Presentation Outline

- Medicaid Program Trends
  - Medicaid Managed Care
  - Fee-For-Service
  - Behavioral Health
  - Long-Term Care

- Alliance

- DHCF’s Response to COVID-19 Public Health Emergency
  - Agency Role
  - ARPA and HCBS

- Conclusion
District Budget Slides
A Message from the Mayor...

We Are All In This Together...

- The **financial impact** of COVID-19 has required us to make sacrifices, while maintaining the critical services our residents expect and protecting our most vulnerable neighbors.
- We have taken **extraordinary steps** to reduce spending, access our reserves, and maximize use of available federal aid in responding to the pandemic and its negative economic impacts.
- In our FY 2022 budget proposal, we are using our significant federal investments to provide relief, recovery, and growth opportunities for an **equitable recovery** across all 8 wards.

We Will Recover and Grow Stronger Together.
Weathering the Financial Impacts

Our strong financial position...
- A balanced budget 25 years in a row
- Aaa bond rating
- Fully funded pension and retiree healthcare
- Strong reserves
- Strong real-estate market

And our prudent budgetary response...
- Targeted reductions to agency spending
- Strategic and measured use of available reserves
- Maximal use of federal relief funds

Allowed us to...
- Avoid more drastic cuts to valued public services
- Maintain a strong financial foundation for future growth
- Invest in high-priority needs to solve some of our city’s biggest challenges
### Turning a Corner

<table>
<thead>
<tr>
<th></th>
<th>SEP 2020</th>
<th>MAY 2021</th>
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<tbody>
<tr>
<td><strong>DISTRICT REVENUES</strong></td>
<td>$742 million</td>
<td>$217 million</td>
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<td><strong>MONTHLY UNEMPLOYMENT CLAIMS</strong></td>
<td>6,432</td>
<td>5,458</td>
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<tr>
<td><strong>FDA-APPROVED COVID VACCINES</strong></td>
<td>0</td>
<td>3</td>
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<tr>
<td><strong>DC ADULTS VACCINATED</strong></td>
<td>0%</td>
<td>50.8%</td>
</tr>
<tr>
<td><strong>CONSUMER / RESTAURANT SPENDING</strong></td>
<td>41% / 49%</td>
<td>17% / 26%</td>
</tr>
<tr>
<td><strong>PUBLIC HEALTH RESTRICTIONS</strong></td>
<td>Numerous</td>
<td>Most lifting June 11</td>
</tr>
</tbody>
</table>

*Consumer spending from approximately the same time in 2019. Restaurant spending from the last week prior to shutdown. Adults vaccinated partially or fully vaccinated.*
OUR OPPORTUNITY

To build a stronger, more prosperous, equitable, and resilient Washington, DC.

- We must support our residents and businesses that have been most impacted by COVID-19
- We must build and preserve more affordable housing for our residents
- We must reduce gun violence
- We must help students accelerate their learning and get back to the classroom ready to grow
- We must reduce health inequities; and
- We must create a stronger and more inclusive economy

The FY 2022 Budget Will Give All Washingtonians a #FAIRSHOT
## Mayor’s Allocation of Federal Aid Under the American Rescue Plan

<table>
<thead>
<tr>
<th>$ millions</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
<th>FY 2024</th>
<th>TOTAL</th>
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<tr>
<td>Affordable Housing</td>
<td>$162.2</td>
<td>$273.3</td>
<td>$36.5</td>
<td>$33.1</td>
<td>$505.1</td>
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<tr>
<td>Economic Recovery for Businesses</td>
<td>$29.8</td>
<td>$186.7</td>
<td>$141.8</td>
<td>$124.7</td>
<td>$483.2</td>
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<td>Economic Recovery for Residents</td>
<td>$85.7</td>
<td>$158.6</td>
<td>$97.9</td>
<td>$45.2</td>
<td>$387.6</td>
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<tr>
<td>Health</td>
<td>$192.4</td>
<td>$128.6</td>
<td>$22.5</td>
<td>$34.9</td>
<td>$378.4</td>
</tr>
<tr>
<td>Learning Acceleration</td>
<td>$35.8</td>
<td>$111.8</td>
<td>$77.2</td>
<td>$39.2</td>
<td>$263.9</td>
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<tr>
<td>Gun Violence Prevention</td>
<td>$9.5</td>
<td>$59.3</td>
<td>$75.7</td>
<td>$49.3</td>
<td>$193.9</td>
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<tr>
<td>COVID-19 Response</td>
<td>$114.5</td>
<td>$74.6</td>
<td>-</td>
<td>-</td>
<td>$189.1</td>
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<tr>
<td>Oversight, Accountability &amp; Efficiency</td>
<td>$4.4</td>
<td>$17.5</td>
<td>$5.5</td>
<td>$6.2</td>
<td>$33.6</td>
</tr>
<tr>
<td>Alternative 911 Response</td>
<td>$0.2</td>
<td>$7.0</td>
<td>$6.9</td>
<td>$6.9</td>
<td>$21.0</td>
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<tr>
<td>Other</td>
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<td>$21.9</td>
<td>$11.0</td>
<td>$10.0</td>
<td>$43.9</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$635.6</strong></td>
<td><strong>$1,039.2</strong></td>
<td><strong>$474.9</strong></td>
<td><strong>$349.5</strong></td>
<td><strong>$2,499.3</strong></td>
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</table>
DHCF Budget Development To Support Services Provided to DC Residents

FY22 DHCF Total Budget $3.6B
FY22 Local Budget $846.8M
CMS provided 6.2% additional federal funding from January 2020 through the end of the pandemic to support increased rates and flexibilities and ensure continuity of care.

Period of the Public Health Emergency and Federal Funding Support

<table>
<thead>
<tr>
<th>FY2019</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
</tbody>
</table>

- **Federal Continuous Coverage Provision in Effect** (March 2020-December 2021)
- **Enhanced Federal Medicaid Assistance Participation (EFMAP) of 6.2%** (January 2020-December 2021)
- **Flexibility in Medicaid and Alliance Eligibility & MOE Requirements** (March 2020-February 2022)
## DHCF FY2022 Local Budget Snapshot

In millions

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2021 Approved Budget</td>
<td>$857,623</td>
</tr>
<tr>
<td>Removed One Time Funding</td>
<td>(62,299)</td>
</tr>
<tr>
<td>FY21 MARC Adjustments</td>
<td>18,953</td>
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<tr>
<td><strong>FY2021 Recurring Budget</strong></td>
<td>$814,277</td>
</tr>
<tr>
<td>Dedicated Tax Adjustment</td>
<td>$ (970)</td>
</tr>
<tr>
<td>Administrative Adjustments</td>
<td>(1,330)</td>
</tr>
<tr>
<td>Provider Payment Adjustments</td>
<td>(5,734)</td>
</tr>
<tr>
<td><strong>Total FY2022 Budget Adjustments</strong></td>
<td>($ 8,034)</td>
</tr>
<tr>
<td>Mayor's Enhancements</td>
<td>40,509</td>
</tr>
<tr>
<td><strong>Final FY2022 Budget</strong></td>
<td>$ 846,752</td>
</tr>
</tbody>
</table>
The Building Blocks to DHCF’s $846.8 Million Local Fund Budget

<table>
<thead>
<tr>
<th>FY22 Baseline Budget</th>
<th>Administrative Changes</th>
<th>Provider Payment Adjustments</th>
<th>Administrative Enhancements</th>
<th>Program Enhancements</th>
</tr>
</thead>
<tbody>
<tr>
<td>$814.3M</td>
<td>($2.3M)</td>
<td>($5.7M)</td>
<td>$34.3M</td>
<td>$6.1M</td>
</tr>
</tbody>
</table>

FY21 Recurring Budget
$857.6M

Less: Net One-Time Adjustments ($43.3M)

Vacancy Savings ($1.3M)

Shift to Hospital Tax for Outpatient ($970k)

Cost Shift to Medicare for End Stage Renal Failure ($809k)

Reduction of Anticipated Impact of CMS Requirements due to PHE ($3.5M)

ICF Rate Increase held at FY21 Inflation ($378k)

FQHC’s Rate Increase held at FY21 Inflation ($116k)

Inpatient/Outpatient Rate Increase held at FY21 Inflation ($790k)

DCAS Eligibility System O&M $9.6M

MMIS Operating Impact of Capital $2.9M

Net Enrollment Adjustments $3.2M

Alliance 6-Month Recertification by Phone $5.3M

Alliance Cost Growth $1M

Hospital Support $8M

Implementation of Neurobehavioral Health Service $698k

Implementation of Doula Services $75k

Practice Transformation Collaborative $1.5M (ARPA Grant Funds)

PHE Enhanced Rates & DSNP Transition $9.6M

Hospital Support $8M
**Program Enhancements**

**Alliance 6 Month Recertification by Phone:** Supports the continuation of the requirements set forth in B23-0761, which provides Alliance participants with the option to recertify by phone when recertification is required more than once in a 12-month period.

**Neurobehavioral Health Service:** Allows licensed practitioners to bill Medicaid’s fee-for-service program independently for providing neurobehavioral health related procedures as well as authorize additional related procedures.

**Doula Services:** In FY2022, DHCF is exploring expanding maternal and child health services to provide coverage and choices to qualifying women during pregnancy and birth.

**DC Practice Transformation Collaborative:** Build on past and current technical assistance to serve as a community-wide place for best practices and learning and provide individualized practice support for providers. It will support healthcare providers in delivering whole-person care across the care continuum, using population health analytics to address complex medical, behavioral health, and social needs, and transition to value-based purchasing.
Additional Highlights in the FY22 Budget

- Increased Community outreach and communication
- One quarter of PHE enhanced rates for multiple providers (October thru December 2021)
- Immigrant Children Program eligibility coverage to 324% of the FPL to fully align with Medicaid
- Managed Care Organization rates paid at the target rate
- Permanent Supportive Housing Services (collaboration with Department of Human Services)
- PACE
- District Dual Choice
- Living Wage assumptions
- Full year of the DD Independent Family Services waiver
- Continuation of ICF DSP wage supplemental payment (2\textsuperscript{nd} increase in addition to annual wage increases from DOES)
- Outpatient payments at 100% of cost (up from 77% of cost in FY21) for fee-for-service
- Rate increase for DC FEMS based on cost report results and emergency medical transportation MCO carve out (paid through fee-for-service) beginning in FY22
- Scheduled rate rebasing for FQHCs, Nursing Homes, Hospitals and ICFs
70% of DHCF’s Budget is Supported by Medicaid Federal Payments in FY22

- **FY 2022 Proposed Budget (1 Qrt COVID-19):**
  - Local: 23.2%
  - Dedicated Taxes: 2.8%
  - Operating Intra-District Funds: 2.5%
  - Federal Payments: 69.8%
  - Total: $3,644,559,437

- **FY 2021 Approved Budget (Full Year COVID-19):**
  - Local: 24.0%
  - Dedicated Taxes: 2.7%
  - Operating Intra-District Funds: 2.3%
  - Federal Payments: 69.1%
  - Total: $3,580,016,534

- **FY 2020 Expenditures (3 Quarters COVID-19):**
  - Local: 20.8%
  - Dedicated Taxes: 2.3%
  - Operating Intra-District Funds: 2.5%
  - Federal Payments: 74.0%
  - Total: $3,441,330,043

- **FY 2019 Expenditures (Prior COVID-19):**
  - Local: 24.0%
  - Dedicated Taxes: 2.5%
  - Operating Intra-District Funds: 2.5%
  - Federal Payments: 70.2%
  - Total: $3,223,861,259

Legend:
- Local
- Dedicated Taxes
- Operating Intra-District Funds
- Federal Payments
- Federal Medicaid Payments
- Special Purpose Revenue Funds ('O'Type)
## Explanation for Variances Between FY2021 and FY2022

<table>
<thead>
<tr>
<th></th>
<th>LOCAL</th>
<th>DEDICATED TAXES</th>
<th>FEDERAL PAYMENTS</th>
<th>FEDERAL GRANT</th>
<th>FEDERAL MEDICAID PAYMENTS</th>
<th>SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)</th>
<th>OPERATING INTRA-DISTRICT FUNDS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2022 Proposed Budget</td>
<td>846,752,958</td>
<td>103,219,385</td>
<td>1,500,000</td>
<td>3,206,819</td>
<td>2,544,794,223</td>
<td>6,434,236</td>
<td>138,651,816</td>
<td>3,644,559,437</td>
</tr>
<tr>
<td>(1 Qtr. COVID-19)</td>
<td></td>
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<tr>
<td>FY 2021 Approved Budget</td>
<td>857,622,717</td>
<td>98,195,140</td>
<td></td>
<td>6,067,676</td>
<td>2,472,818,580</td>
<td>6,596,710</td>
<td>138,715,711</td>
<td>3,580,016,534</td>
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<tr>
<td>(Full Year COVID-19)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2020 Expenditures</td>
<td>716,795,591</td>
<td>78,423,261</td>
<td></td>
<td>1,213,681</td>
<td>2,545,302,473</td>
<td>1,395,253</td>
<td>98,199,784</td>
<td>3,441,330,043</td>
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<tr>
<td>(3 Quarters COVID-19)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FY 2019 Expenditures</td>
<td>774,523,518</td>
<td>81,015,396</td>
<td></td>
<td>1,190,712</td>
<td>2,263,036,125</td>
<td>1,610,580</td>
<td>102,484,928</td>
<td>3,223,861,259</td>
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<tr>
<td>(Prior to COVID-19)</td>
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</tr>
<tr>
<td>FY22/FY21 YoY Change</td>
<td>-1.27%</td>
<td>5.12%</td>
<td>-47.15%</td>
<td>2.91%</td>
<td>-2.46%</td>
<td>-0.05%</td>
<td>0.91%</td>
<td></td>
</tr>
</tbody>
</table>

- **Local**: Decrease due to decline in enrollment and the end of provider relief due to the expiration of the PHE. Please note FY 2021 supplemental budget reduces DHCF’s FY 2021 local budget to $761,776,411 to align with projected spending. From FY 2021 projected spending to FY 2022 budget is an 11.2% increase. This is primarily the net of effect of declining enrollment, the end of enhanced federal reimbursement, the end of COVID provider relief, and enhancements.

- **Dedicated Taxes**: increases in anticipated revenue and utilization of revenue fund balance from FY20

- **Federal Payment**: Increase due to ARPA funds used to support DC Practice Transformation Collaborative

- **Federal Grants**: The Substance Use Disorder Provider Capacity grants ends in the beginning of FY22

- **Medicaid Entitlement**: Federal match for the Medicaid and Children’s Health Insurance Program (CHIP) based on anticipated expenditures; above budget does not include additional federal match due to COVID-19 (EFMAP)

- **O Type**: Net decrease mainly attributed to decrease in anticipated revenue for Third Party Liability recovery and Health Care Bill of Rights

- **Intra District**: Net increase attributed to a full year of funding for the DD Individual and Family Support waiver and the new Permanent Supportive Housing program with DHS.
In FY22 DHCF Will Continue to Focus on Community Outreach and Provider Payments to Ensure Efficient and Effective Health Care

<table>
<thead>
<tr>
<th>DHCF Programs</th>
<th>FY22 Proposed Budget</th>
<th>FY21 Approved Budget</th>
<th>Variance</th>
<th>FY22 Proposed FTE's</th>
<th>FY21 Approved FTE's</th>
<th>Variance</th>
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</thead>
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<td>1000 AGENCY MANAGEMENT</td>
<td>38,707,784</td>
<td>37,458,130</td>
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<td>127</td>
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<td>100F AGENCY FINANCIAL OPERATIONS</td>
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<td>6,824,510</td>
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<td>17</td>
<td>17</td>
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<td>2000 HEALTHCARE DELIVERY MANAGEMENT</td>
<td>29,032,940</td>
<td>25,644,173</td>
<td>3,388,768</td>
<td>34.02</td>
<td>34.02</td>
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<td>200L LONG TERM CARE PROGRAM</td>
<td>23,444,775</td>
<td>23,876,954</td>
<td>(432,179)</td>
<td>38</td>
<td>38</td>
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<td>3000 HEALTHCARE POLICY AND PLANNING</td>
<td>6,196,055</td>
<td>6,219,095</td>
<td>(23,041)</td>
<td>32</td>
<td>32</td>
<td>-</td>
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<td></td>
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<tr>
<td>300A DCAS PROGRAM MANAGEMENT</td>
<td>71,430,481</td>
<td>77,980,136</td>
<td>(6,549,655)</td>
<td>68.02</td>
<td>70</td>
<td>(1.98)</td>
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<td>5000 HEALTH CARE FINANCE</td>
<td>3,407,868,734</td>
<td>3,334,306,238</td>
<td>73,562,496</td>
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<td>0</td>
<td>-</td>
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<tr>
<td>6000 HEALTH CARE OPERATIONS</td>
<td>53,848,979</td>
<td>50,718,255</td>
<td>3,130,724</td>
<td>27</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>8000 HEALTH CARE REFORM AND INNOVATION</td>
<td>7,243,284</td>
<td>16,989,043</td>
<td>(9,745,759)</td>
<td>10</td>
<td>9</td>
<td>1.00</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>3,644,559,437</strong></td>
<td><strong>3,580,016,534</strong></td>
<td><strong>64,542,903</strong></td>
<td><strong>351.03</strong></td>
<td><strong>354.02</strong></td>
<td><strong>(2.99)</strong></td>
</tr>
</tbody>
</table>

Budget Variance Explanations by Program Administration:

- **Agency Management** increase is attributed to the addition of training and support to address racial and social justice training and support for staff, community outreach, continuation of rate studies and IT software and maintenance
- **Agency Financial Operations** decrease in auditing cost and other services
- **Health Care Delivery Management** increase in contractual services to support additional quality oversight and review
- **Long Term Care Administration** slight decrease in contractual services
- **Health Care Policy and Planning** slight decline in subscriptions and contractual services
- **DCAS** net decrease due to purchase of universal licenses budgeted in FY21 in IT software not necessary in FY22 and rental cost. Contractual services increased by $6M as a result of the shift to Operations and Maintenance in FY22
- **Health Care Finance** Net increase to support PHE enhanced rates, new services and spending trends. Decrease in enrollment beginning in March 2022 results in a decrease in payments across the programs
- **Health Care Operations** Increase to support the cost of O&M and training for MMIS system
- **Health Care Reform and Innovation** Net increase in contracts to support DC Practice Transformation Collaborative and a decrease due to the end of the federal SUD grant
94% of DHCF’s $3.6 Billion Budget Supports Direct Care Services for District Residents
The FY2022 Budget Increase of $64.5M over FY2021 Mainly Attributed to Provider Payments

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>FY22 Proposed Budget</th>
<th>FY21 Approved Budget</th>
<th>Variance</th>
<th>FY 2020 Expenditures</th>
<th>FY22 Proposed FTE's</th>
<th>FY21 Approved FTE's</th>
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<tbody>
<tr>
<td>0011-REGULAR PAY - CONT FULL TIME</td>
<td>34,263,485</td>
<td>34,436,169</td>
<td>(172,683)</td>
<td>28,139,386</td>
<td>329.99</td>
<td>327</td>
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<tr>
<td>0012-REGULAR PAY - OTHER</td>
<td>1,549,495</td>
<td>2,091,846</td>
<td>(542,351)</td>
<td>1,390,097</td>
<td>21.04</td>
<td>27.02</td>
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<tr>
<td>0013-ADDITIONAL GROSS PAY</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>170,380</td>
<td>0</td>
<td>0</td>
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<tr>
<td>0014-FRINGE BENEFITS - CURR PERSONNEL</td>
<td>7,909,963</td>
<td>7,788,031</td>
<td>121,932</td>
<td>6,406,100</td>
<td>0</td>
<td>0</td>
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<tr>
<td>0015-OVERTIME PAY</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12,940</td>
<td>0</td>
<td>0</td>
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<tr>
<td>PERSONNEL SERVICES Total</td>
<td>43,722,943</td>
<td>44,316,046</td>
<td>(593,103)</td>
<td>36,118,902</td>
<td>351.03</td>
<td>354.02</td>
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<tr>
<td>0020-SUPPLIES AND MATERIALS</td>
<td>200,953</td>
<td>221,492</td>
<td>(20,539)</td>
<td>93,748</td>
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<td>0</td>
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<tr>
<td>0030-ENERGY, COMM. AND BLDG RENTALS</td>
<td>408,722</td>
<td>355,841</td>
<td>52,880</td>
<td>262,933</td>
<td>0</td>
<td>0</td>
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<tr>
<td>0031-TELECOMMUNICATIONS</td>
<td>388,939</td>
<td>377,255</td>
<td>11,685</td>
<td>330,864</td>
<td>0</td>
<td>0</td>
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<tr>
<td>0032-RENTALS - LAND AND STRUCTURES</td>
<td>1,453,414</td>
<td>1,890,175</td>
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<td>1,340,880</td>
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<td>0</td>
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<tr>
<td>0034-SECURITY SERVICES</td>
<td>309,203</td>
<td>303,123</td>
<td>6,080</td>
<td>91,879</td>
<td>0</td>
<td>0</td>
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<tr>
<td>0035-OCUPANCY FIXED COSTS</td>
<td>434,858</td>
<td>549,525</td>
<td>(114,667)</td>
<td>441,312</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0040-OTHER SERVICES AND CHARGES</td>
<td>2,179,178</td>
<td>3,289,913</td>
<td>(1,110,735)</td>
<td>5,525,480</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0041-CONTRACTUAL SERVICES - OTHER</td>
<td>171,735,006</td>
<td>157,377,097</td>
<td>14,357,909</td>
<td>113,069,355</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0050-SUBSIDIES AND TRANSFERS</td>
<td>3,410,605,086</td>
<td>3,348,957,156</td>
<td>61,647,930</td>
<td>3,283,211,227</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0070-EQUIPMENT &amp; EQUIPMENT RENTAL</td>
<td>13,121,134</td>
<td>22,378,911</td>
<td>(9,257,777)</td>
<td>843,462</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NON-PERSONNEL SERVICES Total</td>
<td>3,600,836,494</td>
<td>3,535,700,488</td>
<td>65,136,006</td>
<td>3,405,211,140</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,644,559,437</td>
<td>3,580,016,534</td>
<td>64,542,903</td>
<td>3,441,330,043</td>
<td>351.03</td>
<td>354.02</td>
</tr>
</tbody>
</table>
DHCF Enrollment Continues to Increase During the PHE; However, Steep Enrollment Decline Anticipated Once the PHE Ends in FY22 to Align with FY19 Enrollment

DHCF Average Monthly Enrollment by Quarter, FY 2019 to FY 2022

- Federal PHE Declared Jan. 2020
- Eligibility System Sync Feb. 2020
- Continuous Coverage Begins Mar. 2020
- Managed Care Transition Oct. 2020
- Federal PHE Anticipated to End Dec. 2021

Federal PHE Declared Jan. 2020
Eligibility System Sync Feb. 2020
Continuous Coverage Begins Mar. 2020
Managed Care Transition Oct. 2020
Federal PHE Anticipated to End Dec. 2021

- Medicaid MCO
- Medicaid FFS
- Alliance
- ICP
Based on guidance provided to governors by the US Department of Health and Human Services (https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf), DHCF assumes that the federal PHE will continue through December 2021 and that all beneficiaries remain enrolled unless they are deceased, move out of the District, or voluntarily request termination of their coverage.

DHCF also assumes that the District PHE will remain in effect during this time and that the Mayor will extend continuous coverage and other eligibility provisions (e.g., no face to face requirement for Alliance eligibility) for an additional 60 days, per authority provided by the DC Council.

Enrollment growth projected through June 2021 is based on the average monthly rate of growth observed during the public health emergency to date. Enrollment growth is projected at a slower rate for July-December 2021, as a growing number of DC residents are vaccinated and the economy recovers.

Redeterminations of eligibility are expected to begin in late 2021, with effective dates beginning in March 2022 (i.e., after the PHE end date plus 60 days). All redeterminations are expected to occur by the end of June 2022, consistent with a federal requirement for the process to be completed within 6 months of the federal PHE ending.

Medicaid enrollment levels and growth for July 2022 and beyond are projected to return to pre-PHE levels.

Alliance enrollment levels and growth based on transition to new enrollment process allowing alternating recertifications by telephone after the PHE ends.

Incorporates shift of adults from Fee For Service to Managed Care in FY2021 and beneficiaries remaining in Fee For Service
Competing Factors Influenced Enrollment and Utilization Trends

The Public Health Emergency and DHCF's transition of certain adult beneficiaries from FFS to the MCO program have had varying and significant impacts on enrollment, utilization and costs. The net effect is a decline in overall budget for provider payments.

<table>
<thead>
<tr>
<th>Key Event</th>
<th>Impacts on Enrollment and Utilization</th>
<th>Budget Impact</th>
</tr>
</thead>
</table>
| Beginning of PHE | • Increased enrollment due to continuous coverage provisions resulting in suspension of eligibility redetermination  
• Decreased utilization of well visits and elective procedures  
• Increased enrollment due to increased unemployment rate and therefore more residents becoming financially eligible | • Increased per-person cost due to incidence of costly COVID-19 related acute stays  
• Increased enrollment resulting in more capitation payments  
• Provider rate enhancements increased cost for certain services |
| FY21 Transition of Adult populations from FFS to MCO | • Decreased enrollment in FFS  
• Increased MCO Enrollment  
• Population remaining in FFS are sicker and therefore more costly | • Overall FFS cost is lower, but per-person cost is higher because healthier FFS population moved to FFS  
• MCO cost are higher due to increased population shift from FFS, but the per-person cost aligned with the MCO case mix |
| End of PHE | • Continuous coverage provision ends  
• Allows eligibility redetermination to resume, resulting in enrollment drops  
• Increased employment rates creates, decreased Medicaid eligibility | • Decreased enrollment results in decreased utilization and monthly capitation payments  
• Decrease in COVID-19 related acute hospitalizations |
FY22 Budget was formulated in the latter portion of FY 2020 which was the heart of the pandemic. This added a degree of complexity to an already arduous budget process.

Some of the assumptions and methods adopted in this formulation are highlighted below:

- Utilized actual expenditures through Quarter 2 of Fiscal Year 2020 (March 2020) to capture payment trends prior to the pandemic
  - There was a general decrease in service utilization during the initial months of the pandemic that was deemed unsustainable. Utilizing actuals through March prevented the declines in utilization from being included in any trend rates.

- Incorporated historic inflation/cost trends as well as Living Wage & Minimum Wage impacts.

- No rate reductions included in the FY 2022 budget.

- Used FY 2021 MCO transition assumptions – adjusted per person projected cost for fee-for-service provider-types by excluding the utilization by beneficiaries who transitioned to managed care.
The FY22 Budget Supports New Programs and Anticipated Increase in Spending Related to Per Person Cost and Rate Increases

**Medicaid Provider Payments**

- **FY2022 Budget $3.2 Billion**
- **Net Increase of $22.4M over FY21**
- **Main factor:** New Services included in FY21 including
  - DD Independent Family Services Waiver ($4.1M)
  - Permanent Supportive Housing ($10.7M)
  - Neurobehavioral Health ($2.3M)
  - Doula Services ($75k)

**Medicaid Public Provider Payments**

- **FY2022 Budget $73.3 Million**
- **Increase of $32M over FY21**
- **Main factor:** FEMS rate increase and impact of policy change to carve out Emergency transportation out of MCO and pay thru the Fee Schedule

**Alliance Provider Payments**

- **FY2022 Budget $120.9 Million**
- **Increase of $19.2M over FY21**
- **Main factor:** Alliance growth in enrollment and spending has increased the budget by $11.2M and new funding for Hospital Support funding for DSH in the amount of $8M
The District is Required by CMS to Provide Certain Benefits and Others are Determined Optional Benefits by CMS

Mandatory Service Benefits

- Inpatient hospital services
- Outpatient hospital svcs. (incl. Emergency Room)
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Service Benefits

- Prescription Drugs
- Clinic services
- Physical therapy and Occupational therapy
- Speech, hearing and language disorder services
- Other diagnostic, screening, preventive and rehab. svcs
- Podiatry svcs, Optometry svcs & Other practitioner svcs
- Dental Services and Dentures
- Prosthetics, Eyeglasses
- Private duty nursing services
- Personal Care
- Hospice
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Intermediate care facility for Individuals with IDD
- Adult Day Health Program
- Inpatient psychiatric services for individuals under age 21
- Health Homes Programs
Some Provider Payment Budgets Decrease Due to a Declining Enrollment in FY22; However Equitable Rates Will Still Be Implemented Based on Cost

<table>
<thead>
<tr>
<th>Services</th>
<th>FY22 Proposed Budget</th>
<th>FY21 Approved Budget</th>
<th>FY20 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>112,947,242.31</td>
<td>101,713,378.03</td>
<td>90,274,253.98</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>163,511,745.66</td>
<td>162,597,482.49</td>
<td>134,591,760.46</td>
</tr>
<tr>
<td>Clinic Services</td>
<td>46,446,501.99</td>
<td>24,949,669.34</td>
<td>73,339,305.14</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>14,945,428.84</td>
<td>17,639,376.78</td>
<td>19,451,471.85</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>191,495,043.60</td>
<td>222,249,939.33</td>
<td>383,152,108.51</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>1,059,286,055.68</td>
<td>969,560,039.38</td>
<td>1,036,172,171.92</td>
</tr>
<tr>
<td>Managed Care</td>
<td>1,475,657,863.23</td>
<td>1,514,929,613.18</td>
<td>1,170,570,990.23</td>
</tr>
<tr>
<td>Other Services</td>
<td>217,600,315.01</td>
<td>218,435,853.62</td>
<td>208,026,800.28</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>27,177,198.25</td>
<td>29,545,756.50</td>
<td>48,848,466.83</td>
</tr>
<tr>
<td>Physicians and Nursing</td>
<td>17,201,773.13</td>
<td>31,045,562.92</td>
<td>49,730,484.16</td>
</tr>
<tr>
<td>Public Provider</td>
<td>73,329,100.00</td>
<td>41,369,100.00</td>
<td>54,673,747.60</td>
</tr>
<tr>
<td>Hospital Support</td>
<td>8,000,000.00</td>
<td>-</td>
<td>8,750,000.00</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,407,598,267.70</td>
<td>3,334,035,771.57</td>
<td>3,277,581,560.96</td>
</tr>
</tbody>
</table>

NOTE: Long Term Care includes Nursing Facility, ICF/IID & EPD and DD Waivers. Other Services include DME, Pharmacy, Medicare Parts A&B; Hospital Supports in FY20 represents a portion of the Surge Grants and in FY22 funding for hospitals providing care to vulnerable populations.

• In FY20, spending includes a larger FFS population in comparison to FY21 and FY22; as well as 9 months of PHE Provider Relief payments and higher enrollment due to flexibilities in eligibility.

• In FY21, spending includes the transition of specific adults from FFS to MCO, continued PHE Provider Relief payments and a growing population due to continued flexibilities in eligibility.

• In FY22, the spending projects:
  • 3 months of Provider Relief thru the end of the pandemic (estimated to end December 2021)
  • Forecasted decline in enrollment due to the expiration of flexibilities in eligibility during the PHE
  • Scheduled rate adjustments
Rate Updates
**Rebasing Rate Update** – In line with the relevant SPA requirements, the reimbursement rates for the following services will be updated in FY 2022 using the provider audited cost information. The rebasing of rates are typically conducted every 3-4 years.

**Services**
- Nursing Facilities
- FQHCs

**Effective Date**
October 1, 2021

---

**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
- Home Health Agency
- ICFIID
- IDD Waiver
- EPD Waiver
- Fee Schedule – *Physician, DME, Lab & Anesthesia*

**Effective Date**
- Living Wage – July 1, 2022
- CMS Market Basket – Jan 1, 2022
- CMS Fee Schedule – Jan 1, 2022
# FFS Program Rate Updates

## Fee Schedule Clean-Up

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduent Work to Begin</td>
<td>July 2021</td>
</tr>
<tr>
<td>Anticipated Study Completion</td>
<td>Part 1: FY2021 and Part 2: FY2022</td>
</tr>
<tr>
<td>New Rate Implementation Date</td>
<td>January 2022</td>
</tr>
</tbody>
</table>

**Purpose**

DHCF is working to conduct a comprehensive update of the fee schedule, particularly around manually priced items and Durable Medical Equipment (DME). As part of this project, DHCF will implement a process to align the ad-hoc coverage determinations, with the fee schedule updates.

## COVID Impact Analysis

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduent Work to Begin</td>
<td>May 2021</td>
</tr>
<tr>
<td>Anticipated Study Completion</td>
<td>On-Going, first draft Fall 2021</td>
</tr>
<tr>
<td>New Rate Implementation Date</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Purpose**

DHCF seeks a comprehensive analysis on the impact of COVID-19, to inform potential policy changes and budgetary considerations.
### Behavioral Health Rate Methodology

<table>
<thead>
<tr>
<th>Rate Study Contract Awarded</th>
<th>May 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated Study Completion</td>
<td>September 2021</td>
</tr>
<tr>
<td>New Rate Implementation Date</td>
<td>October 2022</td>
</tr>
<tr>
<td>Purpose</td>
<td>DHCF is collaborating with DBH to conduct a comprehensive review of the District's Medicaid behavioral health reimbursement and rate structure to more fully integrate behavioral health with primary care and to ensure reimbursement aligns with how services are being and should be delivered.</td>
</tr>
</tbody>
</table>

### Home Health Rate Methodology

<table>
<thead>
<tr>
<th>Anticipated Contract Award</th>
<th>Q4 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated Study Completion</td>
<td>Q1 2022</td>
</tr>
<tr>
<td>New Rate Implementation Date</td>
<td>FY2023</td>
</tr>
<tr>
<td>Purpose</td>
<td>DHCF seeks review home health agency rates and reimbursement structures to facilitate a shift from FFS to value-based care provision and to address provider concerns with rate adequacy.</td>
</tr>
</tbody>
</table>
# FFS Program Rate Updates

## Highly-Integrated Dual Eligible Special Needs Plan (HIDE-SNP) Rate Setting

<table>
<thead>
<tr>
<th>Contract Awarded</th>
<th>May 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated Rate Analysis Completion</td>
<td>July 2021</td>
</tr>
<tr>
<td>Implementation Date</td>
<td>January 2022</td>
</tr>
<tr>
<td>Purpose</td>
<td>DHCF LTCA is expanding its Dual Eligible Special Needs Plan (DSNP) program to provide integrated Medicare and Medicaid services through a risk-adjusted monthly capitation payment for eligible beneficiaries who elect to enroll in the program.</td>
</tr>
</tbody>
</table>

## Permanent Supportive Housing Services

<table>
<thead>
<tr>
<th>Rate Study Completion (By DHS)</th>
<th>September 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Service Implementation</td>
<td>April 2022</td>
</tr>
<tr>
<td>Purpose</td>
<td>DHCF is collaborating with DHS to maximize federal funding and quality of care for housing supportive services (HSS) for District residents who are homeless or at risk of homelessness.</td>
</tr>
</tbody>
</table>
FY2022-FY2027 Capital Budget Investments
## Summary of DHCF's FY22-27 Capital Improvement Plan

<table>
<thead>
<tr>
<th>Project No</th>
<th>Project Title</th>
<th>FY 2022</th>
<th>FY 2023</th>
<th>FY 2024</th>
<th>FY 2025</th>
<th>FY 2026</th>
<th>FY 2027</th>
<th>6-yr Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIM01C</td>
<td>ENTERPRISE DATA INTEGRATION SYSTEM/MEDICAID ENTERPRISE SYS</td>
<td>724,346</td>
<td>1,475,000</td>
<td>1,475,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,674,346</td>
</tr>
<tr>
<td>MES23C</td>
<td>DCAS RELEASE 3</td>
<td>4,497,274</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,497,274</td>
</tr>
<tr>
<td>MPM03C</td>
<td>MMIS UPGRADED SYSTEM</td>
<td>4,939,919</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,939,919</td>
</tr>
<tr>
<td>PBM01C</td>
<td>PHARMACY BENEFIT MANAGER SYSTEM REFRESH</td>
<td>360,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>360,000</td>
</tr>
<tr>
<td>PDM01C</td>
<td>PROVIDER DATA MANAGEMENT SYSTEM REFRESH</td>
<td>400,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>400,000</td>
</tr>
<tr>
<td>UMV01C</td>
<td>SAINT ELIZABETHS MEDICAL CENTER</td>
<td>114,300,000</td>
<td>126,000,000</td>
<td>87,900,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>328,200,000</td>
</tr>
<tr>
<td>CAPITAL IMPROVEMENT PLAN LOCAL TOTAL:</td>
<td></td>
<td>125,221,539</td>
<td>127,475,000</td>
<td>89,375,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>342,071,539</td>
</tr>
</tbody>
</table>
DHCF Program Overview
VISION
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
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
Accountability – Compassion – Empathy – Professionalism – Teamwork

PRIORITIES
DHCF has three priorities for the programs we administer:
1. Building a health system that provides whole person care
2. Ensuring value and accountability
3. Strengthening internal operational infrastructure
DHCF Programs Provide Health Care Coverage to 40% of District Residents – Supporting Near Universal Coverage in DC

Near universal coverage
DC has the second lowest uninsured rate

3.5% 3.0%

Of all eligible DC children are enrolled in Medicaid
98%

DHCF covers about 300,000 people

On average during FY 2020:
- more than 279,000 were in Medicaid;
- 20,000 in the DC Healthcare Alliance and
- 4,000 in the Immigrant Children’s Program

4 out of 10 District residents
7 out of 10 children

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

The Goal: Improve health outcomes so that District residents can live their best lives

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 for key providers (acute care hospitals and FQHCs)
- More coordinated care: transition FFS Medicaid population to managed care organizations (MCOs)

Managed Care as the Vehicle:
- Access to care coordination and case management
- Increased program flexibility promotes innovation
- Utilize plan (Medicaid and Medicare) expertise
- Strengthen program oversight

FY 2021 First Transition to Managed Care:
- Supplemental Security Income (SSI) Adults
- MCO Opt Outs

FY 2022 Medicaid / Medicare Alignment:
- PACE
- District Dual Choice

Percentage of beneficiaries enrolled in managed care increased by 6 percentage points
- September 2020: FFS 23%, MCO 77%
- October 2020: FFS 17%, MCO 83%
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 2020

Source: DHCF Medicaid Management Information System data extracted in March 2021.
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).
Nearly 4 in 10 District Residents Rely on DHCF-Funded Health Care Coverage – Most in Medicaid

Proportion of DC Residents with DHCF-Funded Coverage, FY 2020

- Medicaid, 87%
  - 245,281
- CHIP-Funded Medicaid, 6%
  - 17,426
- Alliance, 6%
  - 16,159
- Immigrant Children's Program (ICP), 1%
  - 4,098

With DHCF Coverage, 40%

Other DC Residents, 60%

Total District of Columbia Residents = 712,816

Source: District population estimate reflects July 1, 2020, from U.S. Census Bureau. Medicaid, Alliance, and ICP data reflects average monthly enrollment in FY 2020, DHCF’s Medicaid Management Information System.

Note: The District resident total may undercount certain individuals (e.g., those who are not US citizens) and thus the percentage with DHCF coverage may be overstated. Sum of components may not equal total due to rounding.
In the District, Most Low-Income Non-Elderly Adults Are Medicaid-Eligible

DC Medicaid Income Eligibility by Federal Poverty Level (FPL)

- CHILDLESS ADULTS*: 215%
- PARENT/CARETAKER RELATIVES*: 221%
- CHILDREN/PREGNANT WOMEN*: 324%
- QUALIFIED MEDICARE BENEFICIARIES: 300%
- AGED, BLIND, DISABLED: 100%
- MEDICALLY NEEDY**: 50%

Note: Low-income is 200% FPL, which is about $25,760 for an individual or $53,000 for a family of four in CY 2021.
* Includes a 5% income disregard.
** The Medically Needy Income Level (MNIL) for 2021 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 2020

Medicaid Enrollment

Aged or disabled individuals, 22%

Non-disabled adults, 45%

Non-disabled children, 33%

Medicaid Spending

Aged or disabled individuals, 59%

Non-disabled adults, 28%

Non-disabled children, 13%

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2021 for eligibility in FY 2020 and claims with dates of service in FY 2020.

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).
Primary and Acute Care Costs Represent Greatest Share of Medicaid Spending

Medicaid Program Spending Based on Services Occurring in FY 2020

Total = $3,123,060,312

- Primary and Acute Care: $1,783,828,791 (57%)
- Long-Term Care: $1,044,882,895 (33%)
- Mental Health: $172,432,247 (6%)
- Managed Care Capitation Payments: $1,015,109,064 (33%)
- Inpatient care: $259,908,286 (8%)
- Other Primary and Acute Spending: $508,811,441 (16%)
- Other Care Spending: $121,916,380 (4%)

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2021 for claims with FY 2020 dates of service.

Note: The “Other Care Spending” category includes health-related services such as optometrist, podiatrist, physical therapy, midwifery, and other services. Although managed care capitation is shown in the primary/acute care category, plans may spend some portion of those payments on services falling into other categories.
Historically, Nearly Three-Fourths of the District’s Medicaid Enrollees Are in Managed Care – Expansion in FY2021 Increased the Number of Enrollees in the Managed Care Program

**Source:** DHCF Medicaid Management Information System data extracted in March 2021.

**Note:** Enrollment reflects average monthly.
Adults Account for Most Medicaid Enrollment Growth From FY 2011 to FY 2020

Medicaid Enrollment Growth by Age, FY 2011-FY 2020

<table>
<thead>
<tr>
<th>Age</th>
<th>FY2011 Total Enrollment</th>
<th>FY2020 Total Enrollment</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 21</td>
<td>88,131</td>
<td>93,136</td>
<td>+6%</td>
</tr>
<tr>
<td>Age 21-49</td>
<td>4,229</td>
<td>20,304</td>
<td>+49%</td>
</tr>
<tr>
<td>Age 50-64</td>
<td>70,306</td>
<td>100,689</td>
<td>+37%</td>
</tr>
<tr>
<td>Age 65-80</td>
<td>31,821</td>
<td>43,736</td>
<td>+73%</td>
</tr>
<tr>
<td>Age 81+</td>
<td>11,766</td>
<td>20,304</td>
<td>+14%</td>
</tr>
</tbody>
</table>

Overall Growth: +27%

Total Enrollment = 206,253

Total Enrollment = 262,707

Source: DHCF Medicaid Management Information System data extracted in March 2021.

Note: Enrollment is average monthly.
Childless Adults and Children Each Represent About One-Third of Medicaid Enrollees

Medicaid Enrollment by Eligibility Category, FY 2020

- 33%, Child
- 31%, Childless Adult
- 14%, ABD, Excluding QMB only and LTSS
- 14%, Parent/Caretaker or Pregnant...
- 2%, LTSS - EPD/IDD Waiver or MFP
- 1%, LTSS - Other
- 4%, QMB Only
- 0.4%, Other

Total Medicaid Enrollment = 265,203

Source: DHCF Medicaid Management Information System data extracted in March 2021.

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.
Medicaid Enrollment Growth Post-ACA Implementation Has Slowed

Selected Chronic Conditions Impacting Medicaid Beneficiaries in FY 2020

• Medicaid-enrolled adults were most likely to have the following chronic conditions:
  ❖ Hypertension (28%)
  ❖ Hyperlipidemia (14%)
  ❖ Diabetes (14%)
  ❖ Rheumatoid Arthritis/Osteoarthritis (10%)
  ❖ Depression (10%)

• 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 (3%)
  ❖ Anemia (2%)

• The high prevalence of certain conditions in the Medicaid population makes individuals particularly vulnerable to the COVID-19 pandemic. Individuals with hypertension, diabetes, and asthma may be at higher risk for severe disease according to the CDC.

Source: DC Medicaid Management Information System (MMIS) data extracted in March 2021.
Note: Beneficiaries identified were enrolled in Medicaid as of September 2020 and claims were examined for diagnoses in FY 2020. 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 CMS. Conditions associated with higher risk of severe disease gathered from the CDC.
All Full-Risk MCOs Spent at Least 85% of Revenue on Enrollee Medical Expenses*

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 2020.

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, 2020, 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.
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 2020 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 is developing new provider-level initiatives to achieve our goal of promoting high value in health care for Medicaid and Alliance beneficiaries.
DHCF Continues Building Infrastructure to Support Increased Program Value and Accountability

- Integrated eligibility system development and implementation continues
- Advancements in health information exchange (HIE)
The Development of DCAS Is Organized In Three Separate Phases

**DCAS Project Status**

**RELEASE 1**
- APTC
- MAGI Medicaid
- QHP (Premium Tax Credits)
- SHOP Eligibility

**Fully Functional**

**RELEASE 2**
- Cash Eligibility
- SNAP Applications
- Fraud Management

**Fully Functional**

**RELEASE 3**
- Non-MAGI Medicaid
- Long Term Care
- TEFRA/Katie Beckett
- Breast and Cervical Cancer
- IDD, EPD, IFS Waivers
- Spend-Down
- Alliance
- Immigrant Children

**July Deployment**

**August Deployment**

**In Remediation**
- SNAP Eligibility
- SNAP Notices
- Payment/EBT Processing

- Case Audit
- Provider Intake
- Interfaces w/ DMV, BOE, OCFO, USPS, Care Connect

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DCAS Project Spending From FY2012 Through FY2020

Total $490,931,497

- Medicaid Federal Capital: 163,362,402
- SNAP Federal Capital: 11,954,592
- Local Capital: 75,186,030
- Medicaid Federal Operating: 78,387,786
- SNAP Federal Operating: 18,504,455
- Local Operating: 68,795,983
- Establishment Grant: 74,740,248

Total $490,931,497
The Last Phase of the DCAS Project: DHCF is going through Release 3

Approved Project Budget FY2019-FY2022

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Q3 FY2018</th>
<th>Q4 FY2018</th>
<th>FY2019</th>
<th>FY2020</th>
<th>FY2021</th>
<th>FY2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2 Fixes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3 Procurement</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>R3 Prep Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3 Implementation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Funding Type FY19 Budget FY20 Budget FY21 Budget FY22 Budget Total
Federal 88,769,385 93,939,448 83,720,450 33,270,453 299,699,736
Local 17,232,749 16,544,506 18,010,003 3,696,717 55,483,975
Total 106,002,134 110,483,954 101,730,453 36,967,170 355,183,711

Source: All Budget information the FY19, FY20 and FY21 Approved IAPD.
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 Nursing Facilities; 20 Home Health Providers
- 8 Federally Qualified Health Centers (all)
- 30 Behavioral Health Providers

DC HIE Use at a Glance (as of February 2021)
- CRISP DC Users: 11,513
- Patient Care Snapshot (Monthly Query)
  - 1,149 users
- Encounter Notification Services access
  - 484 locations
- Sharing Admit, discharge, transfer
  - 200+
- Sharing Clinical care documentation
  - 150+
The DC HIE is a Health Data Utility with Reliable Core Capabilities for Providers

**SIX (6) CORE DC HIE CAPABILITIES FOR OUR PROVIDERS**

- **Critical Infrastructure (e.g. Encounters and Alerts) Lookup**
- **Advanced Analytics for Population Health Management**
- **Registry and Inventory**
- **Simple and Secure Messaging**
- **Consent to Share Data**
- **Screening and Referral (e.g., SDOH)**

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

**CRISP Reporting Services**
- **Performance Dashboards Phase I:**
  - Pay for Performance Phase II:
  - Maternal health
  - Behavioral Health

**Care Management Registry**
**Community Resource Inventory**
- >31,000 contacts from 251 organizations
- Includes data from:
  - 12 national sources
  - 20 DC/Local Data sources

**Provider Directory**
**Consent to Share SUD DATA**
- 42 CFR Part 2 Data (Phase I)
- Other types of consent (Phase II)

**eReferral Screening**
- Mapped screening data for housing and food insecurity
eReferral
- Analytics for follow-up
During the COVID-19 pandemic, the DC HIE demonstrated the ability to adapt quickly to support DC Health, providers, and payers responding to the public health emergency.

**CRISP DC Uses COVID-19 Lab Result Data to Support Providers and Public Health**
- DC Health provides +/- case files to CRISP DC.
- Care teams receive notification on their patient’s +/- results.
- First responders receive notification if a + case occurs subsequent to transport.

**CRISP DC Uses Immunization Data to Support Providers and Payers Track Vaccinations for their Patients/Members**
- DC Health provides daily immunization files to CRISP DC and CRISP provides supplemental race/ethnicity data back to DC Health.
- Providers and payers can track and document vaccine outreach via the Vaccine Data Service.
- Vaccine Data Service allows patient panel view of received vaccine doses.
- Analytics tool provides statistics on vaccination summary via age, race/ethnicity, wards, etc.

*Spring 2020*

*Spring 2021*
In partnership with DBH, DHCF has implemented several changes to support behavioral health providers’ ability to participate in interoperable data exchange across the region:

- **Under DHCF’s 1115 waiver and Behavioral Health Transformation Rule, IMD providers are required to participate in the DC HIE**

- **As of July 12, 2020, all Institutes of Mental Diseases had participation agreements with CRISP DC, receiving appropriate alerts on their patients. This includes Psychiatric Institute of Washington and St. Elizabeth Hospital.**

- **Technical Assistance a DBH providers connect to the DC HIE.**
  - 47 DHB-certified providers received technical assistance for HIE connectivity
  - 30 now have participation agreements with CRISP DC and can view their patient’s clinical and encounter data

- **CMS’ Support Act Provider Capacity Grant - Consent Management Solution**
  - Will allow participating providers to create, manage, sign, and revoke 42 CFR Part 2 compliant consent.
One-Quarter of Medicaid Beneficiaries Have a Behavioral Health Diagnosis

Distribution of Behavioral Health Diagnoses Among Medicaid Beneficiaries, FY 2020

- No behavioral health diagnosis: 202,501 (75%)
- Other: 66,538 (25%)
- Mental health only: 51,869 (19%)
- Mental health and SUD: 9,833 (4%)
- SUD only: 4,836 (2%)

Medicaid beneficiaries = 269,039

Medicaid beneficiaries with BH diagnosis = 66,538

Mental health and SUD
- SMI and SUD = 8,748
- Non-SMI and SUD = 1,085

Mental health only
- SMI = 28,342
- Non-SMI only = 23,527

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2021.
Note: Reflects FY 2020 diagnoses for Medicaid beneficiaries enrolled during September 2020. SUD is substance use disorder; SMI is serious mental illness. 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.
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.

**Phase 1**
- 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.

**Phase 2**
- 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.

**Phase 3**
- Focus on additional opportunities to integrate physical and behavioral health for Medicaid beneficiaries.

**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.
In January 2020, DHCF and DBH began implementing the District’s Medicaid 1115 Behavioral Health Transformation Demonstration

- Under the Demonstration’s Standard Terms and Conditions (STCs), authority for 8 of the 10 approved demonstration services will end effective December 31, 2021 – only IMD services and exemption from $1 copayment for MAT services will remain.

In June 2021, DHCF will propose three Medicaid state plan amendments (SPAs) to transition community-based demonstration services to permanent authority effective January 1, 2022:

- Behavioral Health Services/Other Licensed Providers
- Mental Health Rehabilitative Services (MHRS)/Adult Substance Use Rehabilitative Services (ASURS)/Behavioral Health Stabilization
- Supported Employment Services

Reforms aim to ensure access and utilization of services as part of District’s planning efforts to transition services to managed care authority in FY23 and fully integrate physical and behavioral health care in future years
Demonstration Services are Now Fully Authorized, Though Some Will Transition to State Plan Amendment Authority

<table>
<thead>
<tr>
<th>Name of Service Authorized in the Demonstration</th>
<th>Transitioning to the SPA?</th>
<th>Date Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMD Services (inpatient residential, mental health SUD) for individuals aged 21 - 64</td>
<td>No</td>
<td>January 2020</td>
</tr>
<tr>
<td>Clubhouse (adult psychosocial day rehabilitation services)</td>
<td>Yes</td>
<td>January 2020</td>
</tr>
<tr>
<td>Recovery Support Services (RSS)</td>
<td>Yes</td>
<td>January 2020</td>
</tr>
<tr>
<td>Psychologists/Other licensed behavioral health practitioners</td>
<td>Yes</td>
<td>January 2020</td>
</tr>
<tr>
<td>Eliminate $1 Co-Pay for MAT drug products</td>
<td>No</td>
<td>January 2020</td>
</tr>
<tr>
<td>Supported Employment – Mental Health and SUD</td>
<td>Yes</td>
<td>Mental Health: February 2020; SUD: March 2020</td>
</tr>
<tr>
<td>Trauma-Targeted care (Trauma Systems Therapy and Trauma Recovery and Empowerment Model)</td>
<td>Yes</td>
<td>March 2020</td>
</tr>
<tr>
<td>Behavioral Health Stabilization (CPEP, Psychiatric Crisis Stabilization Beds, Adult/Youth Mobile Crisis and Adult Outreach Services)</td>
<td>Yes</td>
<td>June 2020</td>
</tr>
<tr>
<td>Transition Planning Services</td>
<td>Yes</td>
<td>October 2020</td>
</tr>
</tbody>
</table>
Early District Behavioral Health Waiver Experience Shows Increased Access to Community Care Through Telehealth and Funding for IMD Services

- DHCF and DBH began implementing the District’s Medicaid 1115 Behavioral Health Transformation Demonstration on January 1, 2020, with phased implementation of demonstration services throughout the year.

- Demonstration is the first phase of a three-phase reform effort that aims to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.

- Due to the public health emergency, take-up of new services has been lower than anticipated to start, but increased access to telehealth services has provided a consistent means to access care, especially for individuals with serious mental illness.

- As anticipated, the Demonstration has increased Medicaid funding for short-term, acute stays in institutions for mental disease (IMDs) for Medicaid-covered non-elderly adults who were previously ineligible for Medicaid coverage during their IMD stay.

- DHCF adjusted requirements for Clubhouse psychosocial rehabilitative services during public health emergency to allow for shorter service timeframes and telehealth service delivery.

Of the nearly 4,000 beneficiaries using waiver-based BH services in CY 2020, one-quarter accessed at least one waiver service via telehealth

Source: DHCF Medicaid Management Information System data extracted in March 2021 for claims with CY 2020 dates of service.

Notes: MAT is medication assisted treatment. Number of beneficiaries reflects utilization of behavioral health waiver services, which are paid on a fee-for-service basis. In some cases, similar services are paid by managed care organizations and are not considered to be a part of the Demonstration. Due to claims lag, counts are likely to be higher when run at a future date. The sum of beneficiaries across services exceeds these unduplicated total because some individuals receive more than one of the service types shown.
As part of planning efforts, DHCF and DBH gathered information through three opportunities:

1. **Aurrera Health Group:** produced a report on options to integrate behavioral health services into managed care:
   - Based on interviews with 5 states and a national review of integration efforts.
   - Report included 4 key lessons:
     - Support & Train Behavioral Health Providers Early & Often
     - Support Provider Stability & Enrollee Access to Care
     - Ensure Oversight of MCOs Specific to Behavioral Health Care
     - Build Strong Partnership Between Medicaid and Behavioral Health Teams

2. DHCF and DBH issued a public **Behavioral Health Transformation Request for Information**
   - 16 respondents provided input on the 21 questions.
   - Overall, respondents supported transforming behavioral health care in the District to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is *comprehensive, coordinated, high quality, culturally competent, and equitable.*

3. In FY21, a Behavioral Rate Study is underway to ensure rate methodologies are sufficient to support BH providers to meet District expectations
DC Among 15 States Selected for Substance Use Disorder (SUD) Demonstration Project to Further Transform Behavioral Health

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, section 1003 demonstration project to increase the treatment capacity of Medicaid providers to deliver substance use disorder treatment and recovery services.

**DHCF was awarded $4.75 million. We see this work and the opportunity for a 36-month demonstration as a strong complement to DCOR and 1115.**

Collaborative Funding from

- The Centers for Medicare & Medicaid Services (CMS), in consultation with
- The Substance Abuse and Mental Health Services Administration and
- The Agency for Healthcare Research and Quality, is conducting a 54-month evaluation of the program

Two phases of the project

- Planning grants awarded to 15 states ($50 million aggregate) for 18 months; and
- 36-month demonstrations with up to 5 states that received planning grants.
1. Comprehensive needs assessment of Medicaid provider capacity to diagnose and treat SUD, building on Opioid Strategic Plan, Pew assessment.

2. Education and technical assistance among Medicaid providers to build provider capacity to treat individuals with SUD in community settings (in procurement).

   **Prioritized providers include:**
   - My DC Health Homes
   - My Health GPS
   - Buprenorphine waivered providers

   Pilot e-consult and telemedicine tools to provide access to addiction specialists on-demand who can support Medicaid providers.

3. Upgrade communication and referrals with District behavioral health providers (via MOU to DBH, in progress).

4. Development of consent management tools to facilitate appropriate exchange of 42 CFR part 2 data via the DC HIE (In pilot stag).

5. Supplemental Award (March 2021) for sobering center and crisis stabilization study (via MOU to DBH, underway).
Consistent With Recent Years, Home- and Community- Based Services Represent Greatest Share of LTSS Spending

<table>
<thead>
<tr>
<th>Service</th>
<th>Total Number of Recipients*</th>
<th>Total Service Cost</th>
<th>Average Cost Per Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Institutional Total</strong></td>
<td>4,398</td>
<td>$393,512,349</td>
<td>$89,475</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>4,099</td>
<td>$296,141,134</td>
<td>$72,247</td>
</tr>
<tr>
<td>ICF/IDD</td>
<td>305</td>
<td>$97,371,215</td>
<td>$319,250</td>
</tr>
<tr>
<td><strong>HCBS Total</strong></td>
<td>9,094</td>
<td>$634,886,267</td>
<td>$69,814</td>
</tr>
<tr>
<td>State Plan PCA</td>
<td>5,701</td>
<td>$211,230,719</td>
<td>$37,052</td>
</tr>
<tr>
<td>EPD Waiver</td>
<td>4,905</td>
<td>$137,291,855</td>
<td>$27,990</td>
</tr>
<tr>
<td>IDD Waiver</td>
<td>1,876</td>
<td>$286,363,693</td>
<td>$152,646</td>
</tr>
<tr>
<td><strong>Institutional and HCBS Total</strong></td>
<td>12,885</td>
<td><strong>$1,028,398,616</strong></td>
<td><strong>$79,814</strong></td>
</tr>
</tbody>
</table>

Source: DHCF Medicaid Management Information System (MMIS) data extracted in March 2021 for claims with FY 2020 dates of service.

Note: Numbers reflect individuals ever receiving a given service during FY 2020.

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.
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.

DHCF has made significant strides toward successful implementation of PACE in the District this year, including completion of initial provider selection and program & policy development (*currently stalled pending OCP resolution of two filed protests*).
Approximately 37,000 of DHCF’s enrolled participants are dually eligible for both the Medicare program and Medicaid:

- About 25,000 individuals are “full duals” enrolled in both Medicare and Medicaid coverage
- About 12,000 individuals are “QMB only” enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program

While most District duals access Medicare benefits through fee-for-service Medicare, about a third of these individuals (more than 12,000) are enrolled in special Medicare Advantage plans designed to improve Medicare-Medicaid coordination

The District intends to increase Medicare-Medicaid coordination by implementing a highly integrated dual eligible special needs plan (HIDE SNP) program in CY 2022. The HIDE SNP will:

- Offer enhanced care management for many who now lack access to care management
- Improve coordination of benefits and reduce duplication of services between payers
- Simplify and streamline navigation of services for beneficiaries and their families and caregivers
On 10/1/2020, CMS approved several changes to DHCF’s 1915(c) waiver program for the Elderly and Persons with Physical Disabilities; these include:

- Deduplication of certain services already covered under the Medicaid State Plan
- Modernization and expansion of assistive technology, including coverage of Personal Emergency Response System (PERS) benefits and medication management devices
- Delinking waiver and State Plan personal care aide (PCA) benefits to establish a 16-hour limit on PCA services in the waiver (*implementation of this change will be delayed until the end of the PHE)

These will enable the District to realize several key benefits:

- More person-centered – and less “one size fits all” – care planning: currently 90% of waiver services spending is dedicated to one single overutilized service (personal care aide services)
- More efficient operation of services like PCA and in-home skilled benefits: this will streamline authorizations, reporting, and oversight
- Maintenance of cost-neutral status in the waiver: a Federal precondition of operating a waiver
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 6% of DHCF program enrollment in FY 2020; 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 about $25,760 for an individual or $53,000 for a family of four.

* Expected as of July 2021. 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.
Alliance Population Age 37+ Has Grown While Younger Population Has Fallen

Source: DHCF Medicaid Management Information System data extracted in March 2021.

Note: Data reflects average monthly enrollment. Age 37 corresponds with a cutoff used to determine managed care rates.
Nearly 4 in 10 Alliance Beneficiaries Losing Coverage Re-Enroll in Medicaid or Alliance Within a Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Alliance Beneficiaries Ever Enrolled</th>
<th>Total Terminated</th>
<th>Total Terminated and Re-enrolled in Alliance Within 1 Year</th>
<th>Total Terminated and Re-enrolled in Medicaid Within 1 Year</th>
<th>Net Terminated and Re-Enrolled in Medicaid or Alliance Within 1 Year (% of Total Terminated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>22,183</td>
<td>7,743</td>
<td>2,906</td>
<td>181</td>
<td>3,087 (40%)</td>
</tr>
<tr>
<td>2018</td>
<td>21,467</td>
<td>7,765</td>
<td>3,014</td>
<td>148</td>
<td>3,162 (41%)</td>
</tr>
<tr>
<td>2019</td>
<td>21,162</td>
<td>7,318</td>
<td>2,880</td>
<td>135</td>
<td>3,015 (41%)</td>
</tr>
<tr>
<td>2020</td>
<td>20,309</td>
<td>3,328</td>
<td>909</td>
<td>56</td>
<td>965 (29%)</td>
</tr>
</tbody>
</table>

**Source:** DHCF Medicaid Management Information System data extracted in February 2021.

**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 was significantly lower compared to prior years because coverage was automatically extended to enrollees during the public health emergency.
DHCF is drafting policy reforms for the DC Healthcare Alliance program to comply with recent changes and update eligibility standards consistent with Medicaid for DCAS launch – the new rule would:

- Update Alliance eligibility requirements to ensure greater parity with Medicaid eligibility standards and processes to:
  - Increase Alliance income eligibility levels to 210% of the federal poverty level with a 5% disregard – comparable to Medicaid childless adult limits
  - Adopt Modified Adjusted Gross Income (MAGI) income methodology and other Medicaid eligibility standards and processes
  - Eliminate resource limits, comparable to Medicaid MAGI standards

- Implement changes from the DC Healthcare Alliance Program Recertification Simplification Act to:
  - Allow exemption from in-person interviews for enrollees or their caregivers that are hospitalized, disabled (including an individual who is pregnant), or elderly (65 or older)
  - Limits in-person interviews to only once every twelve (12) months
  - Allows individuals to complete interviews during recertifications over the phone

- Establish a new Alliance eligibility group for individuals determined to have been unjustly convicted of a crime in the District of Columbia, pursuant to statutory requirements under the Unjust Imprisonment Act

- Suspend capitation payments to the Alliance beneficiary’s Managed Care Organization if the beneficiary becomes incarcerated

- Allow DHCF to conduct periodic electronic data matches to update or confirm District residency between annual renewal periods, and to initiate termination of Alliance eligibility if an individual does not resolve the discrepancy

Rule will be shared with Council for approval in Summer 2021
DHCF is proposing policy reforms to Immigrant Children's Program:

- Increase income eligibility to levels comparable to Medicaid/CHIP for children:
  - 319% of the federal poverty level, plus 5% disregard for children 0-18
  - 216% of the federal poverty level, plus 5% disregard for children 19-20

- Streamline and updates ICP eligibility requirements and procedures to ensure greater parity with Medicaid eligibility standards and processes, including:
  - Adopting Modified Adjusted Gross Income (MAGI) methodology for household income; and
  - Updating non-financial eligibility factors to more closely align with Medicaid financial eligibility requirements.
  - Suspending benefits and capitation payments to the enrollee’s Managed Care Organization if the enrollee is incarcerated.
  - Allowing periodic electronic data matches to update or confirm District residency between annual renewal periods, and to initiate termination of eligibility if an individual does not resolve the discrepancy.

Income eligibility changes have been proposed as part of the FY2022 Budget Support Act and other changes will be effectuated through a rule being proposed for implementation in Summer 2021.
DHCF’s Role During the Public Health Emergency

• Ensure **access to coronavirus testing and treatment** for Medicaid/Alliance and eligible beneficiaries

• Ensure **ongoing access to care** for beneficiaries in the event of an emergency

• Support Medicaid **providers** in providing **testing and treatment** for coronavirus, and in continuing **ongoing care delivery operations**
American Rescue Plan Act: Enhanced Funding for Home and Community-Based Services

June 02, 2021
ARPA Provides a One Time Opportunity to Enhance HCBS Services

- The American Rescue Plan (ARPA) of 2021 was signed into law on March 11, 2021

- ARPA Section 9817 Enhances Medicaid Funding for Medicaid Home and Community Based Services
  - 10% FMAP bump for services provided between April 1, 2021, and March 31, 2022;
  - New funds must supplement not supplant level of state funds for programs in effect as of April 1, 2021
  - Eligibility for enhanced requires states to enhance, expand, and strengthen home and community-based services under the state’s Medicaid program

- CMS guidance interpreting Section 9817 provisions released on 5/13
  - On-going guidance through All State calls and other technical assistance

- DHCF, DDS, DBH in ongoing conversations on utilization of funds to enhance Medicaid HCBS
DHCF's Guiding Principles in Developing Potential ARPA Activities

▪ **Level the playing field**: Coordinating across provider types and building out equally for any one-time infrastructure initiatives; especially in areas where HCBS providers uptake has trailed other provider types (e.g. past federal electronic health record initiatives excluded certain provider types)

▪ **Build on existing efforts**: Interested in areas where the District can build on existing work/existing efforts to be inclusive of HCBS providers (e.g. practice transformation efforts; support HCBS providers/building capacity to meet current/future quality initiatives)

▪ **Strengthen system capacity**: Interested in areas where the District can potentially minimize or eliminate existing gaps in the Medicaid service array (e.g. increasing HCBS provider capacity to serve members with behavioral health diagnoses/other complex care needs)
There is an Array of Eligible Enhancement Activities

- States may spend funds attributable to increased FMAP on both HCBS services and HCBS-related administrative activities (non-exhaustive list):
  - Increase amount, duration, scope of HCBS services
  - New/Special Provider Payments and Rate Enhancements
  - Provider Workforce Training/Recruitment/Support Initiatives
  - Quality Improvement/measurement/oversight initiatives
  - Information Technology Implementation
  - Strengthening Assessments practices
  - Changes to streamline Eligibility Systems
  - Expanding use of technology/telehealth
  - Conducting Care Surveys
  - Addressing Social Determinants of Health
  - Enhancing Care Coordination Infrastructure
Eligible HCBS Services are More Broadly Defined Under ARPA

- States will be permitted to use the state funds equivalent to the amount of federal funds attributable to the increased FMAP through **March 31, 2024** on enhancement activities.
- The increased FMAP is only attributable to Medicaid expenditures for certain HCBS services. HCBS defined to include:
  - Home health care services;
  - Personal care services;
  - Case management and targeted case management;
  - All rehabilitative services defined at 42 CFR § 440.130(d);
  - In Home Private Duty Nursing;
  - All 1915(c) services, including CMS-approved “other” services;
  - All 1915(i) services, including CMS-approved “other” services;
  - PACE Services; and
  - HCBS delivered through managed care or approved under 1115 Demonstration.
- Increase additive to increased FMAP for FFCRA; Childless Adults, 1915(k) Community First Choice, etc.
- Increase not attributable to certain Medicaid administrative expenditures, Health Home expenditures, CHIP expenditures, etc.
States Must “Supplement, Not Supplant” HCBS Funding

▪ ARPA legislation required increased FMAP be used to Supplement not supplant level of state funds for programs/services in effect as of April 1, 2021

▪ To meet these requirements States must:
  ▪ Use funds attributable to the increased FMAP to expand, strengthen, enhance HCBS
  ▪ Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
  ▪ Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
  ▪ Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

▪ States are expected to retain temporary changes made under Appendix K; E-SPA for as long as allowable under those authorities, but will not be penalized/deemed non-compliant when/if those changes expire
CMS Must Approve an Initial Plan and then States Commit to Ongoing Reporting

- CMS will require states to submit both an initial and quarterly HCBS spending plan and narrative that describe activities that the state has intends to implement; CMS will share a summary publicly

  - **Initial Spending Plan** should estimate total amount of funds attributable to FMAP increase and anticipated expenditures on enhancement activities
  - **Initial Narrative** must detail how planned activities will enhance HCBS and explain how activities will be **sustained past 2024**

  - **Quarterly Spending Plan** should include estimate by quarter and total the amount of enhanced funds the state will claim through March 31, 2022; actual/anticipated expenditures on enhancement activities
  - **Quarterly Narrative** should include progress reports on enhancement activities

- Initial and ongoing plans must include state attestations/assurances that State is not supplanting existing state funding
DHCF is Collaborating with Sister Agencies to Develop Plan for Submittal to CMS

- Ongoing cross-agency collaboration to finalize enhancement activities scope, narrative, and corresponding spending plans
  - Must consider impact on local budget / cost neutrality
  - Must consider long term sustainability of initiatives funded via time-limited enhanced FMAP
  - Must consider parity/equity of enhancement activities across HCBS programs/providers

- Ongoing discussion with CMS on programmatic requirements

- District has requested additional time to finalize submissions
  - Initial submissions originally required by 6/12; Extension to 7/12 approved by CMS

- CMS expects review and approval within thirty (30) days of initial submissions
Questions