GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2025 Budget Hearing

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

Monday, April 29, 2024
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 2025 (FY2025) Budget and Financial Plan for DHCF. Despite the significant financial challenges faced in the formulation of her proposed budget, the Mayor's commitment to sustaining the District's critical health care insurance safety net is clearly established in this budget, evincing a significant investment of local dollars.

As a prelude to the discussion of the referenced financial challenges and the Mayor's proposal for DHCF, allow me to introduce members of my senior management team. These are staff who played a vital role in helping shape the agency's proposals in response to the budget guidance of the Executive Office of the Mayor, and the explicit instructions of Mayor Bowser. Notably, I am joined today by members of my Executive Management Team (EMT) which includes both my Senior Deputy Director and Medicaid Director, Melisa Byrd, and our Senior Deputy Director of Finance, Angelique Martin. Melisa brings her Medicaid and Alliance policy expertise to this process, while Angelique, and the gifted team that she has assembled, performs the sophisticated data analysis needed by the agency's fiscal officer, Darrin Shaffer, to support his efforts to identify the cost of each proposal.

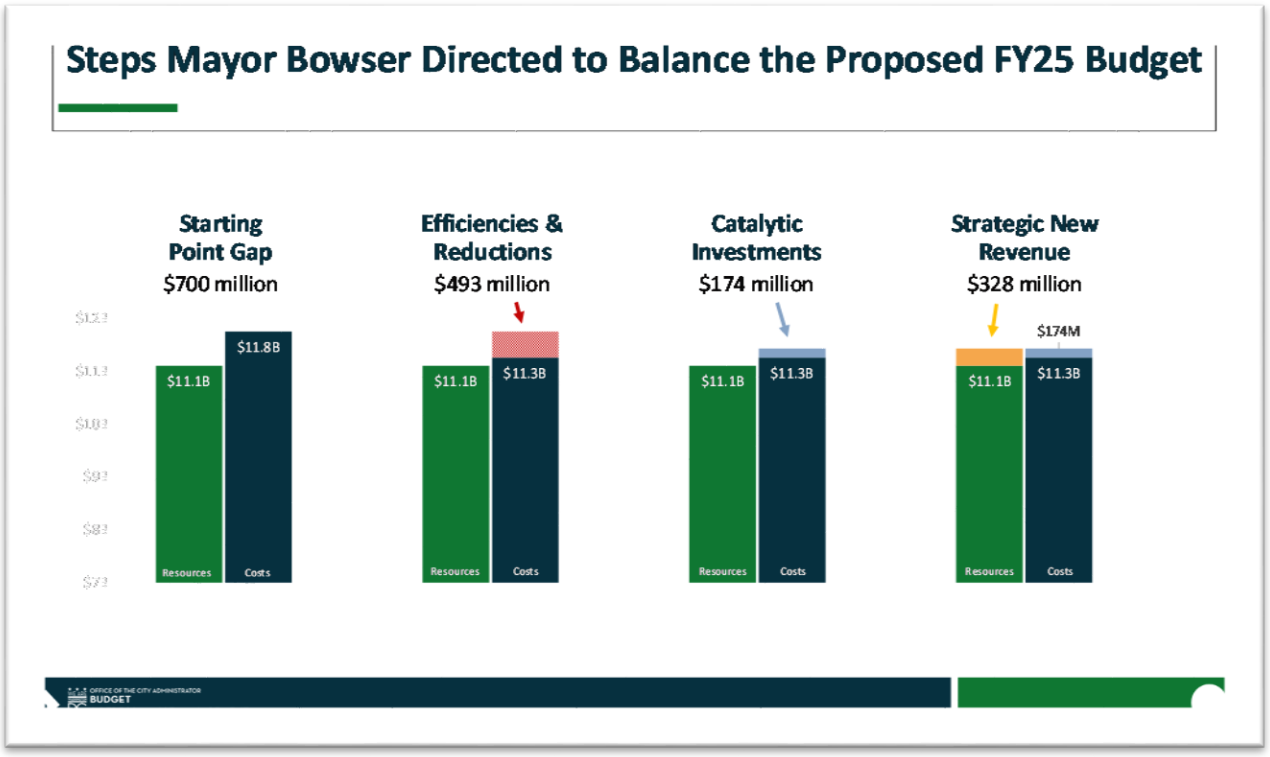
Along with the Administrators of each DHCF division, which includes our program administrators and the director of our Data Analytics division, April Grady, I have asked that two additional DHCF staff from Angelique's finance team attend today's hearing - James Simms, Associate Director of Medicaid Finance, and Joseph Brennan, our actuary. Their discerning and penetrating insight into our budget is the foundation of the proposals that have been advanced to

the Committee on Health as a central component of the Mayor's FY2025 budget proposal. As I have stated in the past, without the collective efforts of this group, DHCF's very complex budget could not have been rationally formulated.

The Financial Environment Impacting Budget Formulation For DHCF

It has been well-documented that Mayor Bowser formulated her FY2025 budget proposal in the headwinds of the most difficult economic forecast witnessed by the District of Columbia in 15 years. While projected revenue growth for the financial plan remains positive, when considered over the span of the plan, these projections fall considerably short of the annual growth rates enjoyed over the preceding 10 years. Further, due to the pernicious interplay of the persistency of remote work, a deteriorating commercial real estate market, and the erosion of sales tax growth rates, the District's Chief Financial Officer has predicted that future revenue growth will remain below the rate of inflation through FY2028.

When these downward adjustments were simultaneously considered with the District's pre-forecast expenditure patterns, the projected financial plan was $4 billion out of balance. The graph shown on page 4 outlines the major steps executed by the Mayor to bring the financial plan into balance, fund the critical functions of government, and make the strategic investments required to move the District forward. Notably, in the initial phases of budget formulation for FY2025 – the first year of the current financial plan – the budget gap was $700 million. However, subsequent developments during the budget formulation process exacerbated this problem, especially the requirement by the Chief Financial Officer that the Executive replenish the reserve fund by no later than FY2028 at a cost of $217 million. Despite the Mayor's concerns about the CFO's authority to mandate this requirement, her budget replenishes the reserve fund in the requested amount.



Addressing The Spending Gap. Through expert stewardship, the Mayor addressed more than half of the FY2025 budget gap with agency spending reductions and efficiencies. Whenever agency retrenchment is required to balance the Mayor's budget proposal to the Council, there are serious questions about whether and how the social safety net can be preserved. This is a necessary consideration because of the substantial amount of government spending on human services programs. Historically, these programs account for more than a third of total District spending – the majority of which is attributable to DHCF programs. So, in working with the Mayor's budget team, the following principles were established to guide the budget development process for our agency:

1. Protect the robust eligibility levels for the Medicaid and Alliance programs.

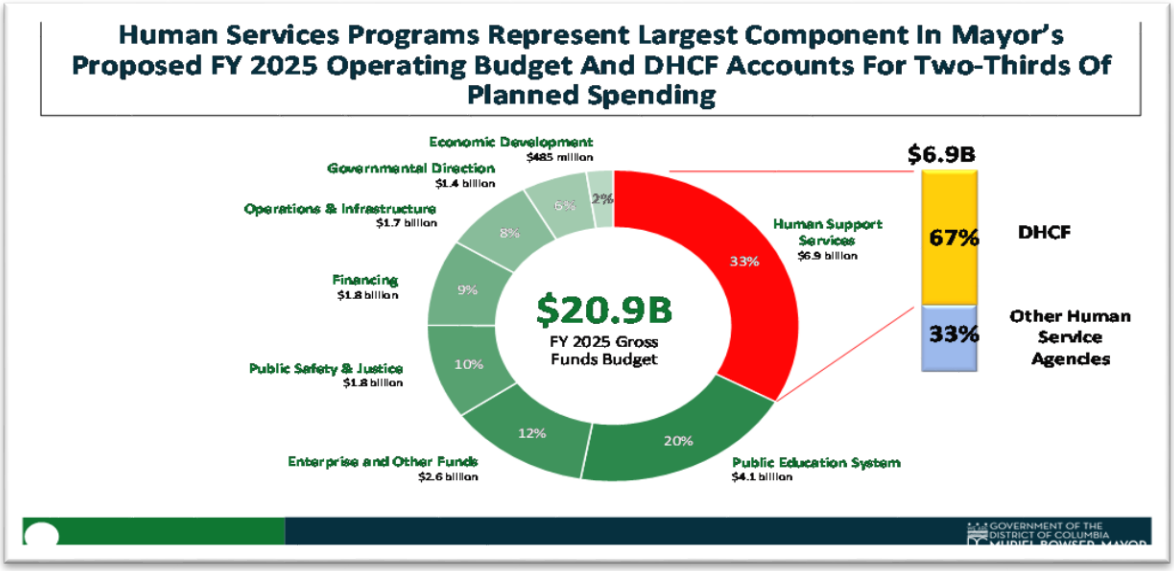
2. Preserve the current scope of expansive benefits in both programs.

3. Where possible, make targeted investments in provider rates, especially for industry groups facing surging costs.

4. Comply with new CMS requirements mandating continuous coverage for children, notwithstanding the assessed cost impact.

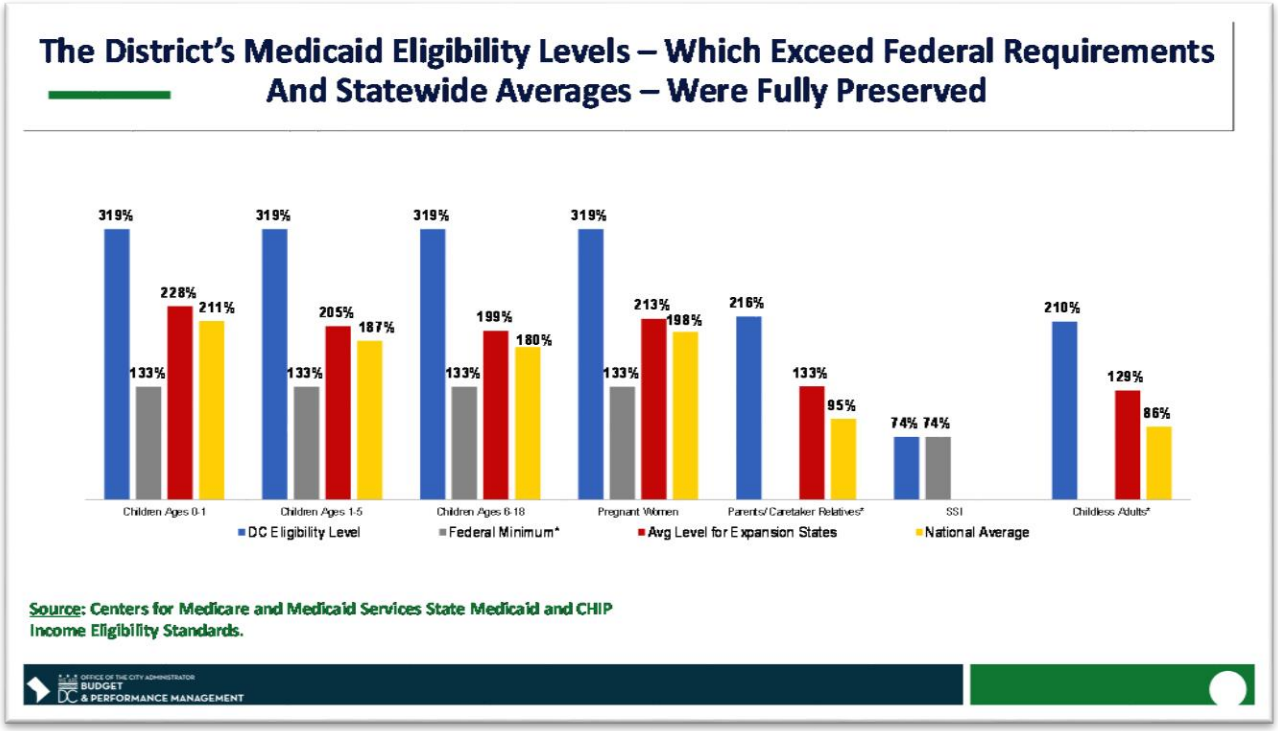
Since major savings in the Medicaid and Alliance program can only be achieved by either lowering eligibility levels, reducing optional program benefits, or slashing provider reimbursement rates, the Mayor needed to pursue more creative options to control spending in DHCF's programs. In addition to pursuing efficiency reductions, the financial challenges also required the Executive to forego opportunities to add new and potentially high-cost benefits, while instructing DHCF to mine our budget for cost-shifting proposals that would relieve local fund pressures across the four-year plan. Finally, in situations where rate increases could not be responsibly held in abeyance, we were challenged to find ways to make such adjustments cost neutral.

Using the established guiding principles listed above, the Mayor's proposal for the Council retains the prominence of DHCF programming in the human services budget (see graph below). Specifically, human service programs are responsible for 33 percent of the Mayor's

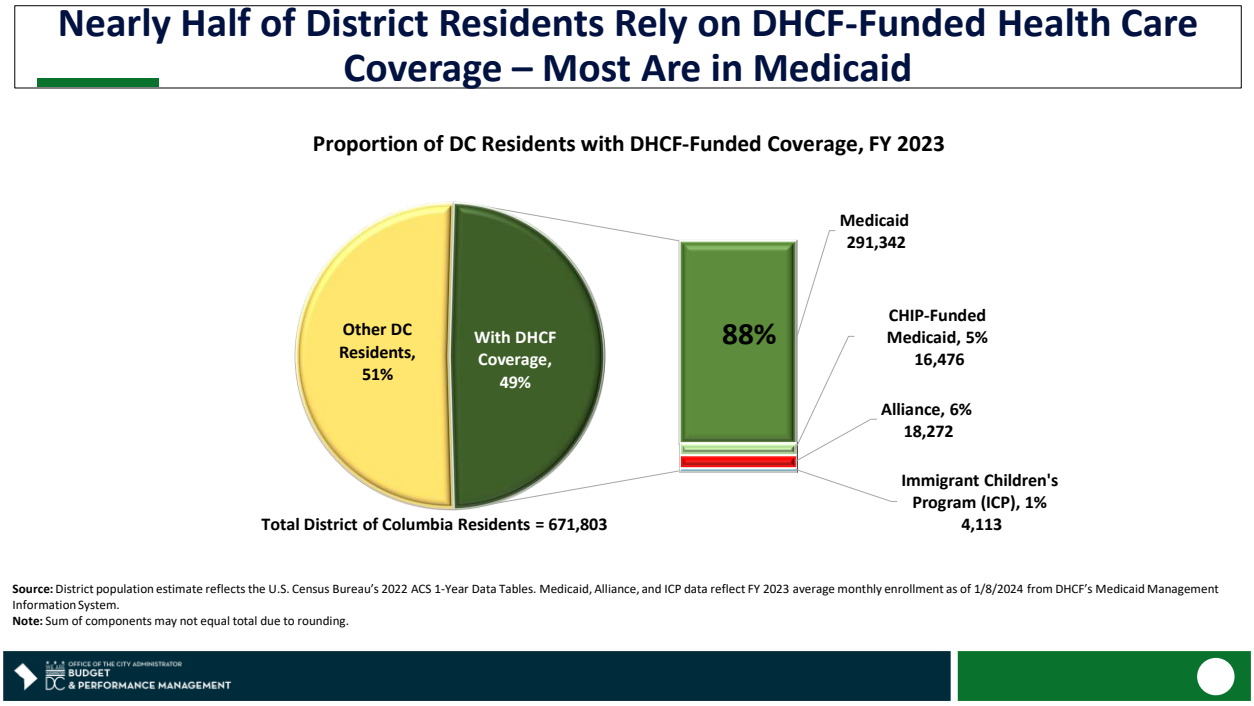


planned spending for FY2025. More than two-thirds of the human services budget is allocated for DHCF programming.

To appreciate the Mayor's commitment to the human services safety net, consider DHCF's eligibility policy. As the graph below reveals, across Medicaid beneficiary groups, the District's eligibility levels are substantially higher than the average levels witnessed for other states, and the federally prescribed minimum levels. Not surprisingly, these aggressive levels have substantially expanded access to fully financed public health care in the District of Columbia.



As the graph on the next page illustrates, when combined with persons who receive Alliance benefits, nearly half of the residents in the District of Columbia (330,203) received health care insurance that is provided free of premium cost, cost-sharing, and co-payments. Among these residents, more than 307,000 are either receiving Medicaid (88 percent) or enrolled in the Medicaid Children's Insurance Program (5 percent). Another 22,000 residents receive full



health care through the Alliance as adults (6 percent), or children (1 percent), through the Immigrant Children's Program.

On the benefit side of the Medicaid program, some services are mandated as a condition of participating in the program, while others are provided as State plan options. Alliance is not subject to federal law and its benefits are largely defined through local agency policy. Notwithstanding these flexibilities, the District has established a history of comprehensive benefits for these programs as a foundational component of the human service safety net, and the Mayor offered no significant changes to these benefits. This means that the Mayor closed a $4 billion budget gap over the financial plan, without changing the framework of the program with the largest amount of total funding in the District – publicly funded health insurance.

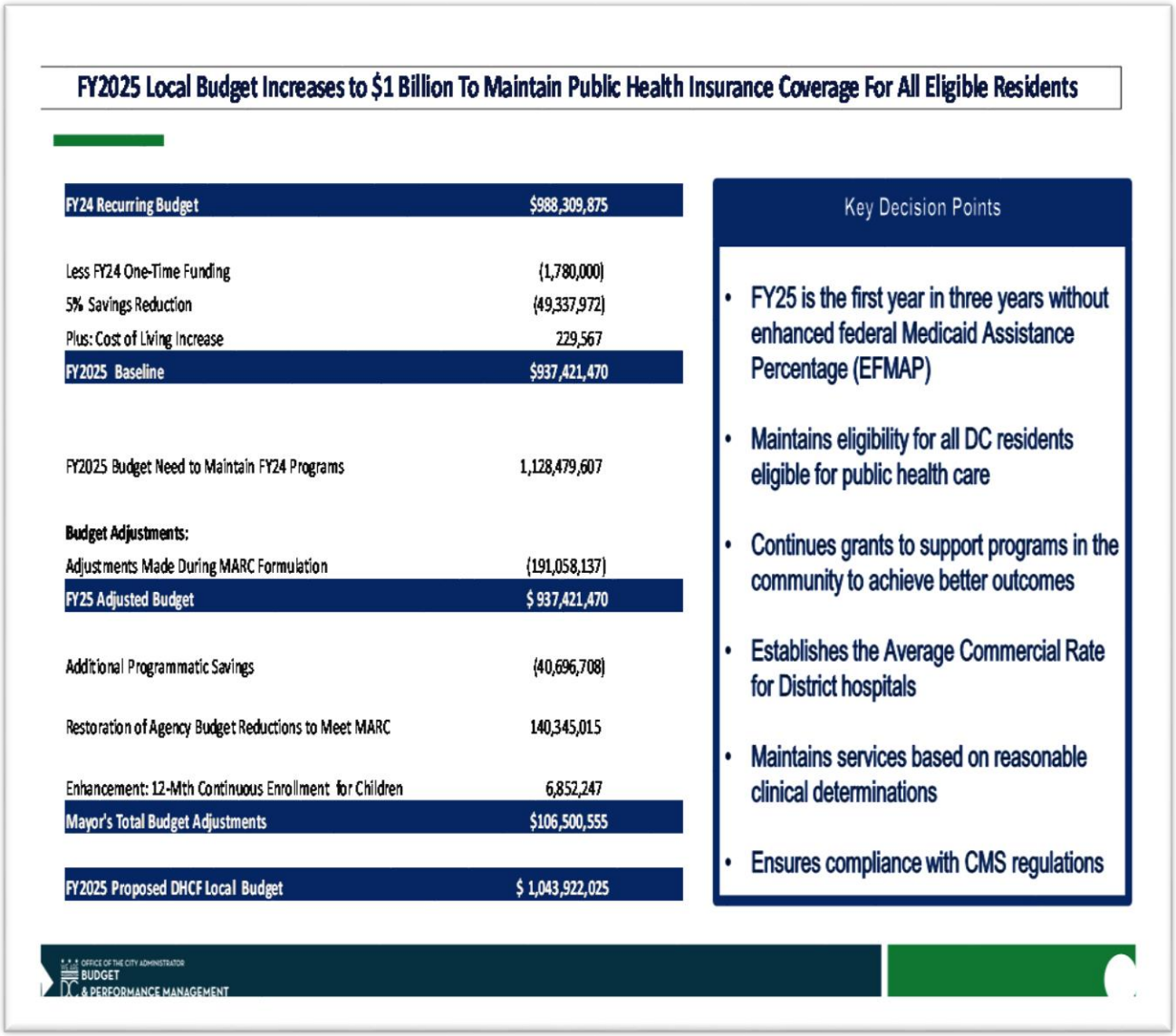
The Building Blocks Of DHCF's Proposed Local Budget

The process used by the budget team to build the agency's FY2025 proposal is iterative, with the FY2024 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, the Mayor's budget team builds a bottom-line local funding amount to represent the agency's proposed budget, subject to final approval by the Mayor.

The table on page 9 illustrates this process for DHCF's FY2025 budget. As shown, the baseline funding amount determined by the previous year's approved budget was $988.3 million. Next, DHCF's one-time funding amounts from FY2024 of nearly $1.8 million were removed from the baseline. Additionally, the budget team imposed a 5 percent savings requirement before adding a cost-of-living increase that resulted in DHCF's Maximum Allowable Request Ceiling (MARC) for FY2025 of $937.4 million. Once the FY2025 baseline was established, the DHCF budget team determined the local fund cost that would be associated with maintaining the existing programs based on projected demand, without any additional downward adjustments. This created a local fund cost of more than $1.1 billion. In other words, this reflected the true cost of operating DHCF before the Mayor considered any additional policy options. Comparing this projected cost to the $937.4 million MARC necessitated a reduction of $191 million, a savings DHCF could only achieve with deep reductions in eligibility levels for both Medicaid and the Alliance members and/or restructuring some program benefits. After assuming an additional $40 million savings requirement for DHCF, the Mayor restored $140.3 million of previously assumed reductions, allowing DHCF to avoid further reductions. All budget adjustments concluded with an enhancement of $6.8 million to fund the federal requirement for 12-month continuous enrollment for children in Medicaid. Together, these series of decisions resulted in a local fund budget for DHCF of $1,043,922,025.

DHCF Budget Adjustment Details – Coverage Cost. The aggregate changes summarized in the previous section obscure the detailed policy changes which comprise DHCF's budget



FY2025 Local Budget Increases to $1 Billion To Maintain Public Health Insurance Coverage For All Eligible Residents

FY24 Recurring Budget	**$988,309,875**
Less FY24 One-Time Funding	(1,780,000)
5% Savings Reduction	(49,337,972)
Plus: Cost of Living Increase	229,567
FY2025 Baseline	**$937,421,470**
FY2025 Budget Need to Maintain FY24 Programs	1,128,479,607
Budget Adjustments:	
Adjustments Made During MARC Formulation	(191,058,137)
FY25 Adjusted Budget	**$ 937,421,470**
Additional Programmatic Savings	(40,696,708)
Restoration of Agency Budget Reductions to Meet MARC	140,345,015
Enhancement: 12-Mth Continuous Enrollment for Children	6,852,247
Mayor's Total Budget Adjustments	**$106,500,555**
FY2025 Proposed DHCF Local Budget	**$ 1,043,922,025**

Key Decision Points

- FY25 is the first year in three years without enhanced federal Medicaid Assistance Percentage (EFMAP)
- Maintains eligibility for all DC residents eligible for public health care
- Continues grants to support programs in the community to achieve better outcomes
- Establishes the Average Commercial Rate for District hospitals
- Maintains services based on reasonable clinical determinations
- Ensures compliance with CMS regulations

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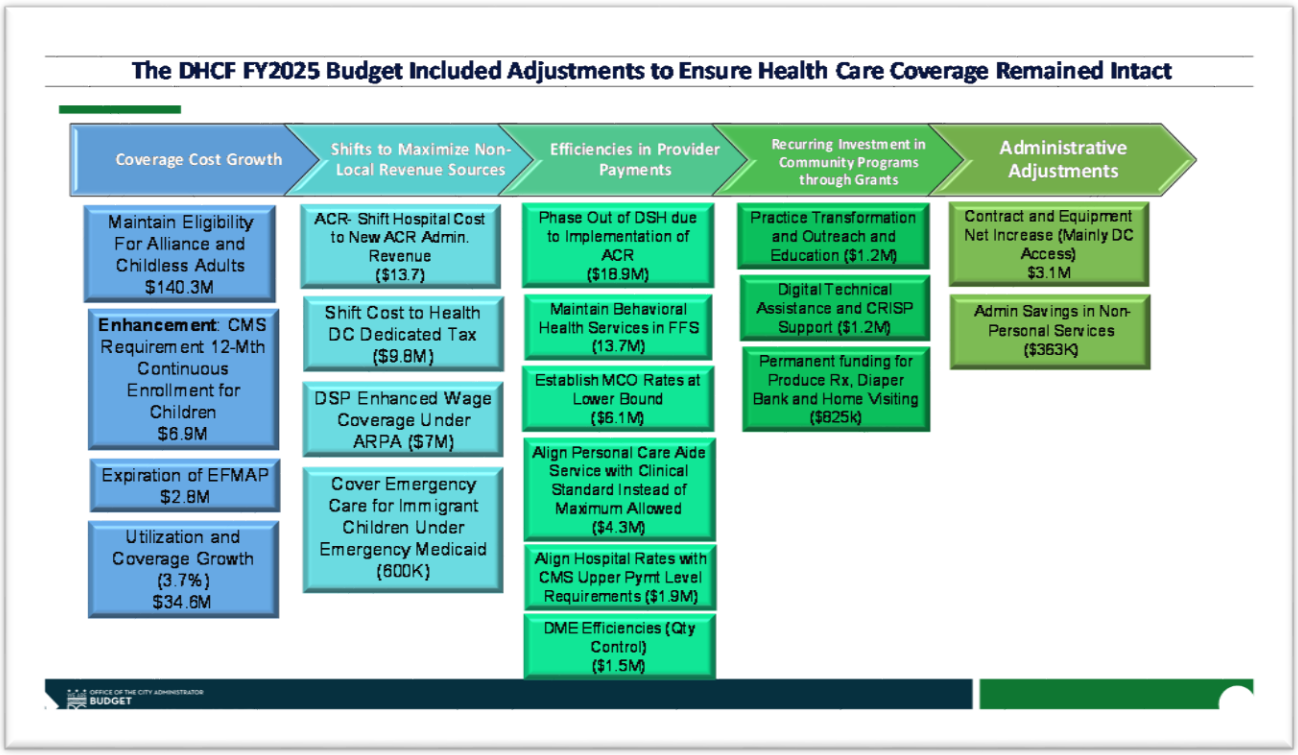
adjustments. This detail is captured in the graph on page 10. Notably, almost $185 million was allocated by the budget team to maintain eligibility for Medicaid and Alliance members, pay for the federal requirement to provide continuous coverage, and fund the expected growth in enrollment and utilization of services. This projected growth was 3.7 percent, which is higher than the predicted growth rate for District revenues.

Local Fund Cost Shifts. By substituting revenue from other sources, DHCF is reducing the use of local funds by more than $31 million. The largest shift of $13.7 million is made



possible using revenue from new hospital provider taxes. Almost $10 million in local fund Medicaid cost was moved off the books and paid for by the Healthy DC Dedicated Tax fund. Another $7 million in local wage cost for Direct Care Professionals will be paid for by special federal funding provided through the American Rescue Plan for Medicaid Home and Community Based Services (HCBS).

Program Reductions and Efficiencies. Through several efficiencies and program changes, DHCF's FY2025 budget was reduced by $46 million. The largest savings of $18.9 million was produced by phasing out the Disproportionate Share Hospital ("DSH") program. Funding for this program – which reimburses hospitals for uninsured costs – will not be necessary in FY2025 because hospitals will be reimbursed at a rate that reduces their uninsured costs to insignificantly small levels. Another $13.7 million is achieved by keeping behavioral health services in the Medicaid Fee-for-Service program, thereby avoiding the administrative

cost that would have been incurred by carving these services into the Medicaid managed care program and paying the associated administrative fee and taxes, as was previously planned. With the administrative costs, though savings were expected over time, the immediate increases would have occurred, in part, due to the maintenance of FFS rates and other thresholds required for 18 months to help bridge providers through transition.

Two additional changes produce smaller, but significant, savings. First, DHCF will reimburse health plans at the lower bound of the capitated rate range established to pay health plans. This change will save $6.1 million, and it is a federally permissible reduction as the rate that will be paid is within the required range that is determined by our independent actuary. Second, DHCF will tie the provision of personal care services more closely to clinical standards instead of defaulting to the maximum allowable number of hours, producing $4.3 million in program savings.

Establishing An Average Commercial Rate For Hospitals

Following the challenges of the pandemic, hospitals in the District witnessed surging non-contract and contract labor costs, rapidly rising drug expenses, and inflationary costs for equipment and supplies. Almost without exception, these expenses have grown at rates that dwarf increases in Medicaid reimbursements, which are typically significantly lower than commercial insurance rates.

This problem of rising costs and constrained Medicaid reimbursements is exacerbated by the fact that Medicaid patients – with the lower payment rates – are growing as a percentage of hospital visits when compared to their commercial counterparts. This trend, which is partly a function of the decline in daily commuters – many of whom were using commercial insurance to

purchase health care services from District hospitals – adds to the financial pressures with which hospitals now struggle.

Current Medicaid law allows states to tax certain provider groups up to, but no more than six percent of net patient revenue to help with the funding of the Medicaid program, provided the tax meets the three following requirements:

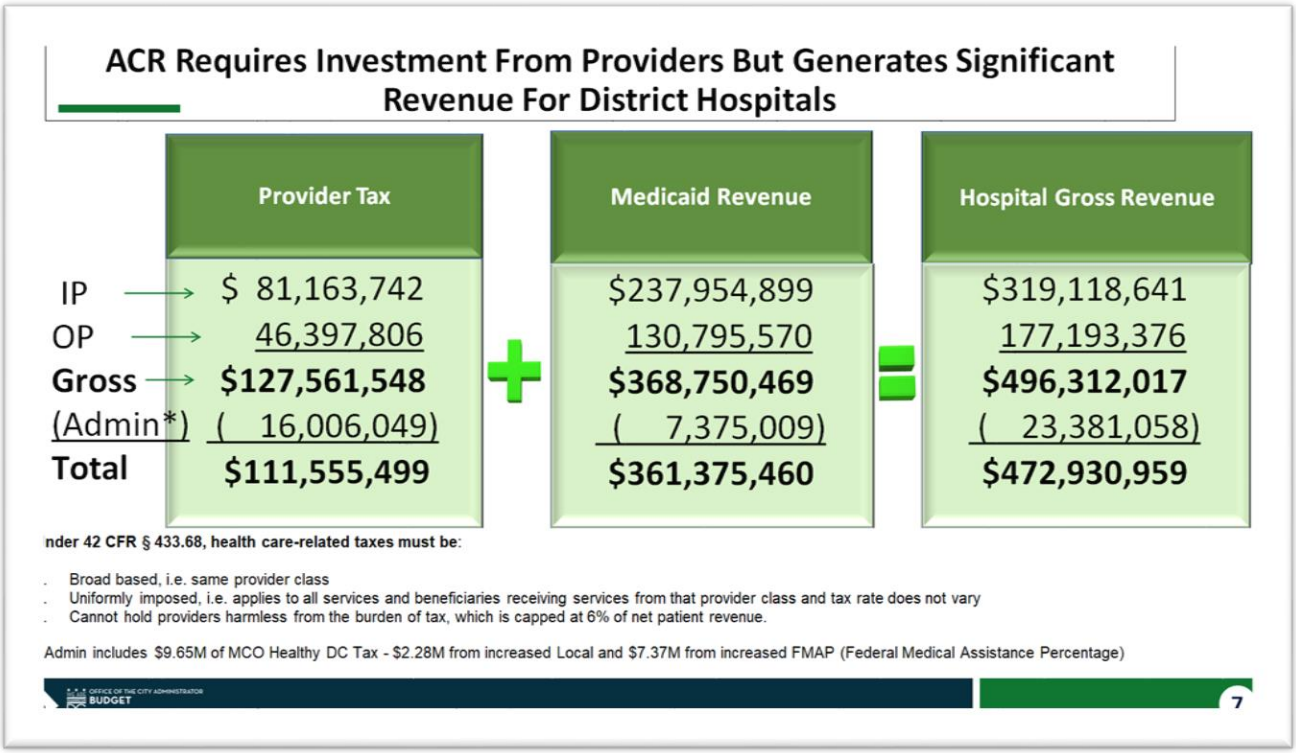
1. The tax must be uniform. This means that all providers must pay the same tax rate.

2. The tax must be broad-based. This means the tax must cover the entire industry – all hospitals must participate equally in the tax unless one or more meets the federal requirements for an exemption.

3. No hospital can be held harmless. Without a federal exemption, no provider in the class can be held harmless from the full burden of the tax through any scheme that increases the tax for some hospitals (those with a larger book of Medicaid business) while reducing the burden for others (those with a smaller book of Medicaid business).

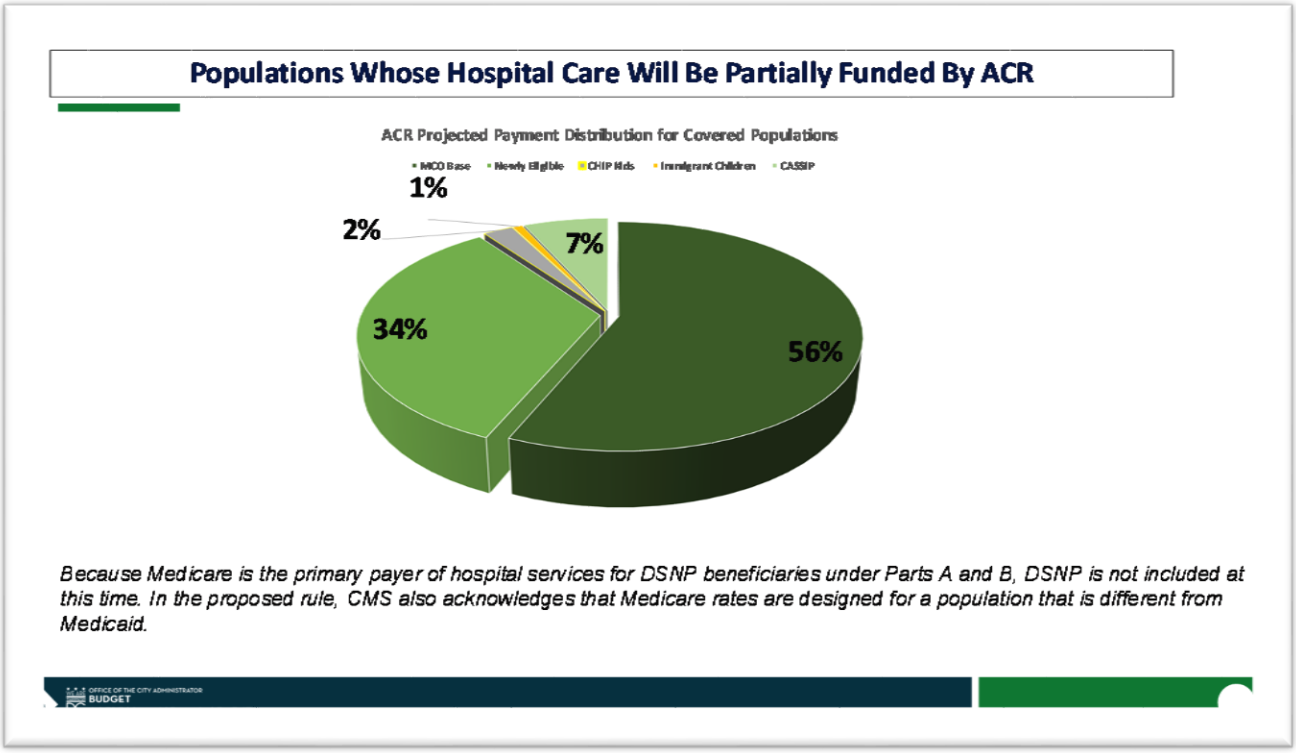
Working collaboratively with the hospital industry, the Mayor is proposing a 2.39% tax on hospital net patient revenue. This policy generates $127.6 million in local funds. As noted earlier, the Mayor proposes to retain $13.7 million of these local funds to defray the ever-rising cost of Medicaid healthcare reflected in DHCF's budget. The balance of the revenue – $113.8 million – will be used by DHCF to draw down $368.8 million in federal funds. This amount will be combined with the remaining local match and used to stabilize and sustain hospital services by paying higher, commercial-like rates for the Medicaid patients they serve (see table on page 13) – this is the so-called Average Commercial Rate ("ACR").

DHCF Implementation Plans For ACR. On an annual basis, ACR will be calculated as a uniform rate increase based on a survey of reimbursement levels for the hospital providers' top 5 commercial payers. Next, we will structure the payment as a tiered percentage increase on top of current reimbursement levels for inpatient and outpatient services.



The responsibility for the payment of ACR to the hospitals will be entrusted to the managed care plans. DHCF will make a retrospective calculation each quarter based on hospital volume. Subsequently, payments will be made to the health plans which are separate from their regular capitation rate. Each health plan will then be directed to filter down payments to each hospital based on actual utilization.

Additionally, ACR will allow hospitals to reinvest in community health care, ensure that District Medicaid beneficiaries will have continued access to a full range of acute care services in all District Hospitals, and give hospitals and DHCF the opportunity to work in partnership on ways to create a nexus between some level of ACR and certain quality strategy and initiatives. The graphic on the next page illustrates the distribution of Medicaid beneficiaries whose care will be supported by the ACR.



Status of the New Hospital

Madam Chairwoman, I close this testimony by providing the latest report on the new hospital. The Mayor's FY25 budget includes **no** new capital funds for this important project and a small amount of operating funds to prepare for opening. As of today, construction remains on schedule for completion at the end of 2024. Presently the exterior is complete, and the major utilities are connected. The work on the interior of the hospital continues.

The precise timing of when the hospital will open for patients is to be determined, but the goal remains early 2025, with a more precise date to be established with UHS at a future time. In the meantime, District agencies and Universal Health Services have begun hospital activation meetings around all local and federal regulatory approvals.

This concludes my testimony and I welcome the opportunity to address any questions therefrom.