GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2026 Budget Hearing

Testimony of
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Deputy Mayor for Health and Human Services
and
Director, Department of Health Care Finance

Before the Committee on Health
Council of the District of Columbia
The Honorable Christina Henderson

Monday, June 9, 2025
9 a.m.
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure to report on Mayor Muriel Bowser's proposed Fiscal Year 2026 (FY2026) Budget and Financial Plan for DHCF. This budget season occasioned several significant developments that forced the Mayor to reconsider the protection proffered by the District's expansive health care social safety net. Separate and apart from the in-year rebalancing required for the FY2025 budget, the Mayor's budget team was forced to confront double digit growth in DHCF's local fund budget for the Medicaid and Alliance programs, juxtaposed against the city's sharp declines in its projected four-year revenue picture. This required cost saving proposals for the city's two publicly funded health care programs that, in some ways, fundamentally depart from prior efforts to wrench savings from the Medicaid and Alliance programs.

To discuss these budget proposals, I am joined by a team of professionals at DHCF who are steeped in health care and well versed in the esoteric and challenging language of the Medicaid program. Melisa Byrd, Senior Deputy Director and Medicaid Director, Angelique Martin, Senior Deputy Director of Finance, and DHCF's fiscal officer, Darrin Shaffer, worked long hours to analyze thoughtful proposals that define DHCF's FY2026 budget proposal for the Executive Office of the Mayor (EOM).

Further, I would be inappropriately remiss if I did not recognize and thank the Administrators and senior staff who supported, without fail, the tireless work of my executive team as we stared down the many formidable tasks of this budget season. To represent this group, I have asked April Grady, the agency's lead data analyst, two key staffers - James Simms,

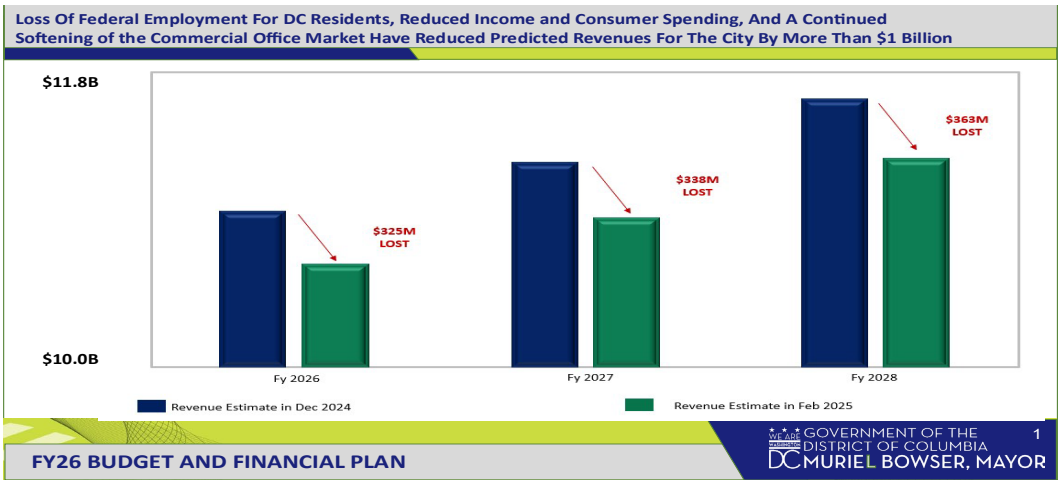
Associate Director of Medicaid Finance, and Joseph Brennan, our highly skilled actuary – to attend this hearing in support of my testimony. Their keen analytical skills, combined with an uncommon insight into the operations of the Medicaid and Alliance programs, allowed for the development of rational budget proposals, as we struggled through the headwinds of the city's declining revenue picture.

My testimony today focuses on the following issues –

- The financial environment in which we formulated DHCF's budget, as we witnessed the countervailing cost growth trends for both the Medicaid and Alliance programs;
- The framework employed by DHCF to slow the growth in funding for Medicaid and Alliance – both of which are entitlement programs that pose special problems with efforts to permanently alter program spending trends;
- The changes made to Medicaid's eligibility thresholds, its program benefits, and our provider rates policies as a means of slowing the projected growth in the program;
- The program changes proposed to reform and reduce the financial footprint of the locally funded Alliance program; and,
- The status of DHCF's proposal to CMS to establish a program of State Directed Payments for hospitals based on an industry provider tax.

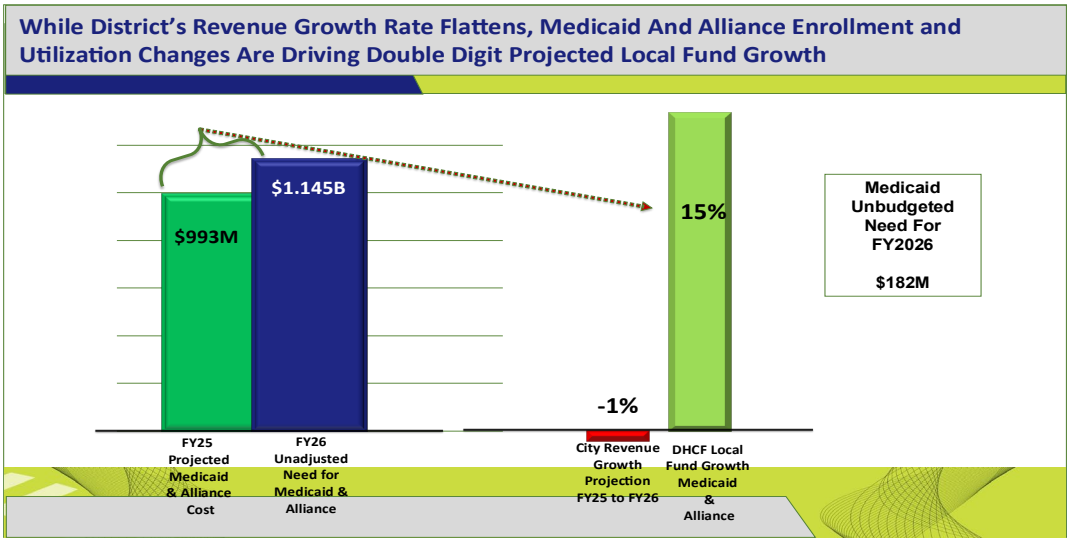
Financial Environment Impacting DHCF's Budget Development

On February 28, 2025, the District's Chief Financial Officer (CFO) released the city's revenue forecast covering the four-year operational plan from FY2026 through FY2029. Driven by damaging federal job losses among District residents, reduced income and consumer spending, and a continued softening of the commercial office market, the CFO revised the revenue estimate sharply downward by more than $1 billion over the next four years – an average of $342 million annually (see graph on next page). In FY2026, the first year for budget



formulation, revenue growth for the District is predicted to be negative – a decline of roughly $50 million from early projections, or -0.5 percent.

In the face of this revenue decline, DHCF witnessed projected spending trends for the Medicaid and Alliance program that were expected to reach double digits for FY2026. Specifically, without any changes in the FY2025 Medicaid and Alliance spending policies, the cost for these programs is anticipated to increase by 15 percent in FY2026 (see graph below). In dollar terms, this meant that DHCF's unadjusted budget need for FY2026 was $182 million more than was available to fund the agency's programs – this while the city's revenue picture continues to deteriorate.



Framework To Reduce Medicaid and Alliance Spending For FY2026

As has been discussed in previous budget hearings, significant savings in public health insurance programs can only be achieved by lowering eligibility levels, reducing program benefits, and/or lowering provider reimbursement rates. With respect to Medicaid, the District funds the highest eligibility levels in the nation and deploys a comprehensive set of benefits which are supported by provider reimbursement rates that are sufficiently robust to ensure beneficiary access to care. In many respects, the eligibility design, benefit framework, and provider reimbursement levels for Alliance are distinguished from Medicaid only by the source of funding – Alliance is paid for with only local dollars.

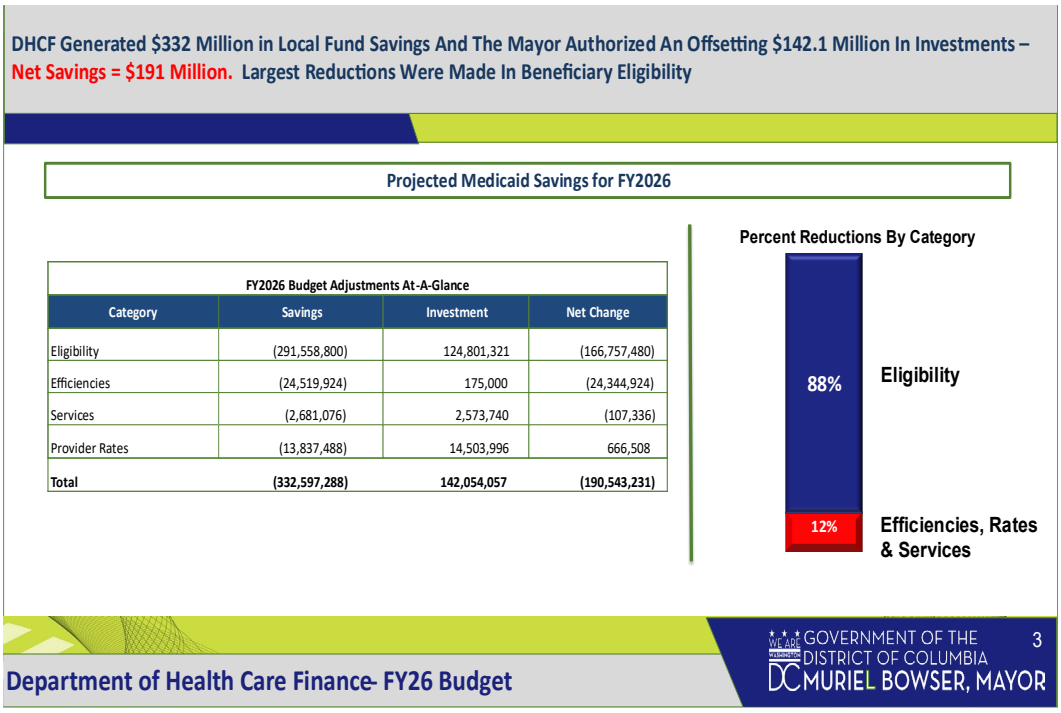
As both these programs are considered entitlements, permanent reductions in policies that control access to Medicaid and Alliance must be a central part of any strategy to blunt the growth in spending. Changes to benefit levels and provider pricing can curtail program cost growth as well, but these type reductions must be more carefully designed to avoid unintended problems that carry the potential to significantly undermine the public insurance safety net. And, in the case of Medicaid, federal policies governing the benefits covered by the program add considerable complexity to any approach aimed at meaningfully and sensibly pruning benefit cost. This in mind, DHCF budget proposals were designed to lower eligibility thresholds, produce program efficiencies or structural changes that reduce the financial footprint of these programs, and selectively delay provider rate increases.

DHCF Proposed Budget For FY2026

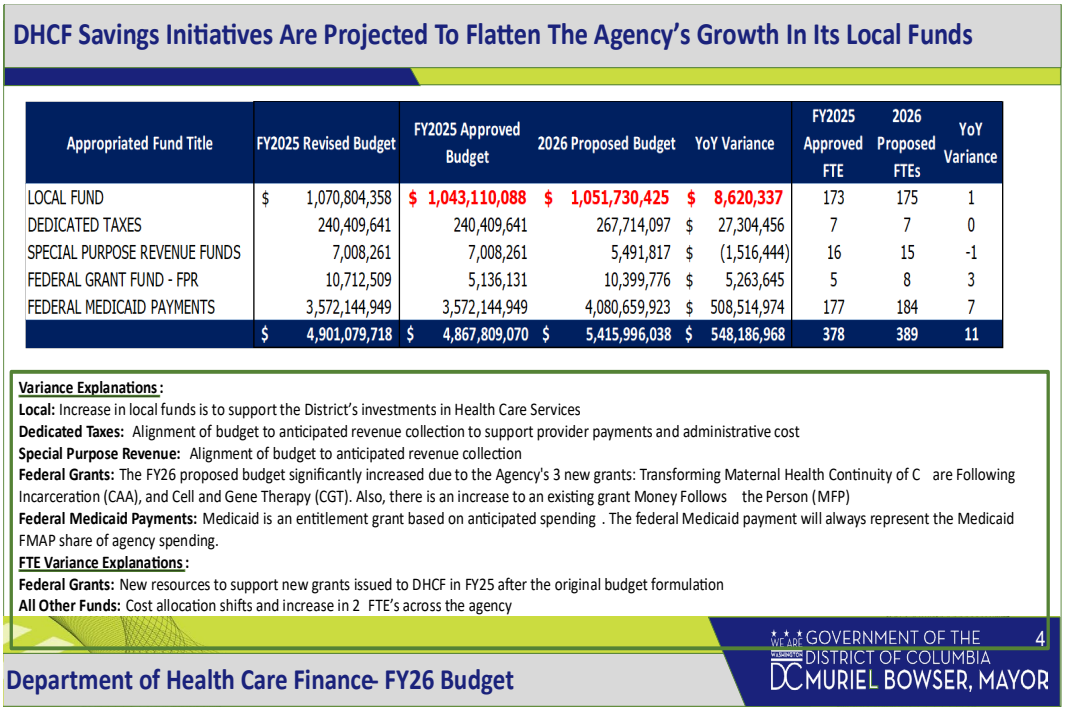
As in past years, the process used by the budget team to build the agency's FY2026 proposal was iterative, with the FY2025 recurring budget as the starting point for the formulation. Then, through a series of debits and credits, governed by broad mayoral policy

goals and specific programming decisions, DHCF staff and the Mayor's budget team built a bottom-line local funding amount to represent the agency's proposed budget, subject to final approval by the Mayor.

The table below first summarizes the savings amounts that were submitted for review by the Mayor, according to several broad policy categories. As shown, DHCF recommended more than $332 million in savings across four separate categories – eligibility, program efficiencies, provider rates, and program services. Next, following a review of this submission along with enhancement requests by the agency, the Mayor approved an offsetting amount of $142.1 million in investments. The net change in eligibility savings ($166.7 million), programming efficiencies ($24.3 million), and minor service reductions totaled $190.5 million. Changes to program eligibility policies are projected to account for 88 percent of these savings, with programming efficiencies and service reductions representing the remaining 12 percent.



With these changes, the Mayor's proposed budget for DHCF is shown in the table below. Notably, DHCF's proposed local budget for FY2026 of just over $1 billion, compared to the approved local budget for FY2025, reflects less than a 1% increase in projected local funds. Because of varying federal match rates and the federal revenue generated by the proposed hospital provider tax, the DHCF's proposed total fund budget of $5.4 billion is 11 percent higher than the approved budget for FY2025, with a year over year variance of nearly $550 million.



DHCF Savings Initiatives Are Projected To Flatten The Agency's Growth In Its Local Funds

Appropriated Fund Title	FY2025 Revised Budget	FY2025 Approved Budget	2026 Proposed Budget	YoY Variance	FY2025 Approved FTE	2026 Proposed FTEs	YoY Variance
LOCAL FUND	$ 1,070,804,358	$ 1,043,110,088	$ 1,051,730,425	$ 8,620,337	173	175	1
DEDICATED TAXES	240,409,641	240,409,641	267,714,097	$ 27,304,456	7	7	0
SPECIAL PURPOSE REVENUE FUNDS	7,008,261	7,008,261	5,491,817	$ (1,516,444)	16	15	-1
FEDERAL GRANT FUND - FPR	10,712,509	5,136,131	10,399,776	$ 5,263,645	5	8	3
FEDERAL MEDICAID PAYMENTS	3,572,144,949	3,572,144,949	4,080,659,923	$ 508,514,974	177	184	7
	$ 4,901,079,718	$ 4,867,809,070	$ 5,415,996,038	$ 548,186,968	378	389	11

Variance Explanations:
Local: Increase in local funds is to support the District's investments in Health Care Services
Dedicated Taxes: Alignment of budget to anticipated revenue collection to support provider payments and administrative cost
Special Purpose Revenue: Alignment of budget to anticipated revenue collection
Federal Grants: The FY26 proposed budget significantly increased due to the Agency's 3 new grants: Transforming Maternal Health Continuity of C are Following Incarceration (CAA), and Cell and Gene Therapy (CGT). Also, there is an increase to an existing grant Money Follows the Person (MFP)
Federal Medicaid Payments: Medicaid is an entitlement grant based on anticipated spending . The federal Medicaid payment will always represent the Medicaid FMAP share of agency spending.
FTE Variance Explanations:
Federal Grants: New resources to support new grants issued to DHCF in FY25 after the original budget formulation
All Other Funds: Cost allocation shifts and increase in 2 FTE's across the agency

Madam Chairwoman, the next section of my testimony outlines the specific Medicaid savings initiatives and enhancements that were approved by the Mayor, including a discussion of the policy framework within which these reductions were considered.

Medicaid Savings Initiatives and Enhancements

The cost reduction plan for Medicaid was designed to address, in varying degrees, the three foundational pillars which support Medicaid – eligibility levels, benefit structure, and provider reimbursement rates. Though separate, these policies are interconnected in ways to

protect the District's Medicaid safety net, ensuring access to a full range of quality health care services. Any changes to these policies must be implemented in a manner that slows the program's cost growth, without vitiating the safety net for those who remain in the program.

Lowering Medicaid Eligibility Levels. The most effective method for slowing Medicaid cost growth is to reduce the number of residents who can lawfully qualify for the program. Thus, reducing the District's eligibility thresholds for Medicaid was a key element of the Administration's reduction strategy. Three goals were pursued with this approach:

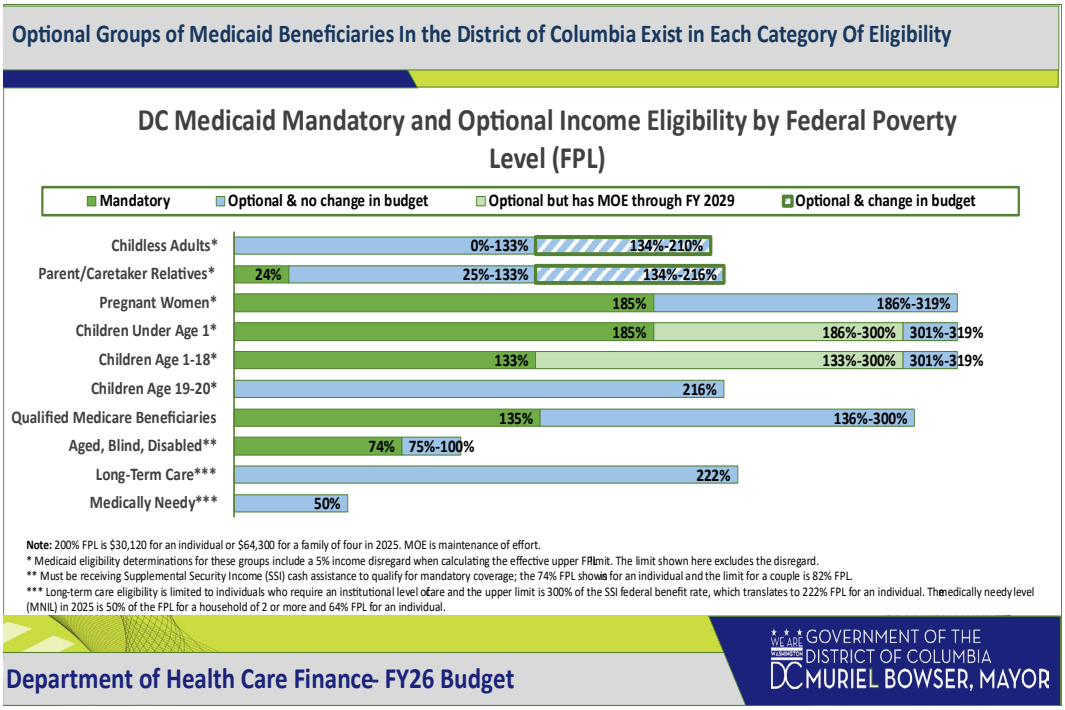
First, the decision was made to focus on Medicaid optional populations whose participation in the program is not protected by federal mandatory coverage requirements, called maintenance of effort, that Congress has enacted over the years. The optional groups in Medicaid are low-income individuals and families that the District has the authority to enroll in the program but is not required to do so. These optional groups are typically distinguished from mandatory members only by the amount of income they earn, and in one case the category of eligibility that they represent which is referred to as the "Medically Needy".

Second, DHCF targeted those beneficiaries who are in the upper tier of the income thresholds for the program. Compared to other states, District residents benefit from a Medicaid program that has the highest eligibility levels in the country. At the top end of the eligibility thresholds, only the District affords health care access to people whose incomes reach 215 percent of the federal poverty level (FPL).

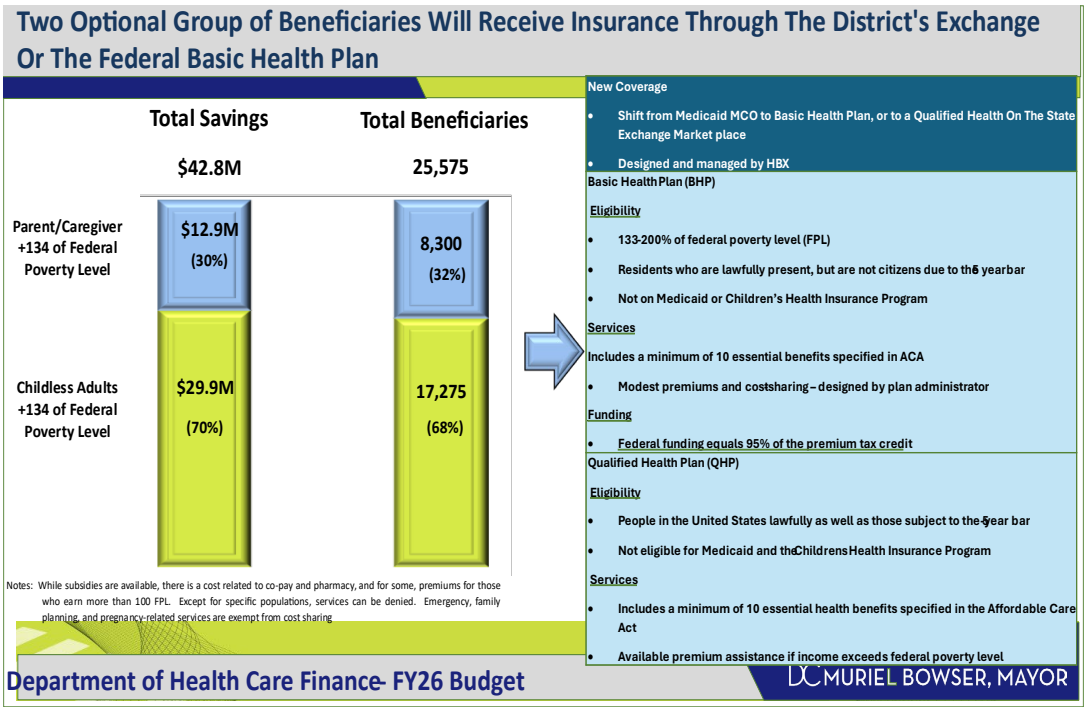
Third, we focused eligibility reductions on people who have other insurance options beyond the Medicaid program. Presently, some of those who will be impacted by this policy will be able to secure heavily subsidized coverage for a Qualified Health Plan on the District's Exchange Marketplace. Others – the majority – who lose Medicaid coverage will be eligible to

enroll in a Basic Health Plan (BHP) that will be designed and implemented by the DC Exchange with limited cost sharing requirements.

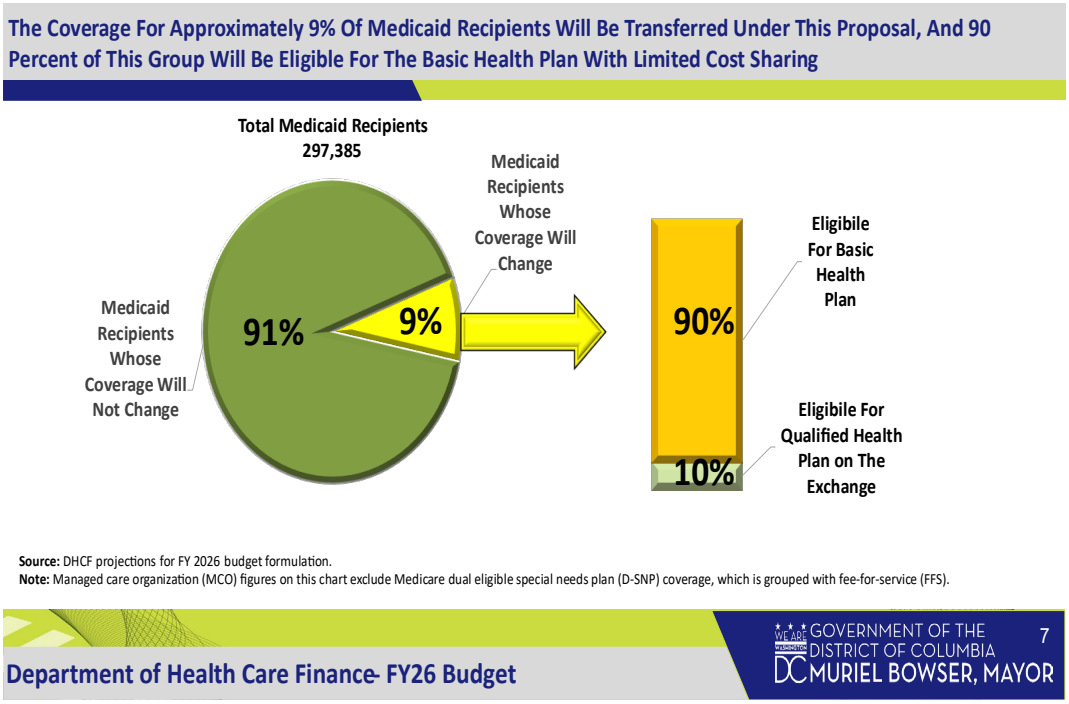
The graph below illustrates Medicaid mandatory and optional populations and indicates the two eligibility groups by income threshold that will no longer qualify for the program. As shown, the two groups impacted by this reduction in eligibility are childless adults with incomes that are above 133% and up to 210% of the FPL (exclusive of the District's 5% income disregard). The other affected group is parents or caretakers with incomes from 134% to 216% of FPL, again exclusive of the 5% income disregard.



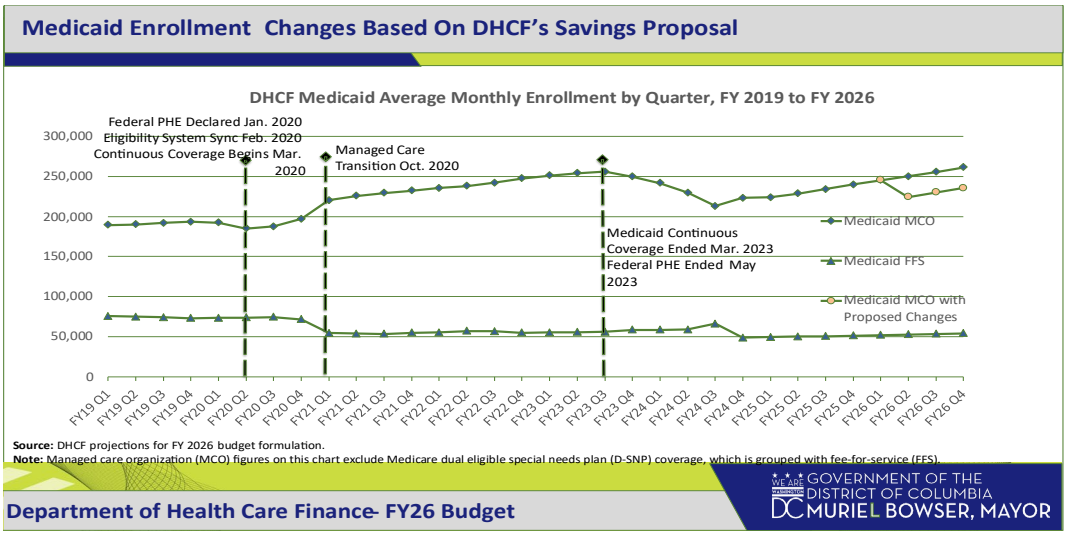
The graphic on page 10 reveals the total number of Medicaid beneficiaries who are impacted (more than 25,500 or 9 percent of all Medicaid beneficiaries in the District) and the projected cost savings for FY2026 of slightly more than $42 million. As noted earlier, people in



both eligibility groups will be encouraged to enroll in either a Qualified Health Plan on the Exchange or the federal BHP, which will be designed by staff at the DC Exchange. We estimate that roughly 10% of those who will lose Medicaid coverage will be eligible to enroll in a Qualified Health Plan (see graph on next page). These residents will face cost-sharing – premiums, co-pays, and deductibles, but will benefit from policies that cap these expenses. Premiums for this group will be capped at no more than 6.8 percent of their income level. Reductions in the allowable cost-sharing amounts are also available depending on income and the specific plan selected on the Exchange marketplace. The remaining 90 percent of those who lose coverage will be eligible for BHP coverage. This program could require monthly premiums and cost-sharing as well. However, these policies are being designed by the Exchange to have no premium and no or more limited cost sharing than private insurance premiums on the marketplace, making health insurance more accessible to low-income individuals. Current data from BHP programs in other states show that monthly premiums range from $0 – $80.



The impact of this proposed reduction in Medicaid enrollments is shown below. With this change, by the end of the 1st quarter of FY2026, average Medicaid enrollment levels are projected to be about 20,000 less than they otherwise would have occurred. At the end of FY2026, there will be 26,000 less people in Medicaid on an average monthly basis, and the associated savings will flow through the entirety of the District's four-year financial plan.



Medicaid Program Efficiencies. Significant savings will be generated by two policies to introduce greater efficiency into the Medicaid program. The first is a $5 million local funds reduction in the capitated payment rate for the MCO program. This is a strategy to encourage the health plans to generate better outcomes in reducing avoidable hospital admissions, limiting hospital readmissions within 30 days of discharge, and driving down the use of the emergency room for low-acuity illnesses by members in their health plans. In previous years, DHCF withheld a small portion of the MCO's capitated payments which they could earn back through improved performance in these areas. The outcomes were uneven to say the least. This, however, is a permanent capture of $5 million in local funds through an upfront reduction in the health plans' revenue.

Also, we project that DHCF can save $9.1 million in local funds through the capture of drug rebates for prescriptions that Medicaid MCOs pay through providers other than a pharmacy – the most frequent occurrences are claims paid to outpatient hospitals. Until recently, these claims have been paid without the agency securing an allowable rebate. Additionally, by cost shifting claims for end-stage renal disease to Medicare and by charging the cost of emergency transportation to the federal Emergency Medicaid program (a program for uninsured residents unable to qualify for Medicaid due to immigration status), we are estimated to save an additional $8.8 million in local funds.

Changes to Medicaid Provider Rates. DHCF made numerous changes to provider reimbursement rates. And while the net effect of these changes was limited by a significant enhancement paid to the dental program and the wage enhancement for direct service professionals (DSP), the actions warrant attention.

Notably, in the table below, DHCF's budget provides over $14.5 million in enhancements for a dental rate increase ($7.9 million) and DSP workers ($6.5 million). The dental rate increase addresses a problem that has lingered for a decade, when the industry last received a rate review and an increase. In a tight budget year, the goal was to better align dental rates with those paid in Maryland and Virginia. Hence, we increased payments for more than 125 dental codes, and the result is that DC has higher rates that witnessed in Maryland and Virgina. DHCF also funded a requirement that MCOs pay a minimum of the FFS rate to dental providers.

The FY26 Budget Supports Increase of Dental Rate and Maintains DSP Enhanced Wages, While Limiting Inflation And Delaying Rate Rebasing For Other Providers

Rates	Amount	Description
Dental Rate Increase	$ 7,994,310	• Last rate review and increase over 10 yrs ago • Increased over 125 dental codes • Alignment with MD and VA recent rate studies, DC pays higher
DSP Wage Enhancement for HHA's	6,509,686	• Transitions ARPA supplemental payment to include in rate • Living Wage is $17.95, DSP enhanced is $21.11 (plus fringe and admin) • Funded in FY26 as one-time; and will remain at $21.11
Total Enhancements	**$14,503,996**	
FQHC Rebasing Delay	($4,438,722)	• Rebasing will be delayed until 2027 • Rebasing assumptions including a scope change that all facilities would provide extended hours • Inflation will be implemented effective January 2026
ICF Reduced Rebasing	(808,333)	• Rebasing will still include increase in nursing component • Overall rebasing outside of nursing will be reduced, including inflation
Nursing Facility Quality of Care Adjustment	(2,400,000)	• Incentive payment funding was shifted to assist in funding the recent 13% rate increase in 2025 • Quality measures will still be reviewed with expectations of metrics being achieved • Last 2 yrs $3 milion was left on the table in quality incentive payments
Hospital Rate and Inflation Adjustments	(6,390,649)	• Outpatient methodology will consider total population (FFS and MCO); same as Inpatient for two years • Pause of inflation for Inpatient and Outpatient rates
Behavioral Health Inflation Adjustment	(224,387)	• Pause inflation for MHRS, FSMHC and BH Waiver Services
Total Unadjusted Savings	**$14,262,091**	

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

For DSP, the hourly wage increases to $21.11 in July 2025 (currently $20.58), which is established above the District's Living Wage of $17.95 effective in July 2025. FY2026 is included as one-time funding and will require DHCF to request funding again in FY27 and beyond. The District's DSP enhanced wage continues to be the highest in the Tri-State area, with Montogomery County, Maryland being the closest at $18.15 per hour. It is important to

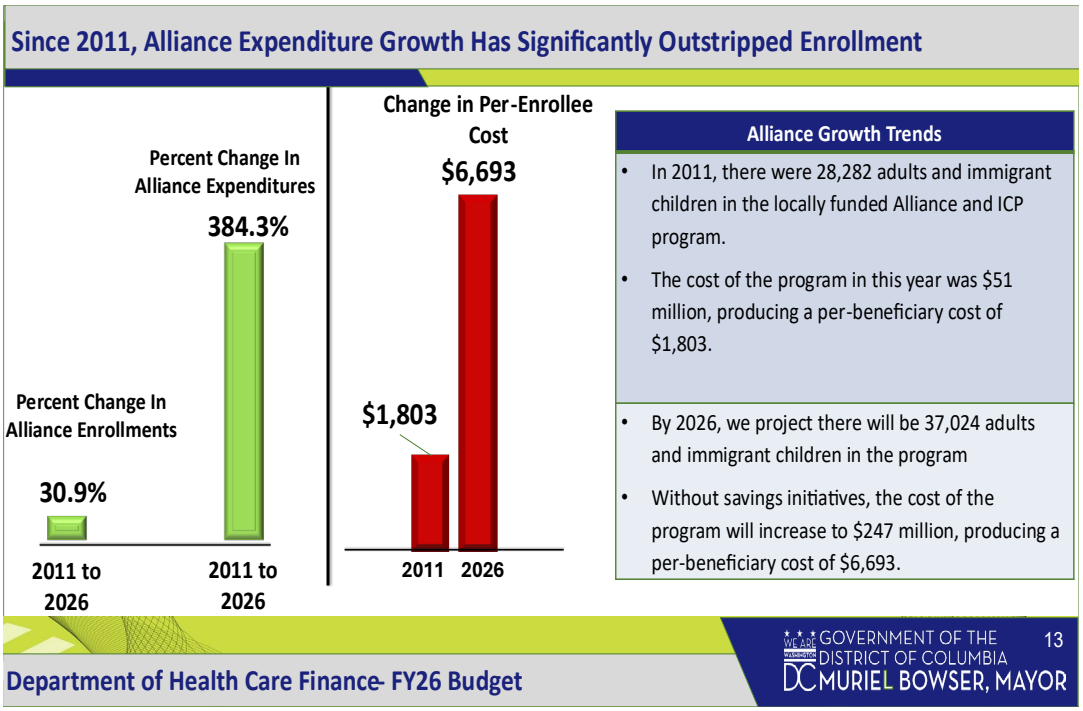
note that the revenue challenges in the final three years of the financial plan require that we limit this increase to a one-time obligation.

The remaining changes to provider rates were designed to produce $14.2 million in total savings. This was achieved through a combination of rate rebasing delays for the Federally Qualified Health Centers ($4.4 million), reductions in rebasing for Intermediate Care Facility for Individuals with Intellectual Disabilities ($808,333), a claw back of the Nursing Facility Quality of Care Adjustment to pay for the recent 13% rate increase in 2025, and downward adjustments in the hospital outpatient methodology, coupled with a pause in inflation for both inpatient and outpatient hospital rates.

While these meaningful reductions will be difficult to manage for providers who are struggling to control a burgeoning cost structure against declining patient volumes, they amount to only 7.8% of the total reductions imposed in the Medicaid and Alliance programs.

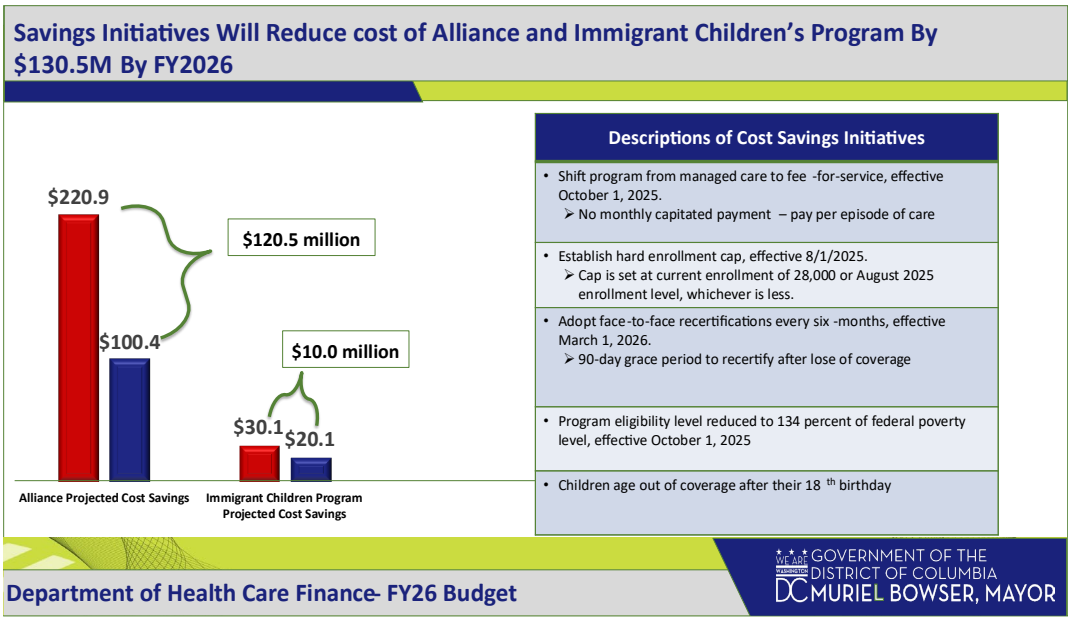
Savings Strategies For The Alliance Program

Madam Chairwoman, this section of my testimony focuses on the savings initiatives we proposed to reduce the financial footprint of the Alliance program. Over the past 14 years, the cost structure of the Alliance program has grown exponentially. In 2011, this was a program of 25,000 adults and slightly more than 3,200 children in a separate Immigrant Children's Program (ICP). The cost of the program at that time was $51 million, which reflected a per-beneficiary cost of $1,803 (see graph on next page). For reasons that are not entirely clear, but likely reflecting rising caseloads, the cost of the Alliance and ICP sharply spiked over the next decade – this while enrollment growth was more modest. Specifically, the number of beneficiaries in the program grew by 30 percent over a 14-year period – just over 2% annually, while program spending accelerated by 384%, a near 28% annual growth rate.



Fortunately, for much of this period, Alliance expenditure growth was buffered by extraordinary revenue growth in the city's finances. However, as city revenues began to slow in recent years, Alliance expenditure growth did not. Now, as the CFO is forecasting negative revenue growth for the city in FY2026, the cost of the Alliance and ICP is projected to reach nearly $250 million, absent major changes to the design and nature of the program. To provide a sense of magnitude, there are approximately 37,000 beneficiaries – adults and children – in the program monthly. This means the per enrollee cost for Alliance of more than $6,690 has grown at a rate that is more than three and one-half times the level observed in 2011.

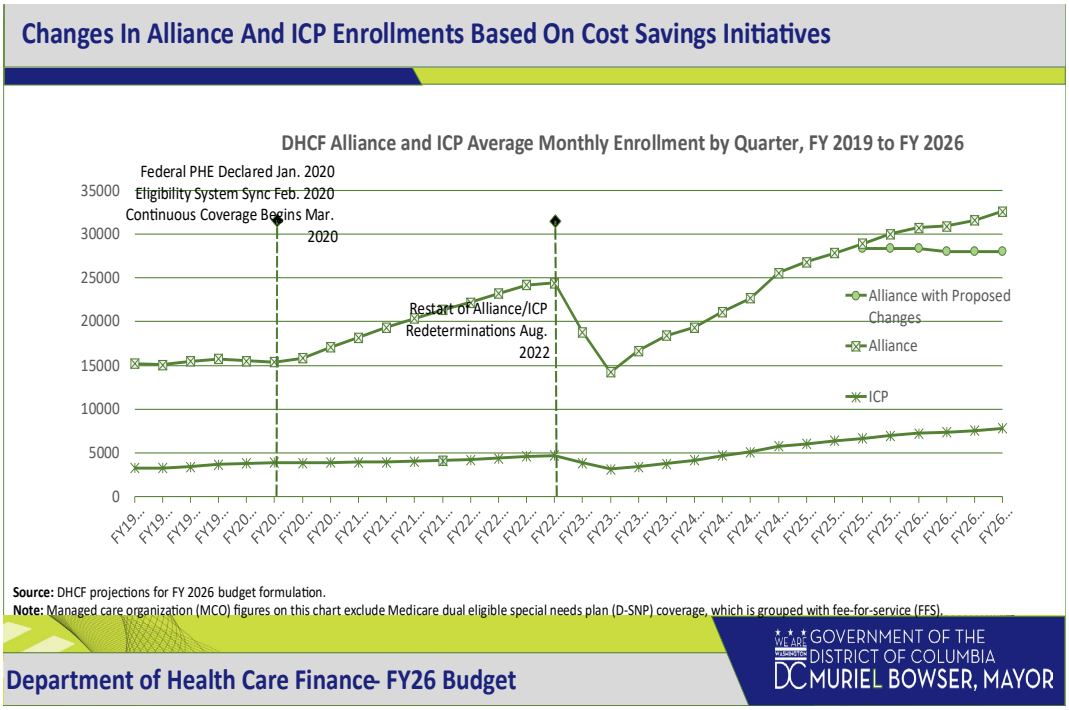
Changes To The Structure and Operation of Alliance. DHCF made several proposals designed to reduce the accelerated cost growth of Alliance (see graph below). These proposals alter the benefits and structure of the program, freeze enrollment levels, increase the nature and frequency of recertifications, and lower the program's eligibility level to match the changes made to Medicaid.



The scope of benefits is limited to pharmacy, primary care, hospital-based care, and non-emergency transportation. The change to program structure will remove Alliance members from the managed care program and allow them to seek the health care they need through DHCF's fee-for-service program. This eliminates the per-member-per-month capitated payment that DHCF currently pays each health plan as revenue for the Alliance members in their panel. With the new fee-for-service model, members will continue receiving primary care and hospital services, prescriptions, and non-emergency transportation, and DHCF will pay valid claims submitted by providers following their delivery of care.

In addition to this change, DHCF is proposing a permanent enrollment freeze for adults in the Alliance program on August 1, 2025. The freeze is based on enrollment at the time this policy takes effect. Alliance members who are in the program will be unaffected by the enrollment freeze if they continue to meet income eligibility thresholds (which will be reduced to 133% on October1, 2025) and successfully complete a face-to-face recertification every six months. The six-month recertification is a change from the current annual requirement and will take effect in March 2026. Should the adult members leave the program for whatever reason, the

freeze will prevent program reentry – this is not the case for children under the age of 21. We estimate that these changes, coupled with the reduction in the top eligibility income category to 134% of FPL, will save the District more than $130 million annually in future Alliance spending, reflecting, in part, the loss of coverage for 4,608 adults who are currently in the program (see graph below).

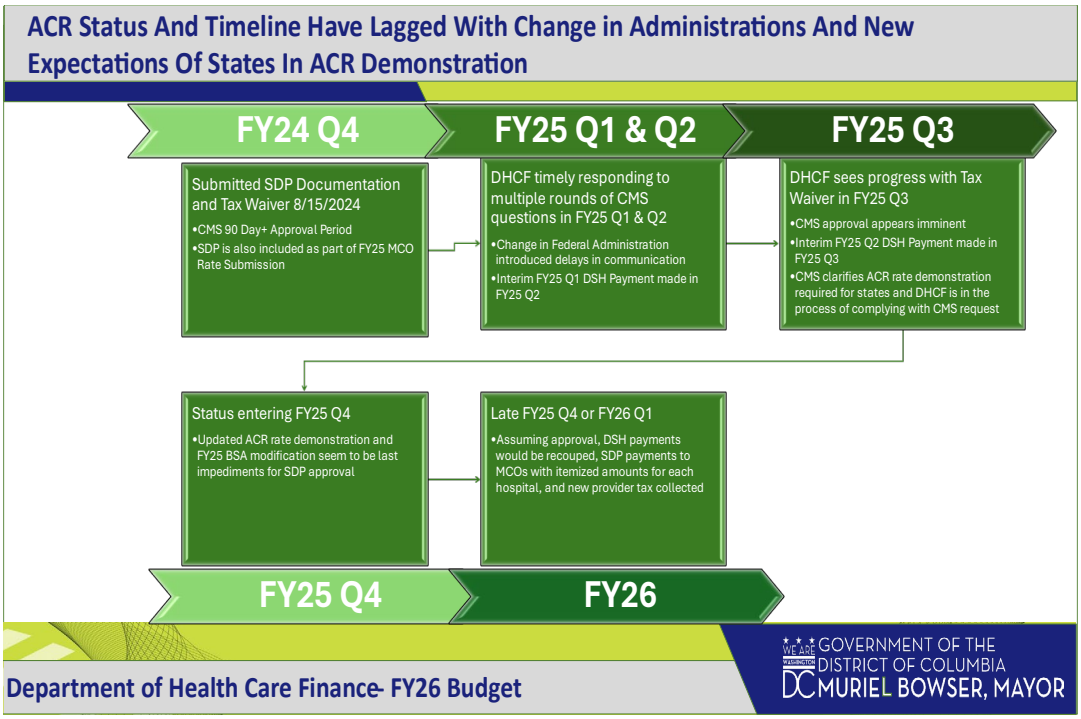


Status of DHCF's Proposal For Hospital State Directed Payments

Madam Chairwoman, I close my testimony with a brief summary of the status of DHCF's proposal for State Directed Payments. Recall that this policy was funded in the Mayor's FY2025 budget and must be renewed each year. The proposed FY25 budget included a total funds amount of $530 million with $128 million to support the Hospital Average Commercial Rate (ACR). The FY26 budget includes $632 million in total funds which includes $145 million in Hospital provider taxes, and a separate ACR payment in the amount of $576 million. The changes incorporate updated utilization calculations and a reduction of outpatient Medicaid rates.

With the proposal, Hospitals pay a provider fee that amounts to 3 percent of their net patient revenue, and this tax revenue is used to pay the local fund cost of higher hospital payments.

As the graph below illustrates, DHCF has timely responded to all requests by CMS in support of this policy. Though we are encouraged, CMS has not approved the FY2025 policy to date. When the proposal is approved – and we believe it will be – the payments to hospitals under this new policy will be retroactive to October 1, 2024. We regularly communicate with the District of Columbia Hospital Association on this matter and will keep you abreast of any changes.



Conclusion

Madam Chairwoman, this concludes my testimony for this budget hearing. As I stated at the outset, the challenging nature of the city's finances, combined with the unsustainable cost growth in both the Medicaid and Alliance programs, required budget saving actions that have no

historical precedent in the District. However, the strategies put forth were thoughtfully deliberated and crafted in a manner to minimize the loss of access to quality health care.

Should the Council pass the mayor's budget for DHCF, there is much work to be done to ensure its effective implementation. To that end, we will work closely with Mila Koffman and her team of experts at the Exchange to make the transition to other insurance programs as seamless as possible for those who will not have access to Medicaid coverage.

My team and I are prepared to receive the Committee's questions.