIRECT	DC HEALTH LINK	Benefits PORTAL
Customers use the District Direct mobile app to **apply and manage their food, cash, and medical benefits (Non-MAGI)**	Customers use DC Health Link **to apply for Medicaid and search for insurance options for themselves or their employees** (small businesses)	Customers use the BSA Portal to **apply, recertify, submit changes of circumstance, and other forms** for food, cash, and medical (Non-MAGI) benefits

CURRENT STATE

DISTRICT DIRECT	DC HEALTH LINK
Customers will come to the District Direct Online or Mobile App to **apply and manage their food, cash, and medical benefits (MAGI and Non-MAGI)** in a single, integrated application	Customers will come to DC Health Link **to search for insurance options for themselves or their employees** (small businesses) if they do not need any financial assistance

The Future of District Direct



DC HIE: Due to Strategic Investments Made Over the Past 5 Years, The District is Connected

The demand and use for HIE is increasing among providers owing it to the vast network connected in the District.

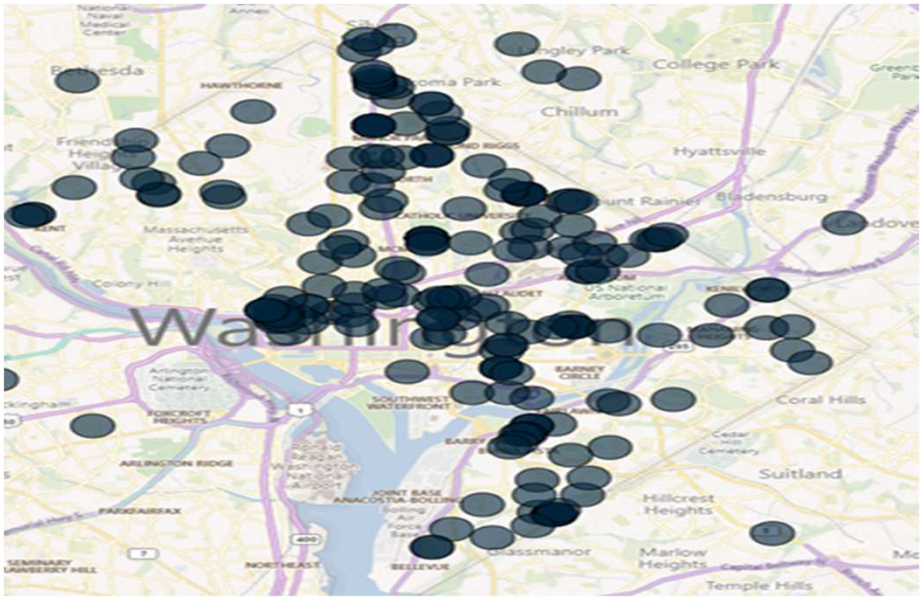
Major Providers and Health Systems are Connected:

- 8 Hospitals
- 36 Long-Term Care Facilities including 15 Nursing Facilities
- 20 Home Health Providers
- 8 Federally Qualified Health Centers (all)
- 30 Behavioral Health Providers
- 8 Community-Based Organizations

HIE Use at a Glance

Metric	Value	YOY Change *(February 2021 to February 2022)*
CRISP DC Users	13,184	15%
Patient Care Snapshot	1,156	1%
Encounter Notification Services access	619	28%
Sharing Admit, discharge, transfer	294	16%
Sharing clinical care documentation	200+	33%

DC HIE Connectivity: DC and beyond the borders of the District



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

Critical Infrastructure (e.g., Encounters and Alerts) Lookup)	Consent	Registries	Directory and Secure Messaging	Screening and Referral (e.g., SDOH)	Advanced Analytics for Population Health Management
ADT Alerts	eConsent Solution	Care Management Registry	Provider Directory	eReferral Screening	CRISP DC Reporting Services
Health Records	-SUD (42 CFR Part 2) Data Consent -HIPAA Consent -Telehealth Consent	Advance Care Planning	Community Resource Inventory	-Social needs screening for housing and food insecurity -eReferral	Performance Dashboards
Patient Snapshot		-Advance Directives -eMOST			Vaccine Tracker
Image Exchange					

2022 Update to the State Medicaid Health IT Plan (SMHP) Reviews Progress to Date

The DC HIE is now a stable, sustainable network, with committed partners and core capabilities that are widely adopted across the care continuum

- Investments in connectivity outreach, engagement, and technical assistance supported growth in the DC HIE participation
- Nearly all Medicaid beneficiaries today have a provider who is sending and receiving data through the DC HIE.
- The Community Resource Information and Exchange (CoRIE) Project expanded sending, receiving, and exchanging capabilities to include Community Based Organizations.

Investment in DC HIE infrastructure and TA have improved access, but challenges remain on use

- Need for greater standardization and timeliness of data flowing into the DC HIE from participating providers.
- More education, training, and technical assistance to promote the use of the DC HIE.
- Need for greater support to ensure that providers, particularly small/under resourced, have the tools and knowledge to participate in the DC HIE.

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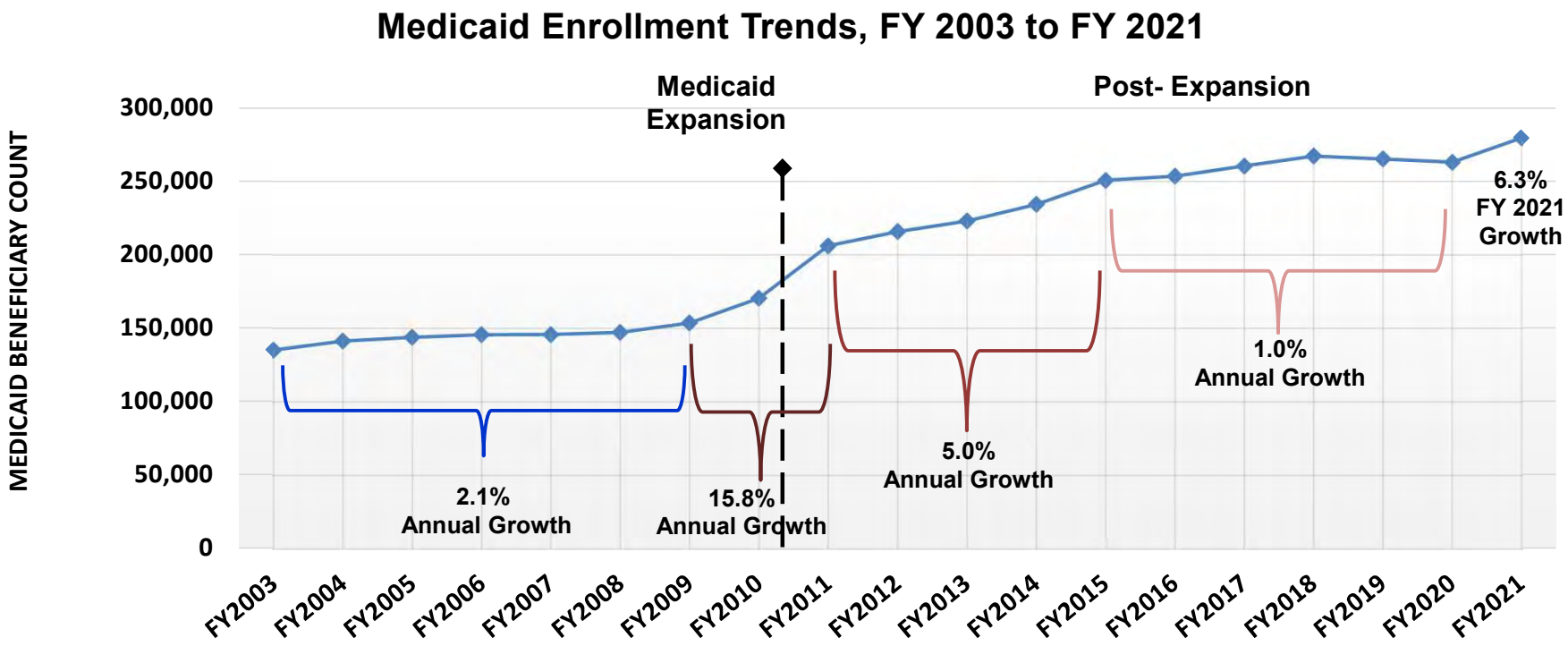
- ❑ **Conclusion**

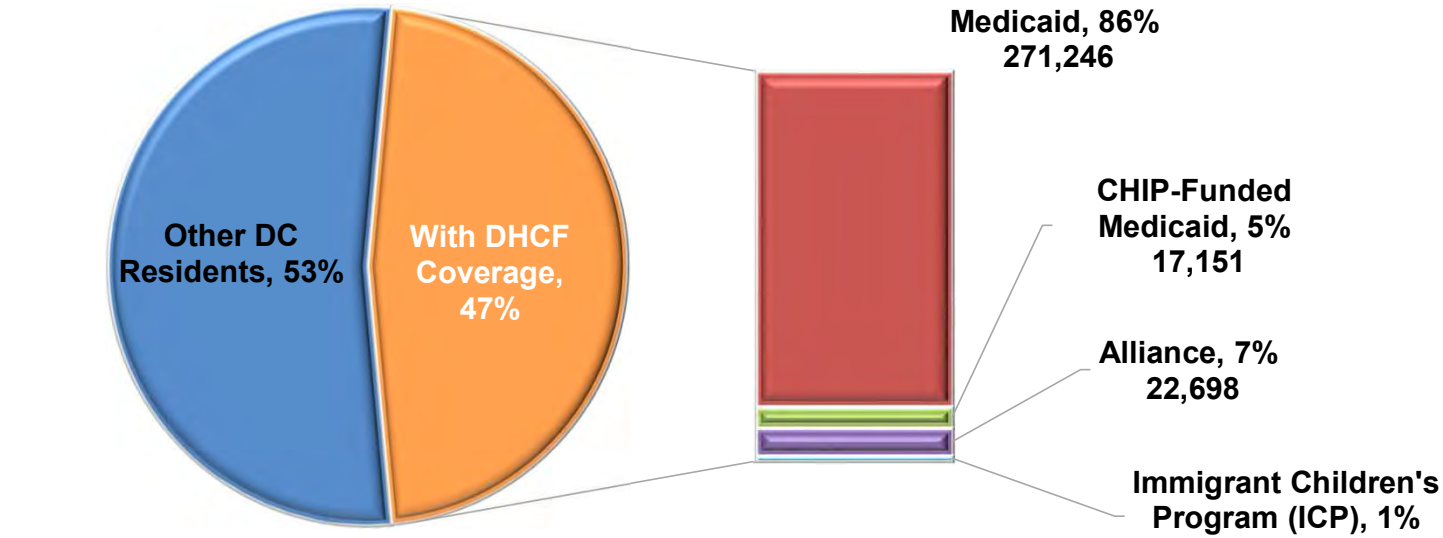
Medicaid Enrollment Is Highest It Has Ever Been



Source: Data for FYs 2000-2009 extracted by Xerox from tape back-ups in January 2010. Data for FYs 2010-2020 from DHCF's Medicaid Management Information System as of March 2022. Figures are average monthly.

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

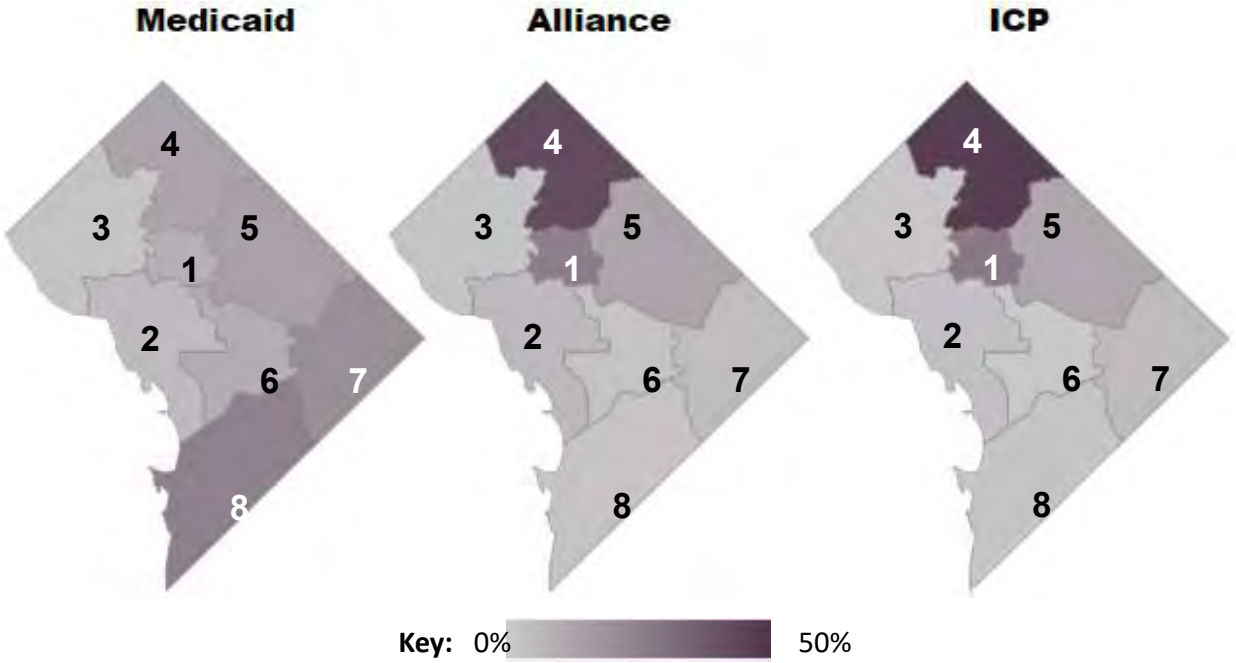
Proportion of DC Residents with DHCF-Funded Coverage, FY 2021



Source: District population estimate reflects July 1, 2021, from U.S. Census Bureau. Medicaid, Alliance, and ICP data reflects January 2022 enrollment as of 1/31/2022 from DHCF's Medicaid Management Information System.
Note: The District resident total was substantially revised downward due to the 2020 Census and may undercount certain individuals (e.g., those who are not U.S. citizens) and thus the percentage with DHCF coverage may be overstated. 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

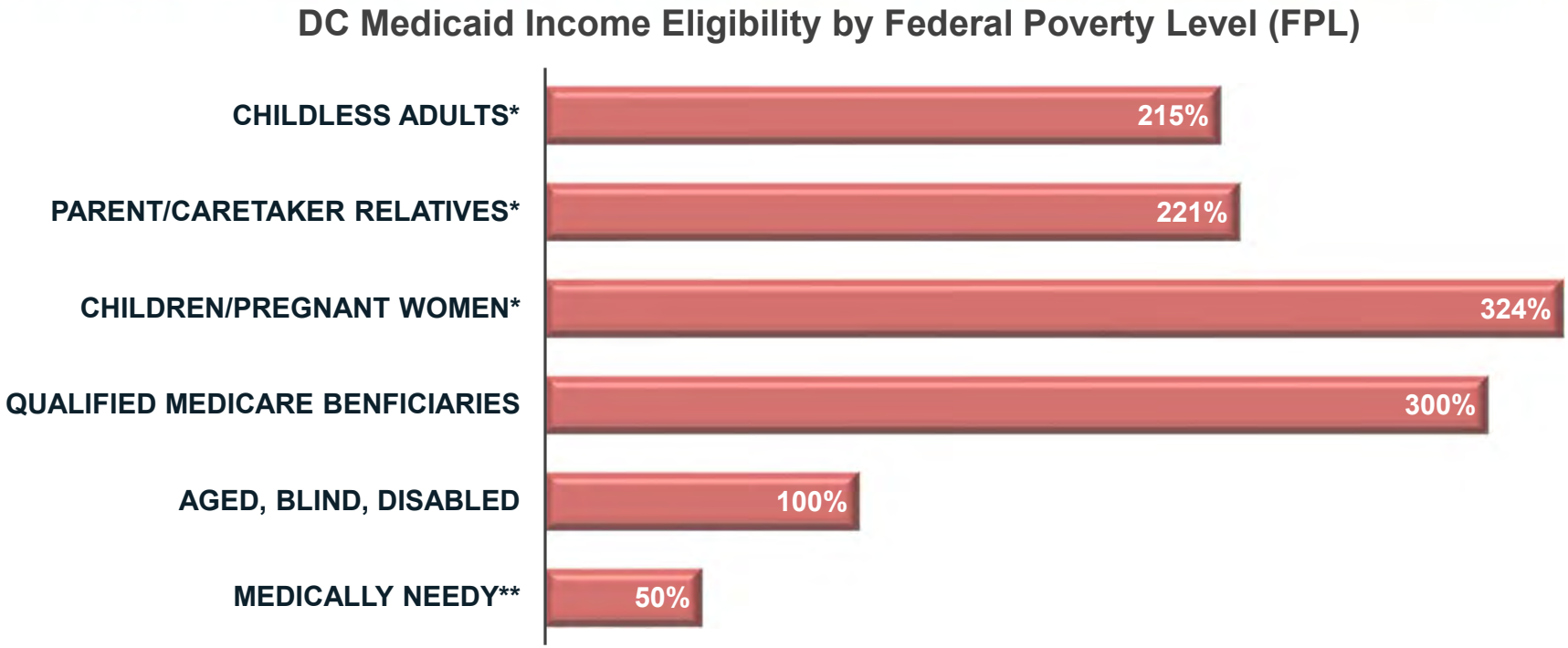
Ward Distribution by Program Type, FY 2021



Ward	Medicaid	Alliance	ICP
1	9%	23%	25%
2	5%	6%	3%
3	2%	2%	2%
4	13%	37%	42%
5	14%	12%	11%
6	10%	2%	1%
7	20%	4%	5%
8	24%	2%	2%
Other*	4%	12%	10%

Source: DHCF Medicaid Management Information System data extracted in March 2022. **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).

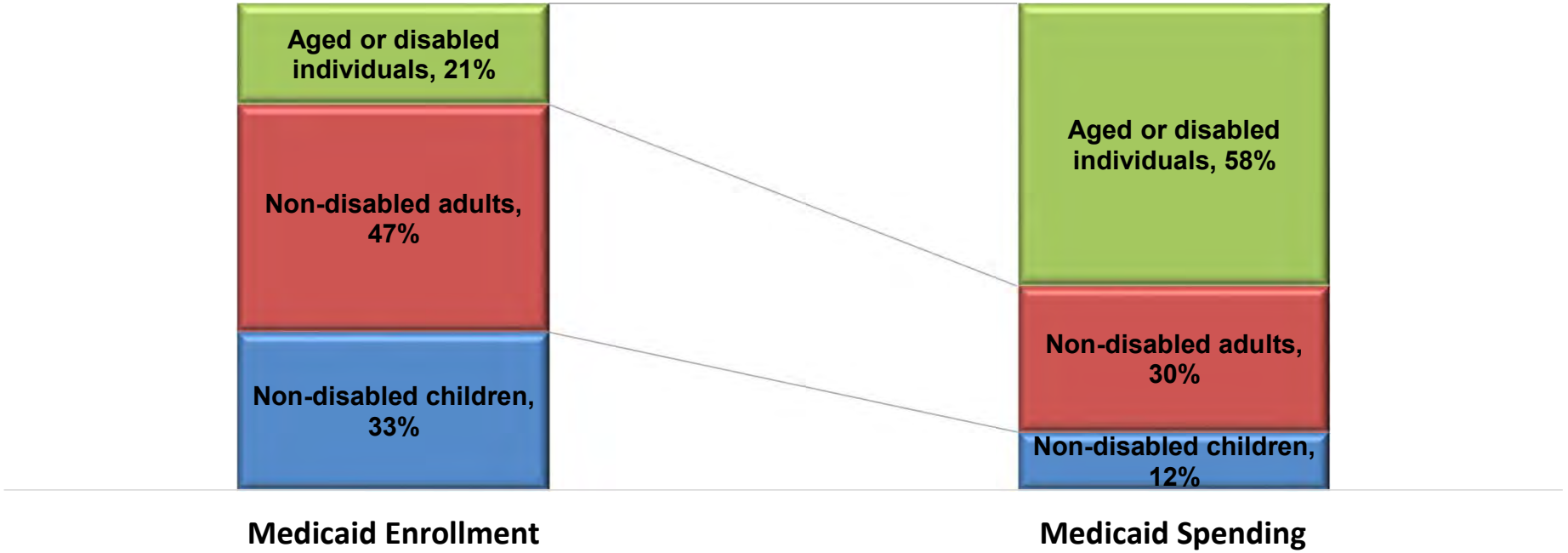
In the District, Most Low-Income Non-Elderly Adults Are Medicaid-Eligible



Note: Low-income is 200% FPL, which is $27,180 for an individual or $55,500 for a family of four in 2022.
* 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

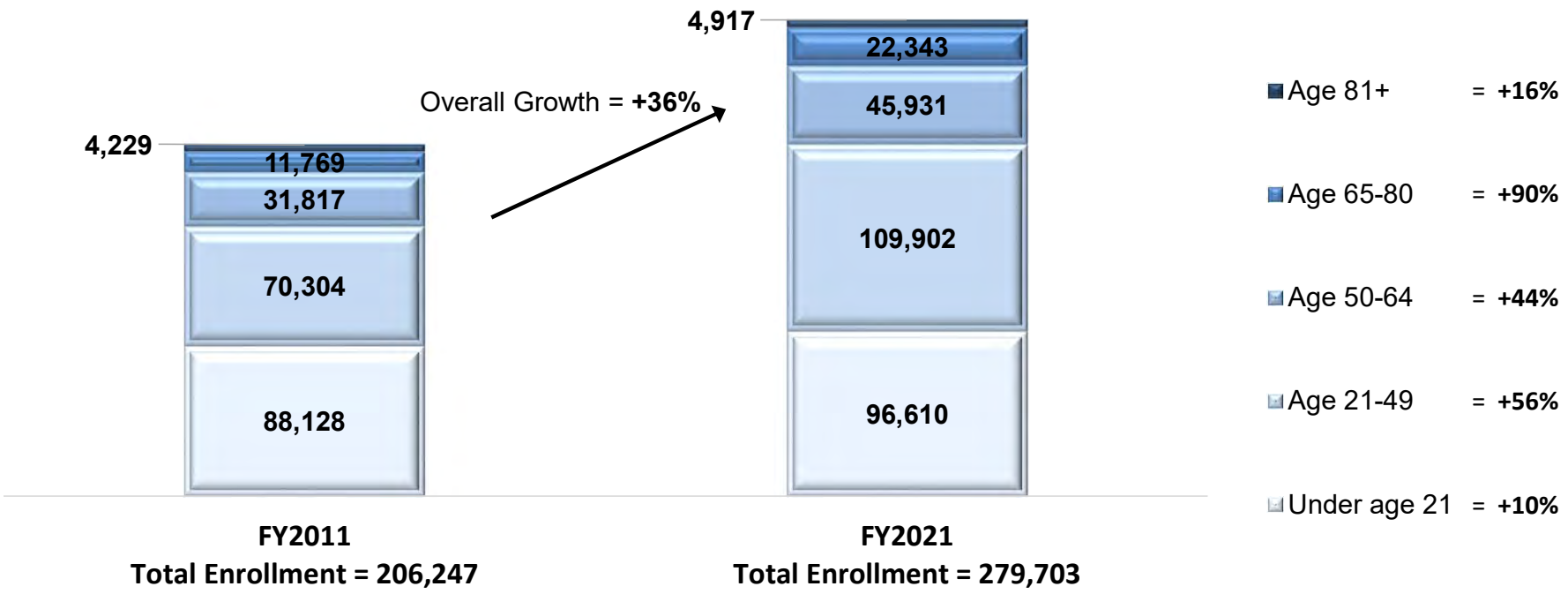
Medicaid Enrollment and Spending by Eligibility Group, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.
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 2021

Medicaid Enrollment Growth by Age, FY 2011-FY 2021

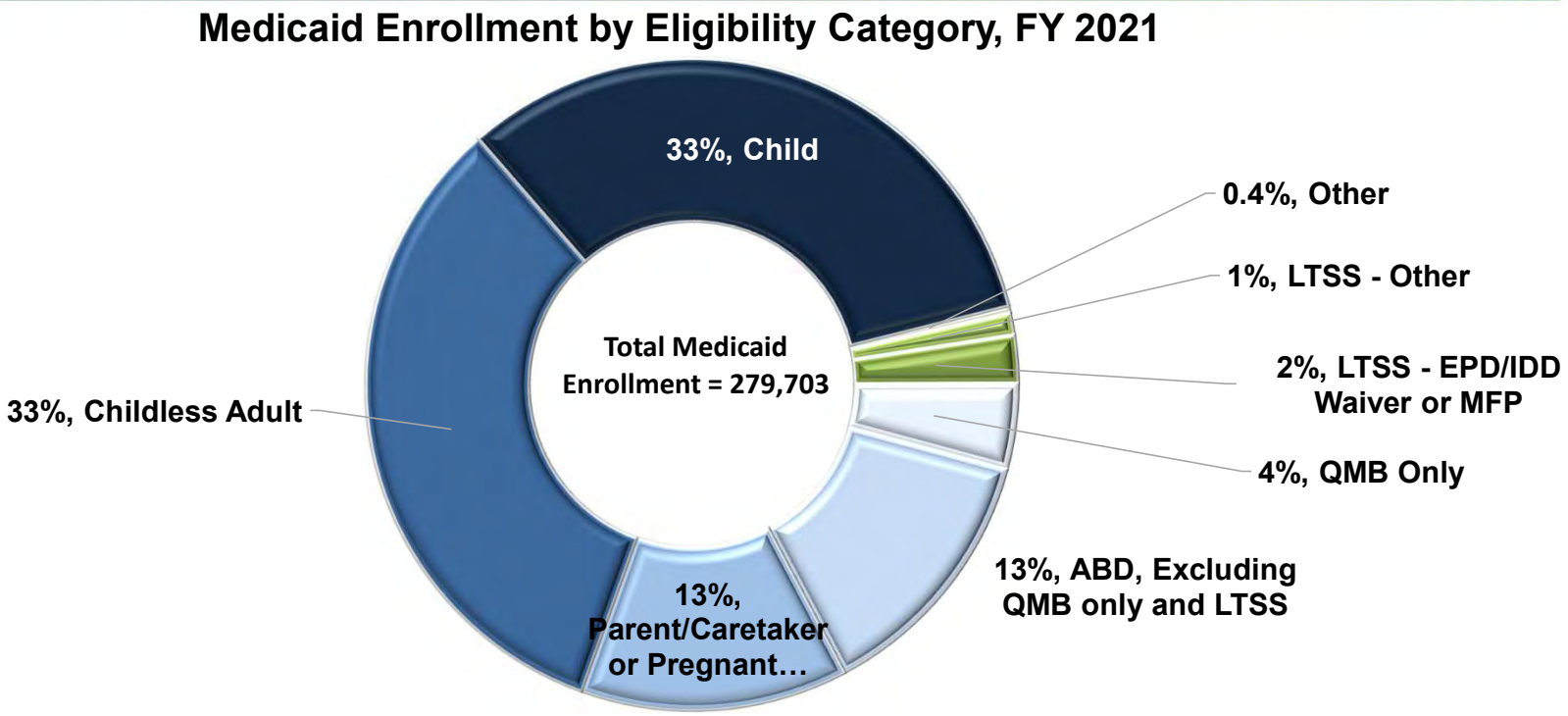


FY2011
Total Enrollment = 206,247

FY2021
Total Enrollment = 279,703

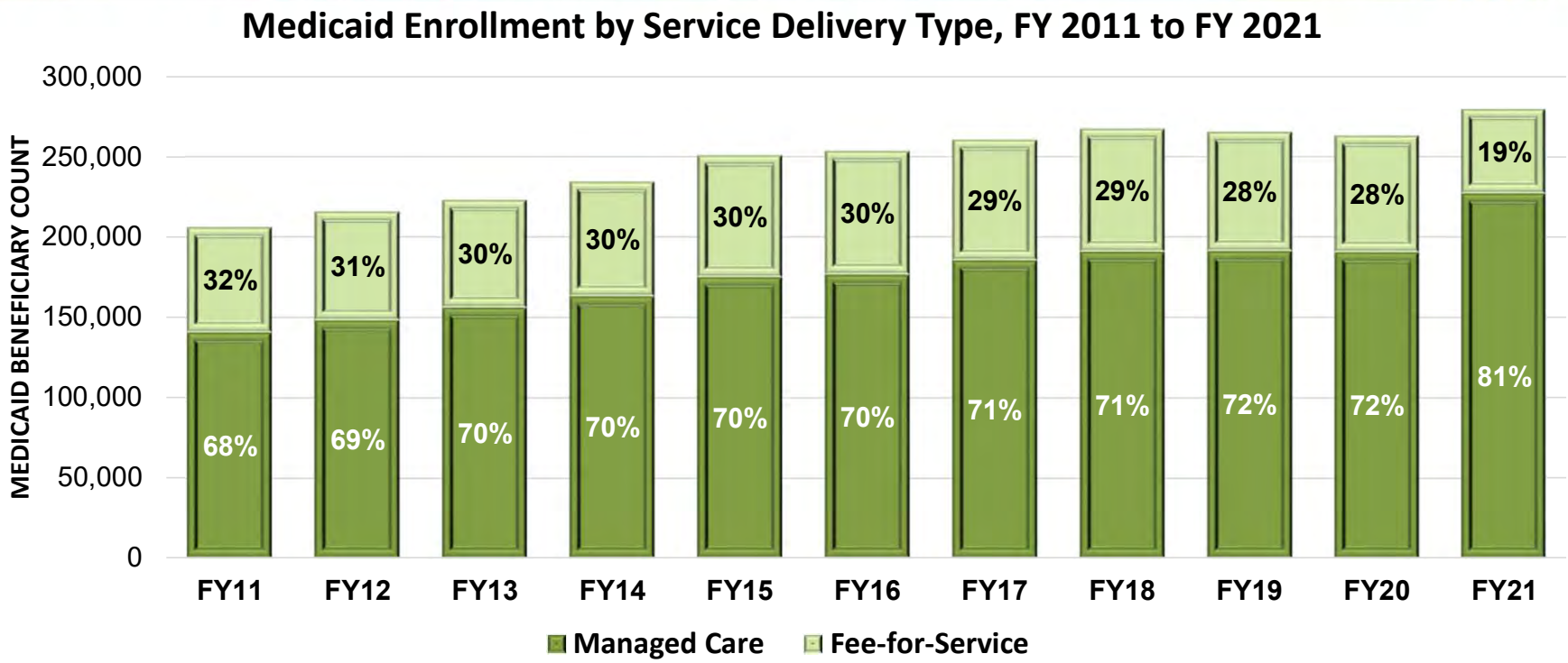
Source: DHCF Medicaid Management Information System data extracted in March 2022.
Note: Enrollment reflects average monthly.

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



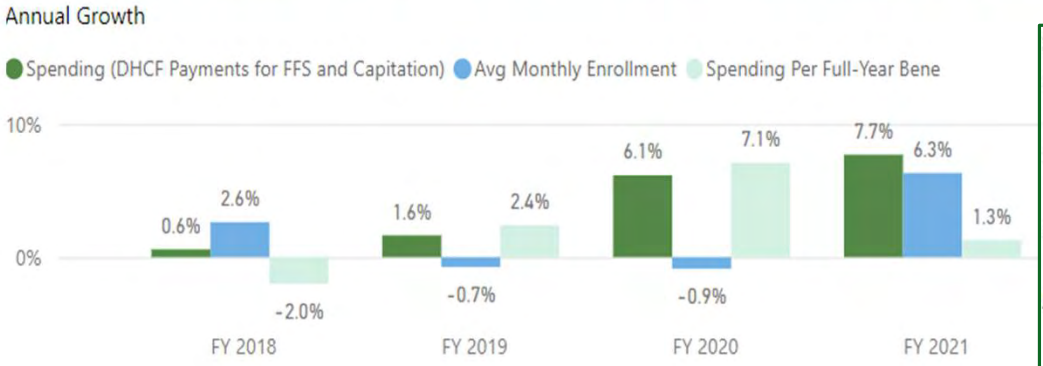
Source: DHCF Medicaid Management Information System data extracted in March 2022.
Note: Enrollment reflects average monthly. ABD = aged, blind, or disabled; EPD = Elderly and Persons with Disability; ICF = intermediate care facility; IDD = Intellectual or Developmental Disability; LTSS = long-term services and supports; MFP = Money Follows the Person; NF = nursing facility; QMB = Qualified Medicare Beneficiary.

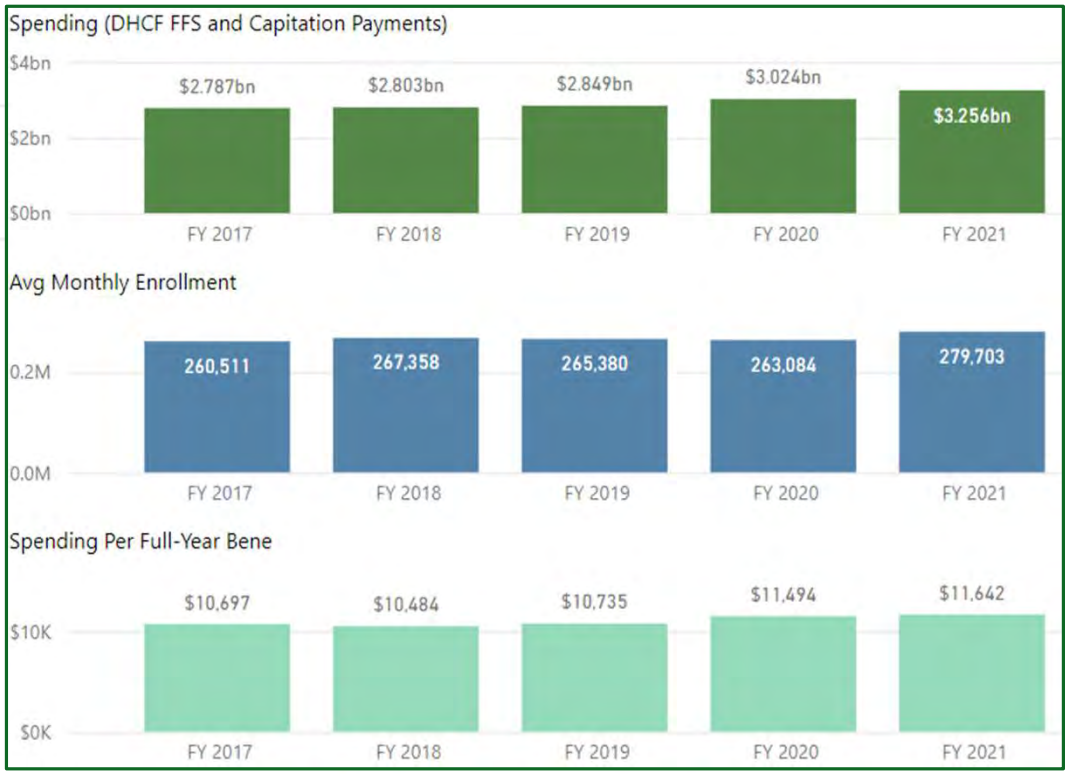
More Than 80% of the District's Medicaid Enrollees Are in Managed Care



Source: DHCF Medicaid Management Information System data extracted in March 2022.
Note: Enrollment reflects average monthly.

Enrollment and Spending Per Beneficiary Contributions to Overall Medicaid Growth Have Varied Over Time

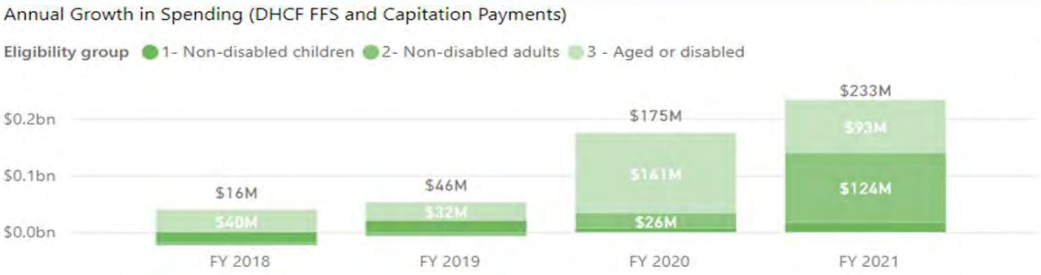


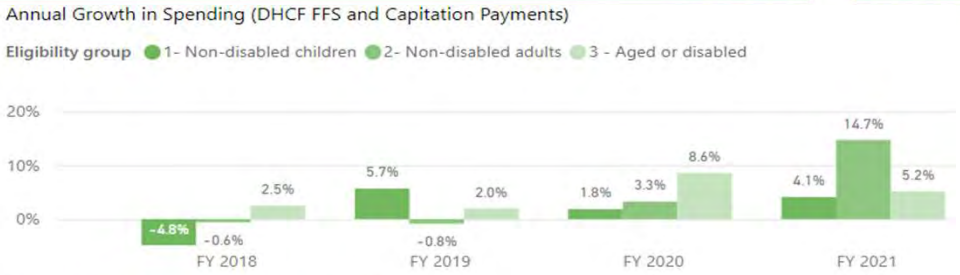


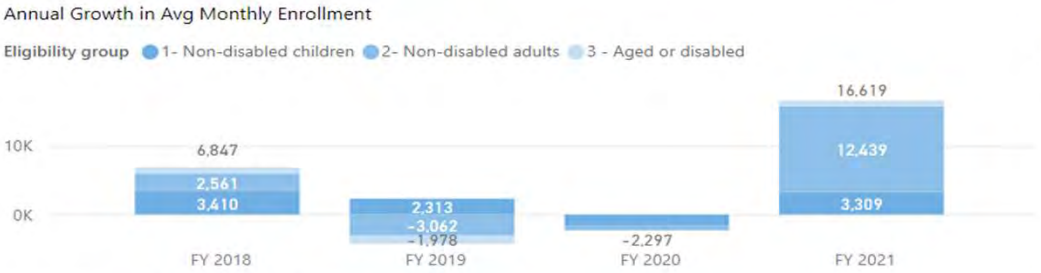
- In FY 2021, growth in **average monthly Medicaid enrollment (6.3%)** was a key contributor to growth in **overall Medicaid spending (7.7%)** while **spending per beneficiary (1.3%)** played a smaller role; enrollment was also the largest contributor in FY 2018
- In FY2020, growth in **spending per beneficiary (7.1%)** was a key factor driving **overall Medicaid spending growth (6.1%)** as there was a slight decrease in **average monthly Medicaid enrollment (-0.9%)**; spending per beneficiary was also the largest contributor in FY 2019

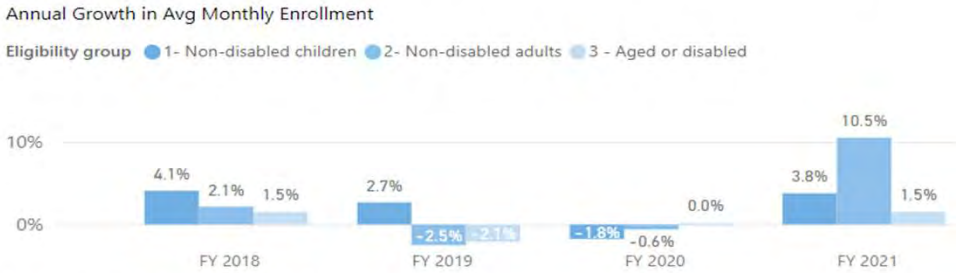
Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.
Note: Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

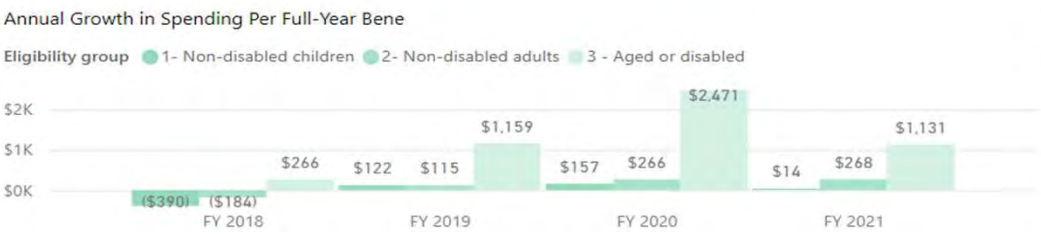
Child, Adult, and Aged/Disabled Population Contributions to Medicaid Growth Also Vary

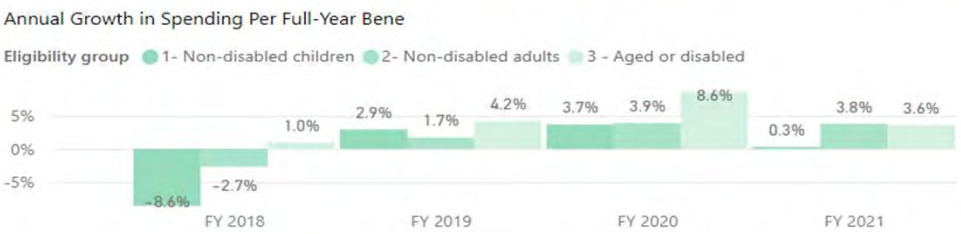












Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.
Note: Spending reflects DHCF payments for both capitation and any fee-for-service utilization. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Child, Adult, and Aged/Disabled Population Contributions to Medicaid Growth Also Vary (continued)

FY 2021

Non-disabled adult enrollment and aged/disabled spending per beneficiary were key drivers of the $233 million in overall Medicaid spending growth

- Non-disabled adults accounted for $124 million (14.7% growth for this group) out of the $233 million; this was mostly attributable to enrollment growth (10.5%), with spending per beneficiary growth (3.8%) playing a smaller role
- Aged and disabled beneficiaries accounted for $93 million (5.2% growth for this group); this reflected modest enrollment growth (1.5%) as well as spending per beneficiary growth (3.6%)
- Non-disabled children accounted for the remaining $16 million (4.1% growth for this group); this was largely due to enrollment growth (3.8%) rather than spending per beneficiary growth (0.3%)

FYs 2018-2020

Aged and disabled beneficiaries were the largest contributor to overall Medicaid spending growth, but reasons varied

- For example, growth in overall spending for this group in FYs 2019-2020 was entirely due to spending per beneficiary, as enrollment was flat or decreased
- In FY 2018, growth was attributable to an increase in both spending per beneficiary and enrollment

FY 2019

Spending on non-disabled adults fell by 0.8%, due to a decrease in enrollment

FY 2018

Spending on non-disabled children fell by 4.8%, due to a decrease in spending per beneficiary

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with dates of service in FY 2021.
Note: 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).

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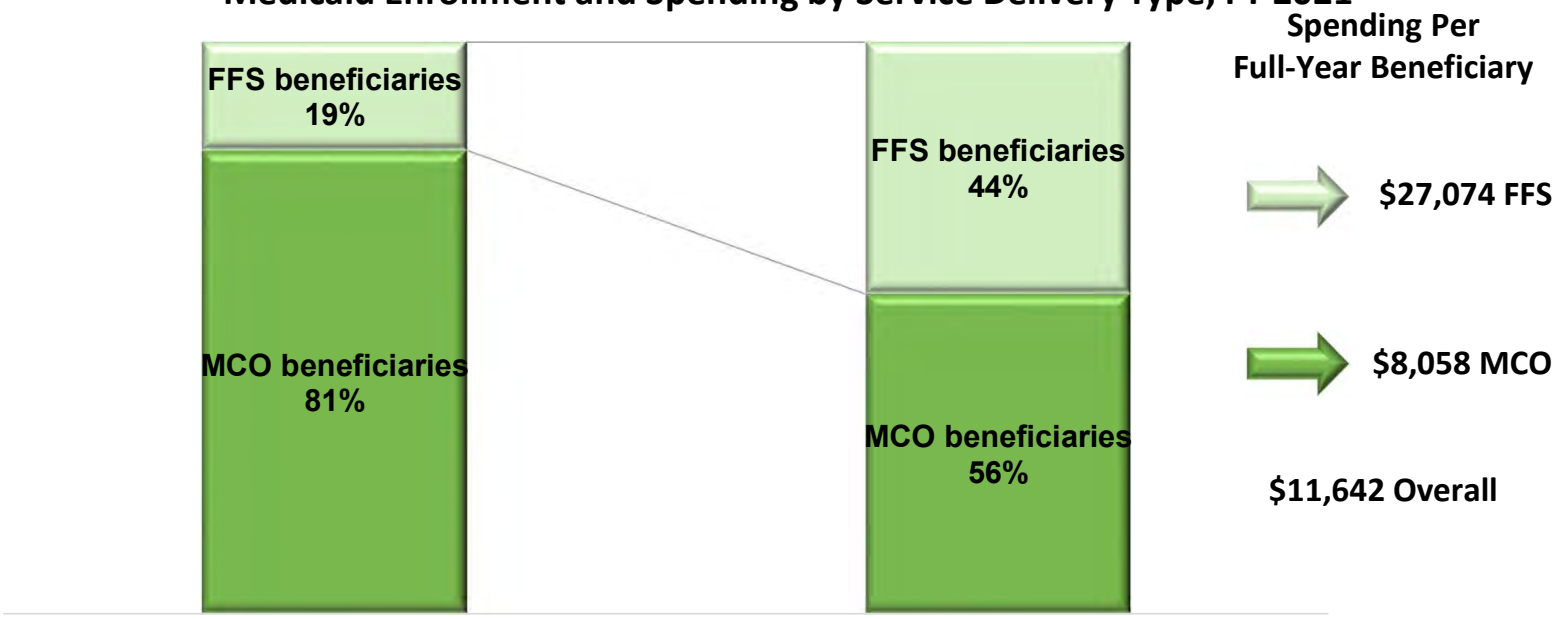
Most Beneficiaries Are in Managed Care But Spending Is Substantial for Those Remaining Fee-For-Service

Medicaid Enrollment and Spending by Service Delivery Type, FY 2021



Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for eligibility in FY 2021 and claims with dates of service in FY 2021.

Note: Enrollment reflects average monthly and spending per full-year beneficiary reflects 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 (48%)
  - Diabetes (27%)
  - Hyperlipidemia (27%)
  - Rheumatoid Arthritis/Osteoarthritis (19%)
  - Chronic Kidney Disease (18%)

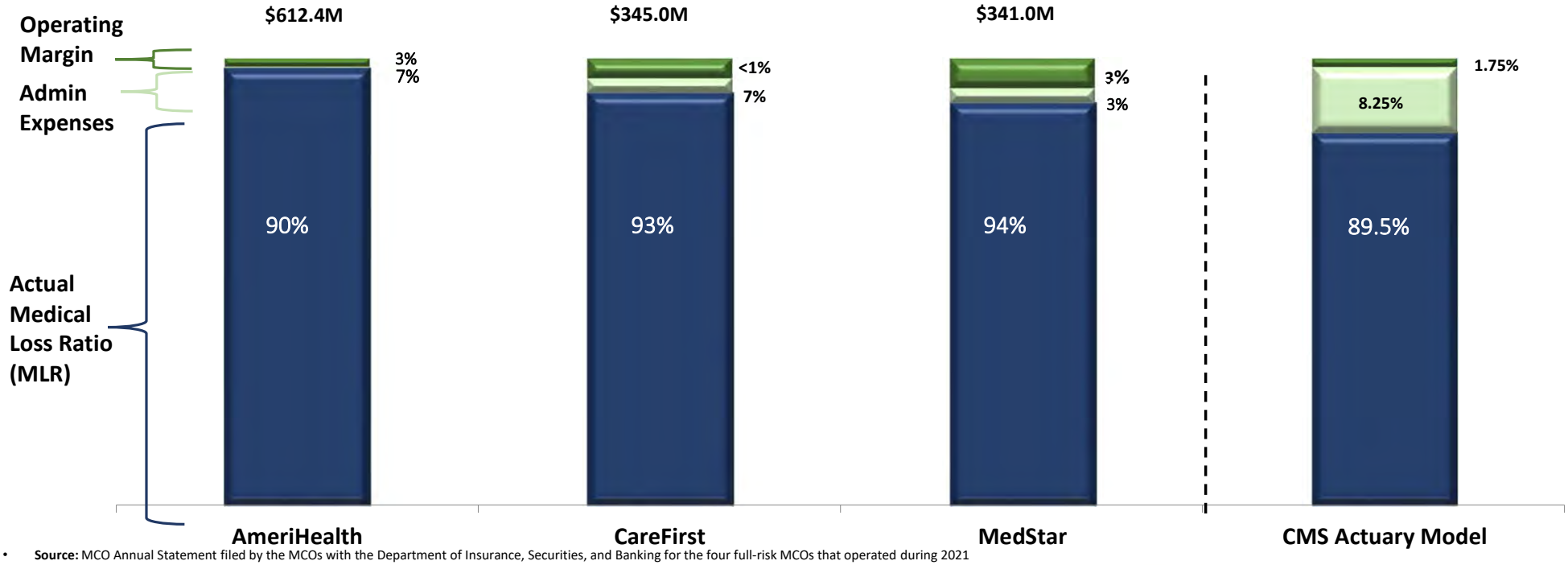
- **FFS Medicaid-enrolled children were less likely than adults to have a chronic condition and were more likely to have different conditions affecting them:**
  - Asthma (8%)
  - Depression (3%)
  - Anemia (2%)

- **MCO Medicaid-enrolled adults were most likely to have the following chronic conditions:**
  - Hypertension (19%)
  - Hyperlipidemia (11%)
  - Depression (9%)
  - Diabetes (9%)
  - Asthma (9%)

- **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 (10%)
  - Depression (3%)
  - Anemia (2%)

The Unquestioned Value Of Universal Contracting In The Managed Care Program

Actual MCO Revenue for January 2021 to December 2021



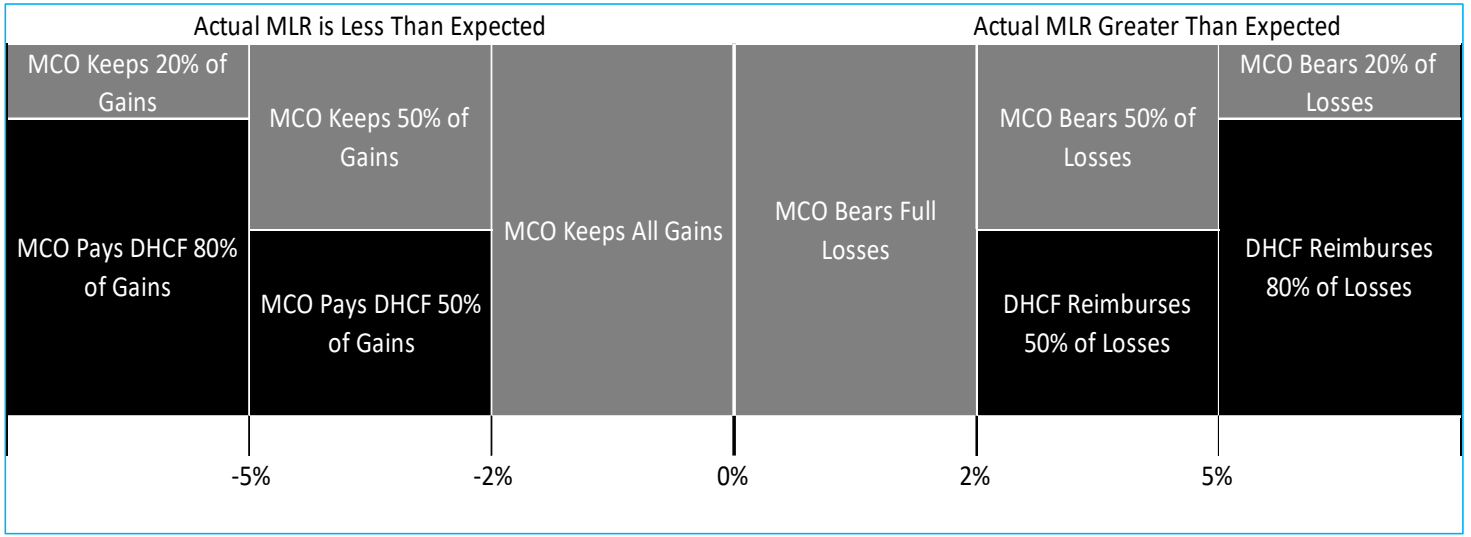
- **Source:** MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the four full-risk MCOs that operated during 2021
- **Note:** MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments 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, 2021, 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.

Methodological Rate Shift (Risk Corridors)

DHCF implemented risk corridors for the DCHFP and Alliance programs starting in FFY 2022. Prior to FFY 2022, these programs were full risk to the MCOs. The CASSIP has had a risk corridor in place prior to FFY 2022.

- **What is a risk corridor?** A risk corridor is a two-sided financial risk mitigation tool that provides protection to both the MCOs and the District by limiting the losses or gains an MCO can experience during a specified time period. The MCO retains much of the front-end risk of this arrangement, with the District sharing in an increasing share of the risk if the costs escalate.

The risk corridor for DCHFP and Alliance is designed around the Medical Loss Ratio (MLR) developed in rate setting as follows:



Several Metrics Quantitatively Assess the Efforts by MCOs to Achieve Value in Health Care

DHCF continues to monitor the Pay for Performance (P4P) indicators for each of the District's full-risk health plans but suspended the financial withhold in FY 2021 due to a new procurement of health plans.

P4P indicators include:

- Emergency room utilization for non-emergency conditions
- Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
- Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization

DHCF continues to develop and implement provider-level practice transformation initiatives (i.e., Integrated Care DC, RevUp DC, and the business transformation grant) to assist in their successful transition to value-based payment models as a part of the MCO VBP contract requirements.

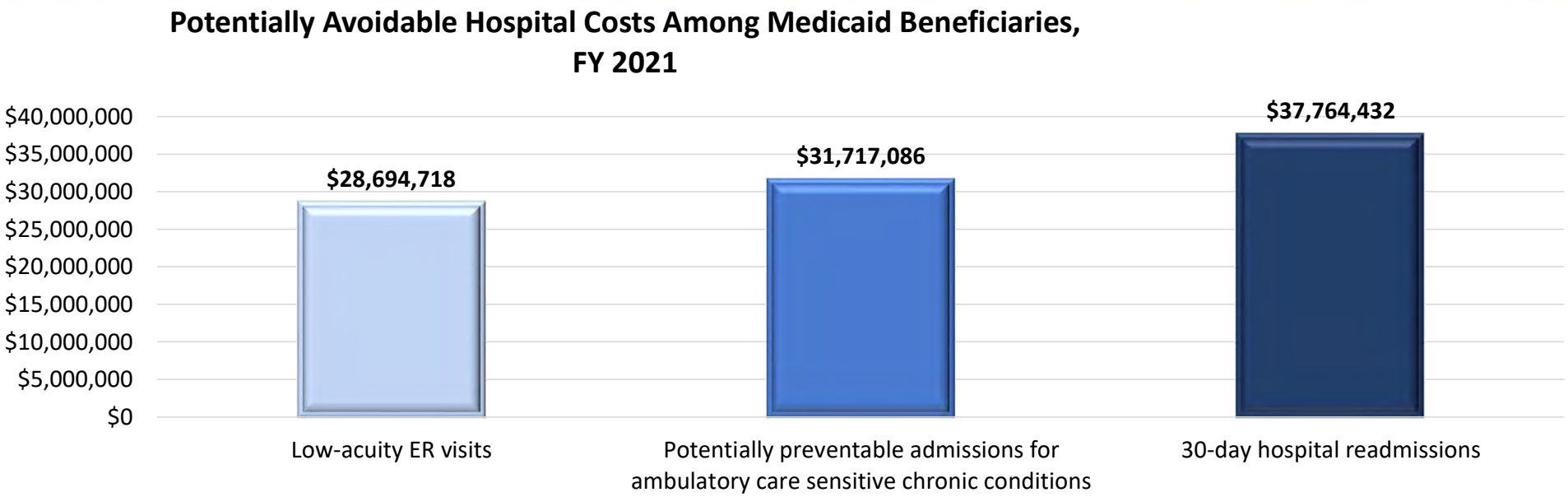
Medicaid MCO Results Mixed During FY 2021 due to SSI Inclusion, COVID-19

Performance Metrics			
Health Plan	Preventing Use of Emergency Room for Non-Emergencies	Preventing Hospital Readmissions Within 30 Days of Previous Admissions	Preventing Avoidable Hospital Admissions
Did the Health Plan Improve From FFY20 Results?			
AmeriHealth	Yes	No	No
CareFirst	Yes	No	No
MedStar	*	*	*

Health Plan Improvement From FFY20			
AmeriHealth	9.5%	-58.0%	-29.4%
CareFirst	6.4%	-48.9%	-48.0%
MedStar	*	*	*

- **Source:** Calculations performed by Mercer Consulting using MCO encounter data.
- **Note:** Results reflect experience from FFY21 (October 2020 to September 2021) with runout through December 2021. In FFY21 SSI Adults transitioned to the managed care program. This population has significantly higher PPA and inpatient readmission rates, which drives the rise in these metrics when comparing FFY20 to FFY21. Both FFY20 and FFY21 experience is affected by depressed medical service utilization due to the impact of COVID-19, which may influence the P4P metric results.

Over $ Million Medicaid Costs Potentially Avoidable in FY 2021



Number of Medicaid beneficiaries in population analyzed = 286,248

Source: DC Medicaid Management Information System (MMIS) data extracted in March 2022 for FFS claims and MCO encounters with FY 2021 dates of service.

Note: Beneficiaries identified were enrolled in Medicaid as of September 2021. There may be an undercount of service use for enrollees who are dually eligible for Medicare due to incomplete crossover claims.

Well Child Visit Rates Have Fallen During the COVID-19 Pandemic

Fiscal Year	Percentage of Children Under 21 with a Well Child Visit	Number of Children Under 21 with a Well Child Visit	Total Children Under 21
2018	63%	57,528	91,450
2019	63%	59,535	94,048
2020	50%	46,234	92,023
2021	54%	52,252	96,294

- Prior to the COVID-19 pandemic, the percentage of Medicaid children receiving a well child visit was steady or increasing
- Similar to other states, the District experienced a drop in well child visits early in calendar year 2020 that coincided with the start of the pandemic
- Well child visits rates have not yet rebounded to reach pre-pandemic levels, but the rate increased from 50% to 54% between FY 2020 and FY 2021

Source: CMS Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report. Results are preliminary for FY 2021.
Note: Reflects Medicaid beneficiaries under the age of 21 with at least 90 days of continuous coverage.

Drugs in the Pipeline and Pharmacy Payment Trends

New and evolving drug treatments

- Drugs in the pipeline that may have a fiscal impact in FY23 includes treatment for Cancer, Alzheimer's Disease, Plaque Psoriasis, and Type 2 Diabetes.

Pharmacy Payment Trends			
FFS	FY 2019	FY 2020	FY 2021
Pharmacy total	$216,218,694	$226,527,602	$165,745,862

FFS Pharmacy

- Drugs that have impacted pharmacy costs are treatments for HIV/AIDS, Antipsychotics, Pulmonary Arterial Hypertension (PAH) Oral & Inhaled Agents, Opioid Dependence (Medication-Assisted Treatment) & Movement Disorders
- 27% decrease from FY20 to FY21 due to the transition from FFS to MCO of the Adults with Special Health Care Needs population, effective 10/1/2020.

MCO population	Pharmacy PMPM trend in FY 2023 rate development
Medicaid children	+3.6%
Medicaid adults	+4.0%
Alliance adults	+6.8%

MCO Pharmacy

- Pharmacy per member per month (PMPM) trend is driven by unit cost and utilization increases
- Growth is particularly high for Alliance adults

New in FY2023: Expansion of Pharmacist Responsibility in Providing Access to Care

- **Expanding Scope of Practice for Pharmacists to provide enhanced patients services**
  - Wellness screenings
  - Immunizations
  - Smoking Cessation counseling
  - Telepharmacy counseling
  - Point of care testing (HIV, influenza, blood pressure, COVID, etc.)
  - Providing diagnosis for acute conditions (influenza, COVID, etc.)
  - Prescribing medications under Collaborative Practice Agreements (e.g., oral contraceptives, antivirals, smoking cessation, etc.)
  - Medication Therapy Management

- **Provider Status Recognition Equals Provider Reimbursement**
  - Pharmacists and pharmacists' patient care services are not included in key sections of the Social Security Act (SSA), which determines provider eligibility for health care programs such as Medicare Part B and Medicaid, thereby not allowing reimbursement to be paid to pharmacists for their provision of patient care
  - The omission of pharmacists as listed providers limits Medicare and Medicaid beneficiaries' access to pharmacists' services in the outpatient setting.
  - Pharmacists have demonstrated their value while playing a crucial role in COVID-19 pandemic response by being available and accessible as front-line health care professionals
  - The District's inclusion of pharmacists as Medicaid providers will enhance the access of beneficiaries to the most accessible of health care providers

- **Continuation of COVID-19 Enhancements**
  - Maintain the flexibilities and authorities extended to pharmacists by the federal government under the District's State Plan once the PHE has ended
    - Pharmacist administration of childhood vaccines to patients ages 3 and greater to increase access to care

New in FY2023: Medication Therapy Management (MTM) Services Implementation

- **MTM** is service, or group of services provided by a pharmacist to a patient with the aim to optimize therapeutic outcomes for that individual patient. The services are distinct from medication dispensing & the routine patient counseling provided by a pharmacist when a patient picks up a prescription medication.

- **Services:** Medication Therapy Review (MTR), Pharmacotherapy Consults, Anticoagulation Management, Immunizations/Vaccinations, Health and Wellness Programs, & Other Clinical Services.

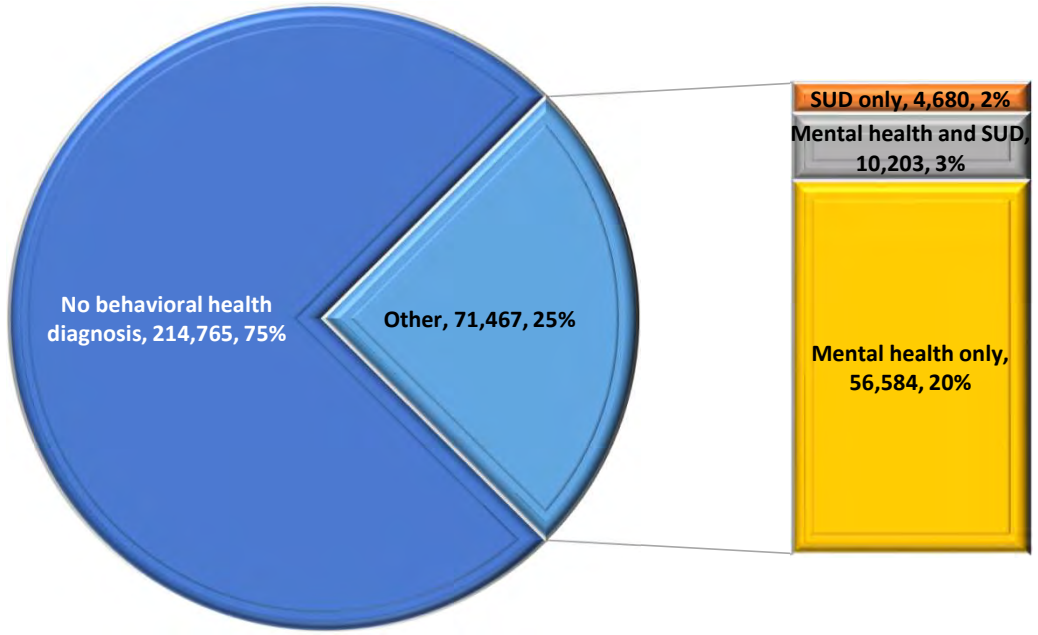
- **Benefits:** Offer patient-centered process of care, increase patient education of medication(s) & management of disease state(s), identify & resolve medication-related problems, reduce healthcare cost, optimize therapeutic outcomes for individual patients, provide collaboration with other healthcare providers, & support continuity of patient care.

- **Current MTM Services:** One (1) DHCF Pharmacist and Two (2) Pharmacy Benefit Manager (PBM-Magellan) Pharmacists provide telephonic MTR to select FFS Medicaid beneficiaries identified from the Pharmacy Lock-In Program, Drug Utilization Review Profiles, & PBM Case Referrals. Also, the MCO Pharmacy Directors/Pharmacists provide telephonic MTR to select MCO Medicaid & Alliance beneficiaries.

- **Future MTM Implementation:** Procure a MTM platform for documentation purposes & expand MTM services role to pharmacy providers for reimbursement, thereby impacting more FFS, MCO, and Alliance beneficiaries.

One-Quarter of Medicaid Beneficiaries Have a Behavioral Health Diagnosis

Distribution of Behavioral Health Diagnoses Among Medicaid Beneficiaries, FY 2021



Mental health and SUD
- SMI and SUD = 8,930
- Non-SMI and SUD = 1,273

Mental health only
- SMI = 31,913
- Non-SMI only = 24,672

Medicaid beneficiaries = 286,232

Medicaid beneficiaries with BH diagnosis = 71,467

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022.
Note: Reflects FY 2021 diagnoses for Medicaid beneficiaries enrolled during September 2021. 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.

The Work on Behavioral Health Transformation Continues

Re-Procurement of the Managed Care Contracts-anticipated October 2022

- To include the majority of the BH Services not currently within the scope of Managed Care
- To include Equitable BH Benefits for Alliance Members

Comprehensive Rate Study –In progress

- Rate Enhancements
- Scheduled rate adjustments for Inflation
- New Services
- Alternative Payment Models that shift from Volume to Value

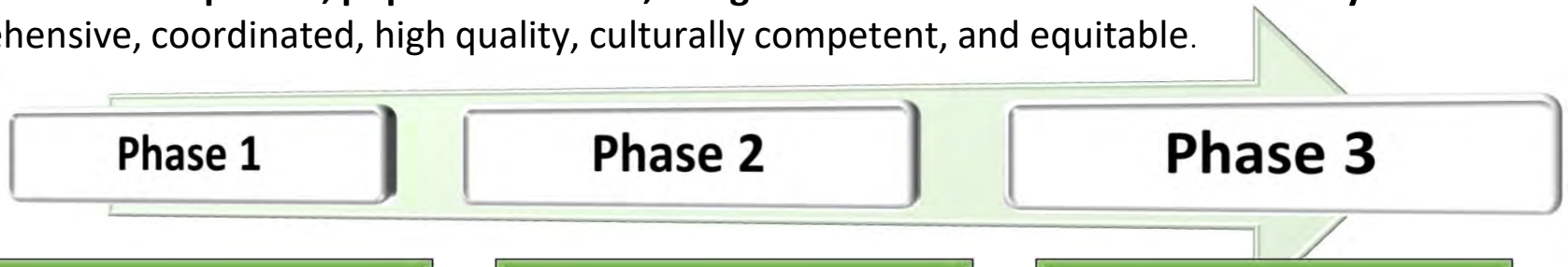
1115 BH Transformation Demonstration Waiver Service Expansion-anticipated April 2022

- Impending CMS SPA Approval to shift Waiver Services to Medicaid Authority
- Advances the District's goals to reduce Opioid Use & Deaths outlined in *Live.Long.DC*

CMS SUD Provider Capacity Grant enters its final year and will focus on sustaining infrastructure and technical assistance to achieve the District's overall objective of providing whole person care.

Planning for FY23 Behavioral Health Changes

DHCF and DBH are implementing a **three-phased approach to Medicaid behavioral health transformation** to achieve a **whole-person, population-based, integrated Medicaid behavioral health system** that is comprehensive, coordinated, high quality, culturally competent, and equitable.



January 2020

- Implementation of the District's Medicaid 1115 Behavioral Health Transformation Waiver
- In FY21, work on the Waiver continues as the District is transitioning 8 of the 10 Waiver services to permanent State Plan authority, beginning January 1, 2022.

October 2022

- Incorporate a full continuum of behavioral health services into Medicaid managed care plans
- **Five key areas of focus**: Services, MCO Contractual Considerations, Provider and Beneficiary Support and Communications, Performance Management, and Provider Rates.

FY23 and Beyond

- Focus on additional opportunities to integrate physical and behavioral health for Medicaid beneficiaries.

Consistent With Recent Years, Home- and Community- Based Services Represent Greatest Share of LTSS Spending

Medicaid LTSS Institutional and Waiver Spending, FY 2021

Service	Total Number of Recipients*	Total Service Cost	Average Cost Per Recipient
Institutional Total*	**4,162**	**$400,148,841**	**$96,143**
Nursing Facility	3,887	$302,524,036	$77,830
ICF/IID	280	$97,624,805	$348,660
HCBS Total*	**8,717**	**$655,519,496**	**$75,200**
State Plan PCA	4,891	$169,861,705	$34,729
EPD Waiver	5,481	$176,372,560	$32,179
IDD Waiver	1,823	$309,285,231	$169,657
Institutional and HCBS Total*	**12,925**	**$1,055,668,337**	**$86,262**

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2022 for claims with FY 2021 dates of service.
Note: Numbers reflect individuals ever receiving a given service during FY 2021.
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.

The District Expanded its D-SNP Program to Improve Alignment and Service Integration for Dual Eligibles

Approximately 39,000 of DHCF's enrolled participants are dually eligible for both the Medicare program and Medicaid:

- About two-thirds are "full duals" enrolled in both Medicare and full Medicaid coverage
- About a third are "QMB only" enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program
- Both can benefit from improved coordination across Medicare and Medicaid

The District seeks to increase Medicare-Medicaid coordination, consistent with federal standards, through its new highly integrated dual eligible special needs plan (HIDE SNP), launched February 1, 2022, in partnership with UnitedHealthcare. The program:

- Offers enhanced care management for many who otherwise lack care management
- Improves integration of benefits and reduce duplication of services between payers
- Simplifies and streamlines navigation of services for beneficiaries and their families and caregivers

The District Expanded its D-SNP Program to Improve Alignment and Service Integration for Dual Eligibles

The program covers a variety of District residents:

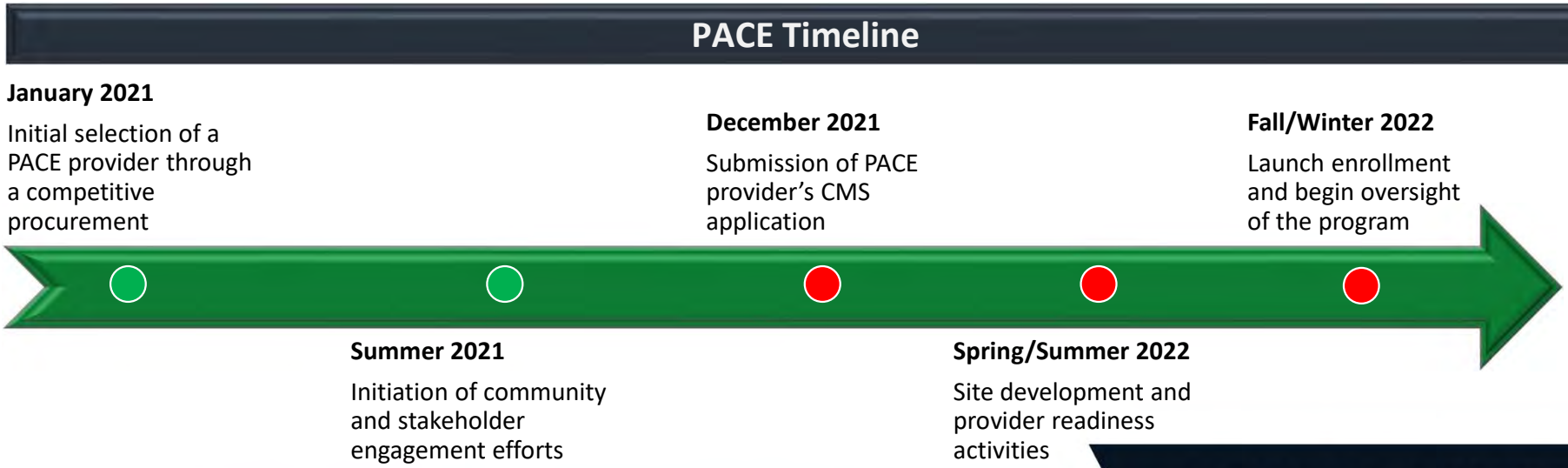
- ❑ About 12 percent are EPD HCBS waiver participants, accessing all of their Medicare and Medicaid benefits through one single program with an integrated, comprehensive care management approach that adheres to the standards set forth in our EPD Waiver
- ❑ More than 40 percent are “QMB only”: enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program. These individuals have access to Medicare coverage, supplemental benefits and cost-sharing
- ❑ The balance are eligible for full Medicaid and Medicare coverage and accessing care management tailored to their health care needs and risks

The program is voluntary; beneficiaries may opt in and out according to their preference.

DHCF Continues Its Efforts to Establish the Program of All-Inclusive Care for the Elderly (PACE)

PACE is a nationally recognized model of care integrating Medicare and Medicaid benefits for some of the District's highest-need beneficiaries: individuals 55+ meeting nursing facility level of care residing in ZIP codes east of the river.

DHCF has made significant strides toward successful implementation of PACE in the District this year, including ongoing partnership with the selected PACE Organization (PACE4DC), submission of its application to CMS for review and approval, and additional policy and program development.



The EPD Waiver Was Renewed for Another Five Years with Key Program Changes

Effective February 2022, CMS approved a five-year renewal of DHCF's 1915(c) waiver program for the Elderly and Persons with Physical Disabilities. Programmatic changes included:

- ❑ Integration of Medicare and Medicaid for waiver enrollees through the HIDE SNP program
- ❑ Increased efficiency and automation in the provider enrollment process
- ❑ Administrative process improvements for the *Services My Way* participant-directed program within the waiver

This renewal also amended a change made in 2020 "delinking" waiver and state plan benefits, which means waiver enrollees will not be limited to a maximum of 16 hours of PCA services per day.

- ❑ This 2020 change was not effectuated during the PHE
- ❑ As a result of the change in the renewal, the 16-hour cap will also not go into effect after the PHE concludes

The renewal allows DHCF to continue the key community-based services that allow enrollees to age in place in the District, including among others:

- ❑ Assisted living facility services
- ❑ Personal care aide services
- ❑ Participant-directed services

Presentation Overview

- ❑ **Overview Of District's Budget For FY2023**
- ❑ **Overview of Deputy Mayor, Human Support Services Cluster Priorities**
- ❑ **Cedar Hill Regional Medical Center Progress**
- ❑ **DHCF Program Overview**
- ❑ **DHCF Budget Development and Rates**
- ❑ **Building Infrastructure to Support Program Value & Accountability**
  - **DC Access System Eligibility System**
  - **Health Information Exchange**
- ❑ **Medicaid Program Overview**
  - Eligibility
  - Enrollment
  - Utilization and Spending Trends
- ❑ **Medicaid Program Trends**
  - Medicaid Managed Care
  - Fee-For-Service
  - Pharmacy
  - Behavioral Health
  - Long-Term Care
- ☑ **Alliance**
- ❑ **Conclusion**

Updates To Alliance Coverage Eliminate Barriers to Coverage and Expand Access to Care

- Alliance beneficiaries now have access to non-emergency transportation to maternal related medical appointments through their health care coverage

- Alliance beneficiaries no longer must recertify face to face and can utilize the various modes of application (mobile, on-line, fax and in person)

- Alliance beneficiaries are only required to recertify once a year

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

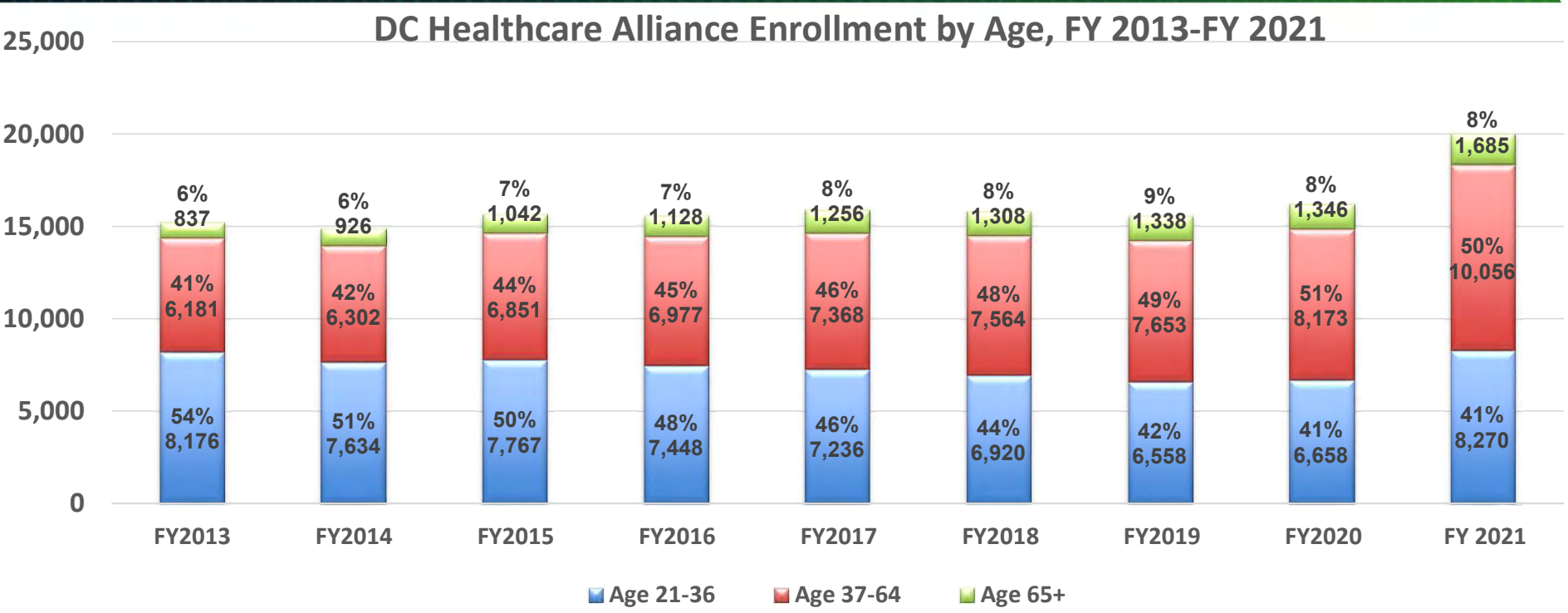
DC Alliance and ICP Income Eligibility by Federal Poverty Level (FPL)

Key facts about Alliance/ICP:

- Alliance beneficiaries accounted for 7% of DHCF program enrollment in FY 2021; 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 2019 uninsured rate for noncitizens (12.7%) was substantially less than the national rate (32.1%)

Note: Low-income is 200% FPL, which is $27,180 for an individual or $55,500 for a family of four in 2022.
* DHCF is in the process of rulemaking to align Alliance and ICP income thresholds and methodologies with Medicaid income levels shown here. Current thresholds for Alliance and ICP are at 200% FPL.
** Data extracted from U.S. Census Bureau, 2019 American Community Survey 1-year estimates. Rates reflect the civilian noninstitutionalized population.

Overall Alliance Enrollment Has Increased Substantially During the PHE; Alliance Population Age 37+ Has Grown While Younger Population Has Fallen



Source: DHCF Medicaid Management Information System data extracted in March 2022.
Note: Data reflects average monthly enrollment. Age 37 corresponds with a cutoff used to determine managed care rates.

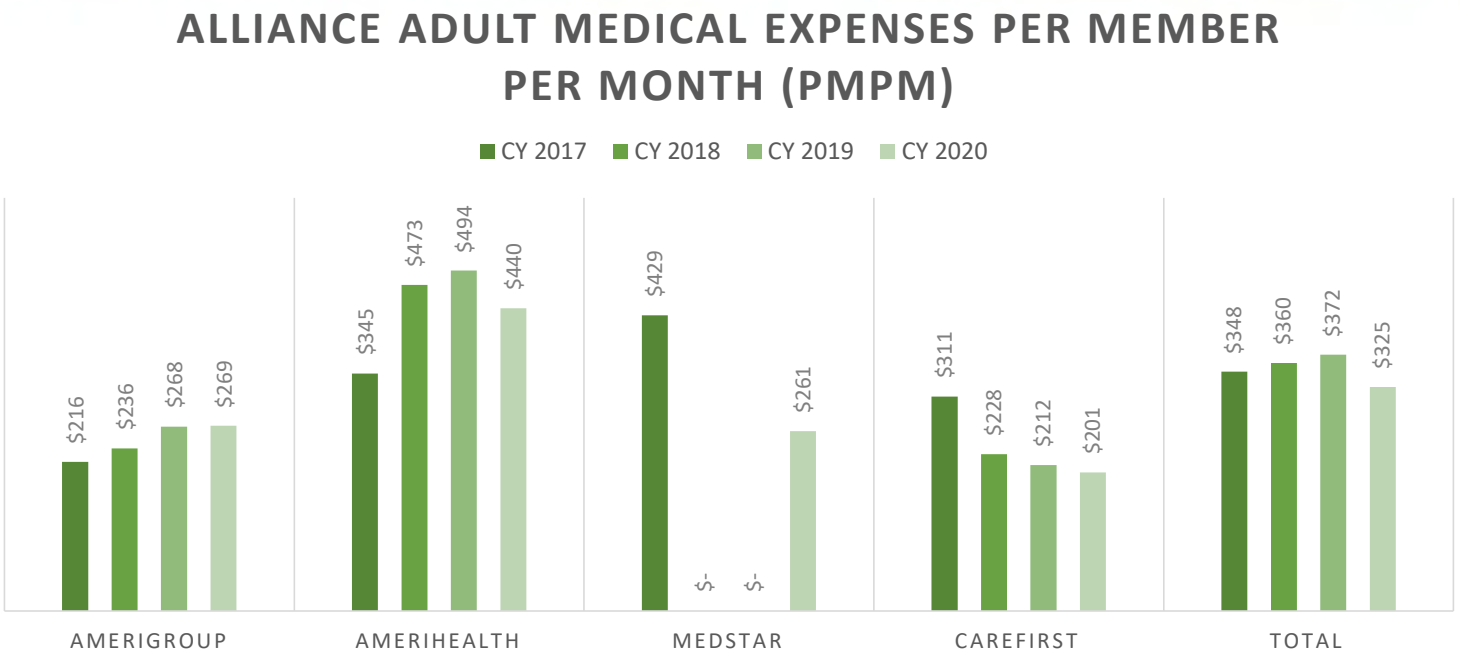
Prior to Continuous Coverage Provided During Public Health Emergency, Nearly 4 in 10 Alliance Beneficiaries Losing Coverage Re-Enrolled Within a Year

Fiscal Year	Total Alliance Beneficiaries Ever Enrolled	Total Terminated	Total Terminated and Re-enrolled in Alliance Within 1 Year	Total Terminated and Re-enrolled in Medicaid Within 1 Year	Net Terminated and Re-Enrolled in Medicaid or Alliance Within 1 Year (% of Total Terminated)
2018	21,469	7,759	3,012	148	3,160 (41%)
2019	21,179	7,312	2,888	136	3,024 (41%)
2020	20,368	3,346	934	60	994 (30%)
2021	22,299	456	18	1	19 (4%)

Source: DHCF Medicaid Management Information System data extracted in January 2022.

Note: Beneficiaries who disenrolled from the Alliance program but immediately enrolled in the Medicaid program are not included in the count of disenrolled beneficiaries. The number of Alliance enrollees who had their coverage terminated in FY 2020 and FY 2021 was significantly lower compared to prior years because coverage was automatically extended to enrollees during the public health emergency.

Alliance Cost Per Beneficiary Grew Modestly from CY 2017 – CY 2019 with Decreases in CY 2020 Due to COVID-19 Pandemic



Source: Mercer Consulting

Notes:

- All results are based on financial medical claim data provided by the MCOs. CY 2017 incurred claims paid as of January 31, 2018, for MedStar and as of January 31, 2019, for Amerigroup, AmeriHealth, and Trusted. CY 2018 incurred claims paid as of January 31, 2020. CY 2019 and CY 2020 incurred claims paid as of January 31, 2021. MedStar was in contract until September 30, 2017, and exited the program from October 1, 2017, through September 30, 2020. CY 2017 expenses are based on nine months of experience, and CY 2020 are based on three months. Amerigroup was in contract from October 1, 2017, through September 30, 2020. CY 2017 results are based on three months of experience, and CY 2020 are based on nine months.

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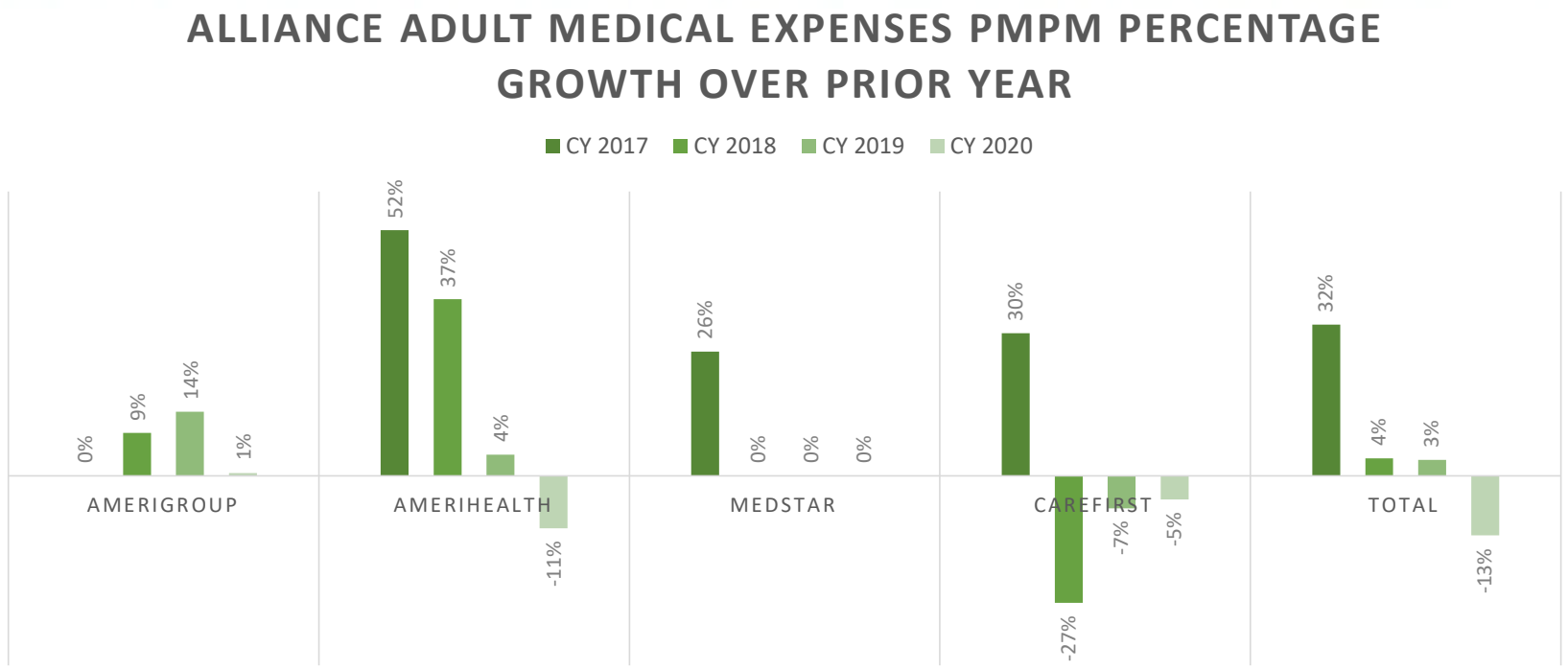

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GOVERNMENT OF THE
DISTRICT OF COLUMBIA

MURIEL BOWSER, MAYOR

FY 2023 PROPOSED BUDGET AND FINANCIAL PLAN

A Fair Shot