FY 2022 PROPOSED BUDGET AND FINANCIAL PLAN

PRESENTATION TO THE COUNCIL OF THE DISTRICT OF COLUMBIA

A FAIR SHOT

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

Mayor Muriel Bowser's Proposed FY 2022 Budget

The Department of Health Care Finance
June 7, 2021

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Deputy Mayor for Health and Human Services

Presentation Outline

- ☑ **Introduction**
- ☐ DHCF Five-Year Program Of Reform Is Underway
  - *Impact of Transition Of Fee-For-Service To Managed Care On Hospitals*
  - *Impact of Transition Of Fee-For-Service To Managed Care*
- ☐ DHCF Budget Formulation
- ☐ Conclusion

Introduction

- Good afternoon, Chairman Gray 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 today to report on Mayor Muriel Bowser's Fiscal Year 2022 (FY2022) Fair Shot Budget and Financial Plan for DHCF. I am joined by my executive and senior team members who were instrumental in helping craft DHCF's budget proposals for the Mayor's consideration

- Special recognition is due to the agency's Medicaid Director, Melisa Byrd, and our very capable Deputy Director of Finance, Angelique Martin. Their analytical efforts, in conjunction with the work of Darrin Shaffer, our Agency Fiscal Officer, have been instrumental in producing this budget.

DHCF's Mission And Values

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

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- ☑ **DHCF Five-Year Program Of Reform Is Underway**
  - ***Impact of Transition Of Fee-For-Service To Managed Care On Hospitals***
  - ***Impact of Transition Of Fee-For-Service To Managed Care***
- ☐ DHCF Budget Formulation
- ☐ Conclusion

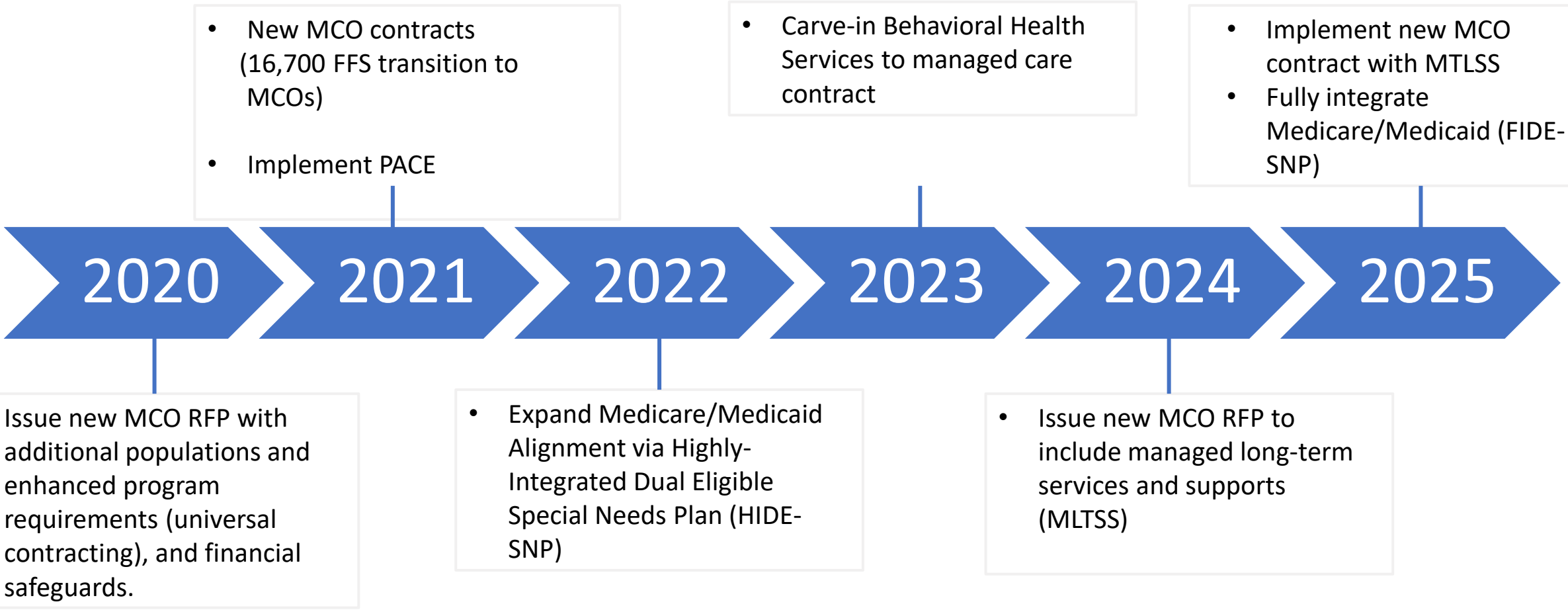
Major Reform Underway Guided By Three Priorities

- DHCF has three priorities for the agency programs which perfectly align with major reforms that are currently in process –

1. Build a health system that provides whole person care
2. Ensure value and accountability
3. Strengthen internal operational infrastructure

DHCF Reform Plans Are On A Five-Year Timeline

Medicaid Reform Milestones



Compared To FY2019, Overall, Medicaid And Alliance Hospital Payments In FY2020 Were Virtually Flat Due To Decreased Utilization

Managed Care And Fee-For Service Hospital Payments, FY2019 and FY2020

	FY2019				FY2020			
Hospital	Inpatient	Outpatient	Total	% of Total Pymt	Inpatient	Outpatient	Total	% of Total Pymt
Children's Natl Medical Ctr	74,455,397	58,365,160	132,820,557	20%	62,554,050	55,133,451	117,687,501	18%
George Washington Univ Hosp	92,017,564	30,665,085	122,682,650	18%	101,217,743	26,768,256	127,986,000	19%
Georgetown Univ Hosp	28,135,070	10,519,742	38,654,813	6%	32,256,241	12,548,749	44,804,990	7%
Howard Univ Hosp	73,281,309	37,268,317	110,549,626	17%	75,791,776	34,097,888	109,889,663	17%
Sibley Mem Hosp	5,039,983	6,191,684	11,231,667	2%	6,044,552	8,478,818	14,523,369	2%
United Medical Ctr	22,860,500	16,299,085	39,159,585	6%	24,714,755	17,594,869	42,309,624	6%
Washington Hosp Ctr	133,661,787	57,953,761	191,615,548	29%	136,439,184	57,416,712	193,855,897	29%
Total Cost	432,233,262	231,267,034	663,500,296	100%	439,018,301	218,601,548	657,619,849	100%

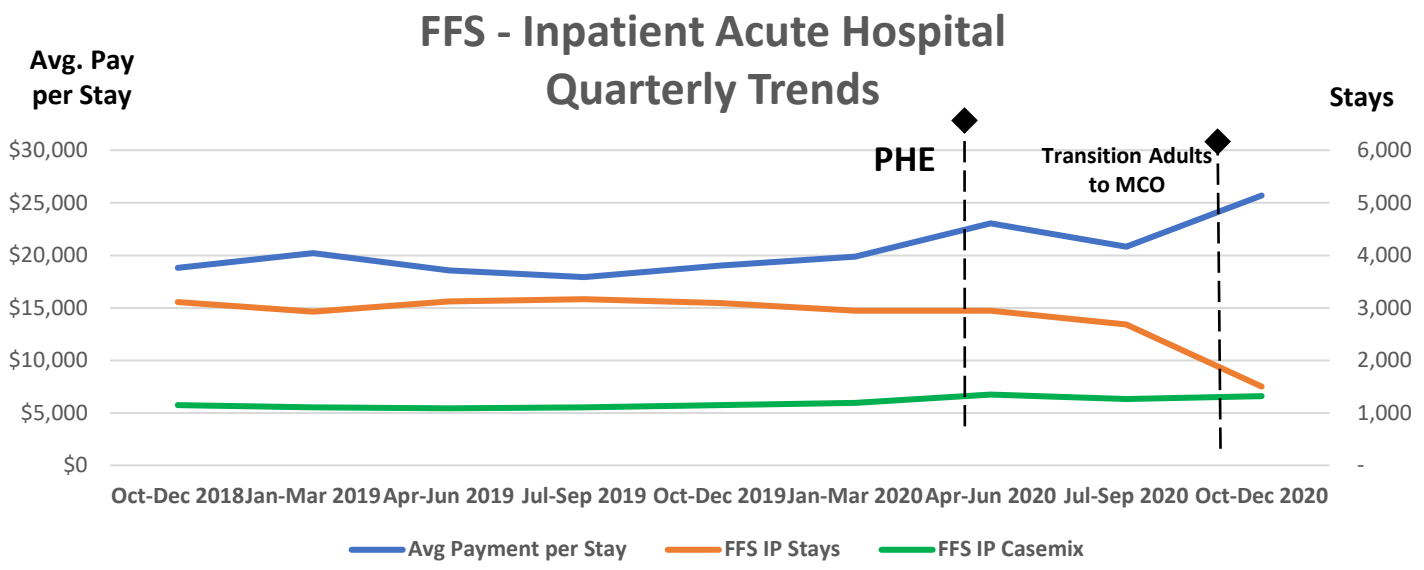
Note: Totals include payments for HSC Pediatric Center, National Rehabilitation Hospital, and Out-of-District payments – all amount to less than 1% of total hospital payments. Emergency room payments are included.

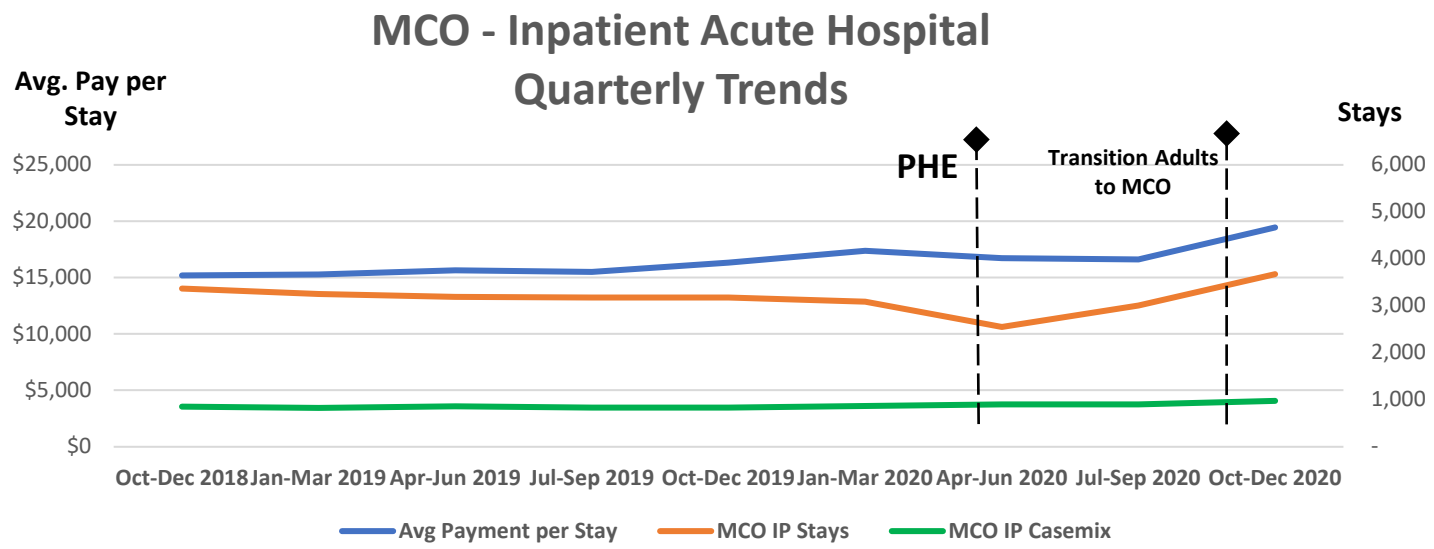
Payments For Disproportionate Share Hospitals Are Declining

Hospitals	FY 2019	FY 2020	FY2021 (estimated)
PIW	$2,231,149	$2,646,421	$74,857
Howard	$63,103,094	$63,847,202	*$51,087,545
UMC	$11,567,351	$10,755,008	$19,954,295
HSC	$1,676,045	$1,381,087	$718,633
St. E's (federal share only)	$2,729,100	$2,910,390	$2,729,100
TOTAL	$81,306,739	$81,540,108	$74,564,430

*Note: Howard Hospital experienced a $21 million loss in DSH for FY2022 due to a change in the federal law which produced unintended consequences. DHCF adjusted the local formula to cover $13 million of this loss without impacting other hospital DSH payments. The Mayor's budget addresses the remaining gap with a one-time $8 million payment.

Inpatient Acute Hospital Trends Indicate That The FFS Population That Was Moved To The Health Plans Are Exerting Upward Pressure On Average Stays And Cost



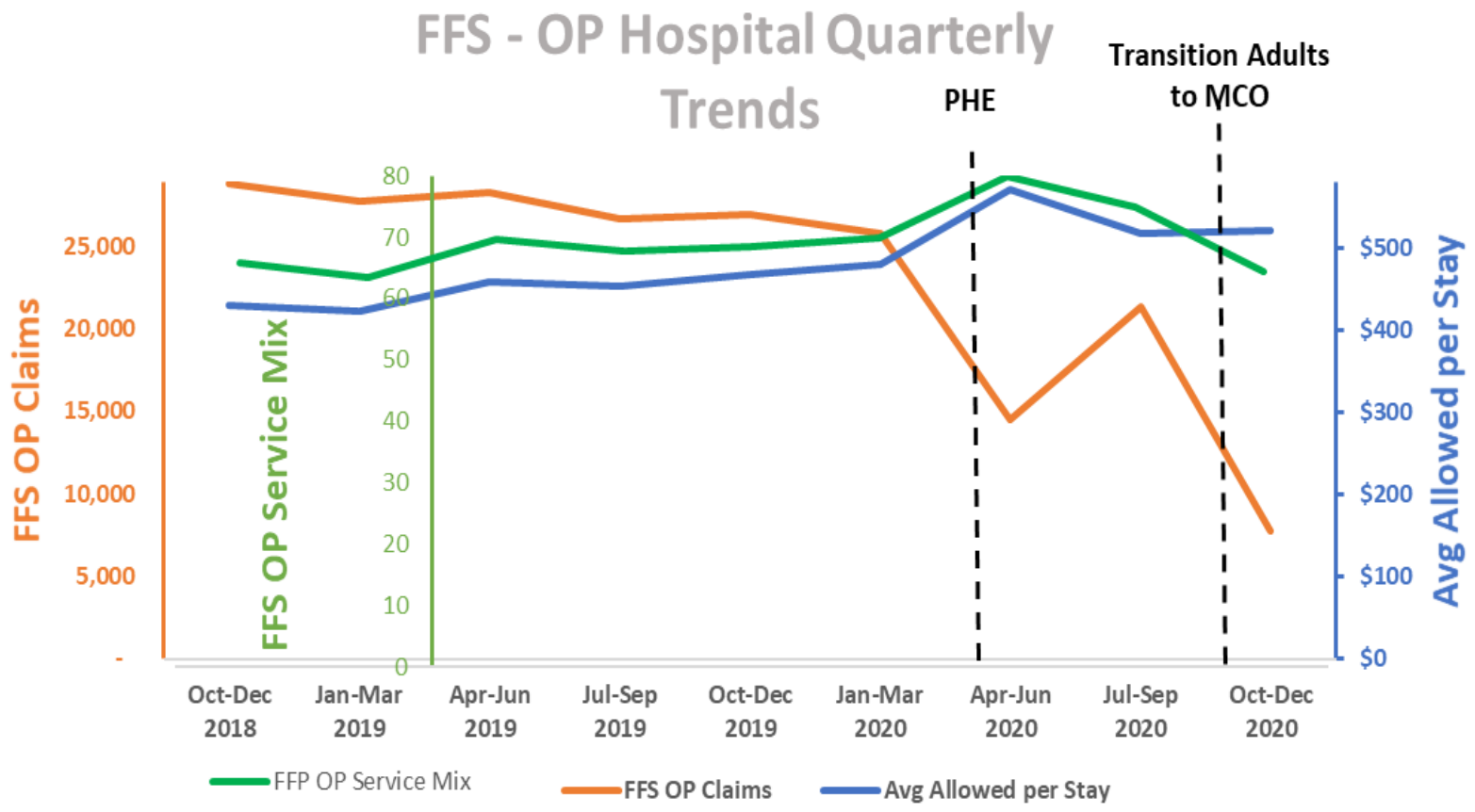


Key Insight

- Quarterly outpatient hospital trends beginning Oct 1, 2018, and ending December 31, 2020 (Q1 FY 2019 thru Q1 FY2021)
- Data is based on date of payment
- Overall increase in the average expenditure/ per stay.
- Continuous decrease in the # of FFS stays, while MCOs stays are on the increase.
- Overall increase in the case mix of both FFS & MCOs
- Though the FFS case mix is historically higher than MCOs, the transition shows slight increases in the MCO case mix.
- Transition has some impact in the swings between FFS & MCO stays.
- ***Key Take-Away***

  The increasing average pay per stay and higher case mix levels, show the FFS is more expensive with more complex needs.

While Outpatient Acute Hospital Visits Declined During the PHE, Spending Trends Show That the Cost Per Visit Has Increased



Key Insight

- Quarterly outpatient hospital trends beginning Oct 1, 2018 and ending December 31, 2020 (Q1 FY 2019 thru Q1 FY2021)
- Data is based on date of payment
- Overall increase in the average payment per visit (or averaged Allowed per Visit) .
- Significant decrease in the volume of FFS visits.
- Transition has significant impact in the swings between FFS & MCO stays.
- ***Key Take-Away:***

  Fee For Service visit volumes decreased, while casemix, and payments increased.

The Movement Of The Fee-For-Service Into Managed Care Holds Both Promise And Challenges

- The promise –
  - Coordinated care for a previously unmanaged population
  - Improved health outcomes – better health care value per dollar spent
  - Lower cost for a high need and high-cost population

- The challenge -
  - Will the FFS population respond positively to a program of managed care
  - Will segments of the FFS population embrace front-end prevention and diagnostic treatment as opposed to a central reliance on emergency room care
  - Can health plans drive down cost for a high need population while ensuring quality care

- DHCF will track the former FFS members who are now in managed care and, beginning in FY2022, will report quarterly on their pre-to-post changes in health care status and cost of care

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- ☐ Conclusion

The Building Blocks Of DHCF's Budget

$ 814.3M	($2.3M)	($ 5.7M)	$ 34.3M	$ 6.1M
FY22 Baseline Budget	Administrative Changes	Provider Payment Adjustments	Administrative Enhancements	Program Enhancements
FY21 Recurring Budget $857.6M	Vacancy Savings ($1.3M)	Cost Shift to Medicare for End Stage Renal Failure ($809k)	DCAS Eligibility System O&M $9.6M	Alliance 6-Month Recertification by Phone $5.3M
Less: Net One-Time Adjustments ($43.3M)	Shift to Hospital Tax for Outpatient ($970k)	Reduction of Anticipated Impact of CMS Requirements due to PHE ($3.5M)	MMIS Operating Impact of Capital $2.9M	Implementation of Neurobehavioral Health Service $698k
		ICF Rate Increase held at FY20 Inflation ($378k)	Net Enrollment Adjustments $3.2M	Implementation of Doula Services $75k
		FQHC's Rate Increase held at FY20 Inflation ($116k)	Alliance Cost Growth $1M	Practice Transformation Collaborative $1.5M (ARPA Grant Funds)
		Inpatient/Outpatient Rate Increase held at FY20 Inflation ($790k)	Hospital Support $8M	
			PHE Enhanced Rates & DSNP Transition $9.6M	

Some Provider Payment Budgets Decrease Due To Declining Enrollment in FY22, But Equitable Rates Will Still Be Implemented Based on Cost

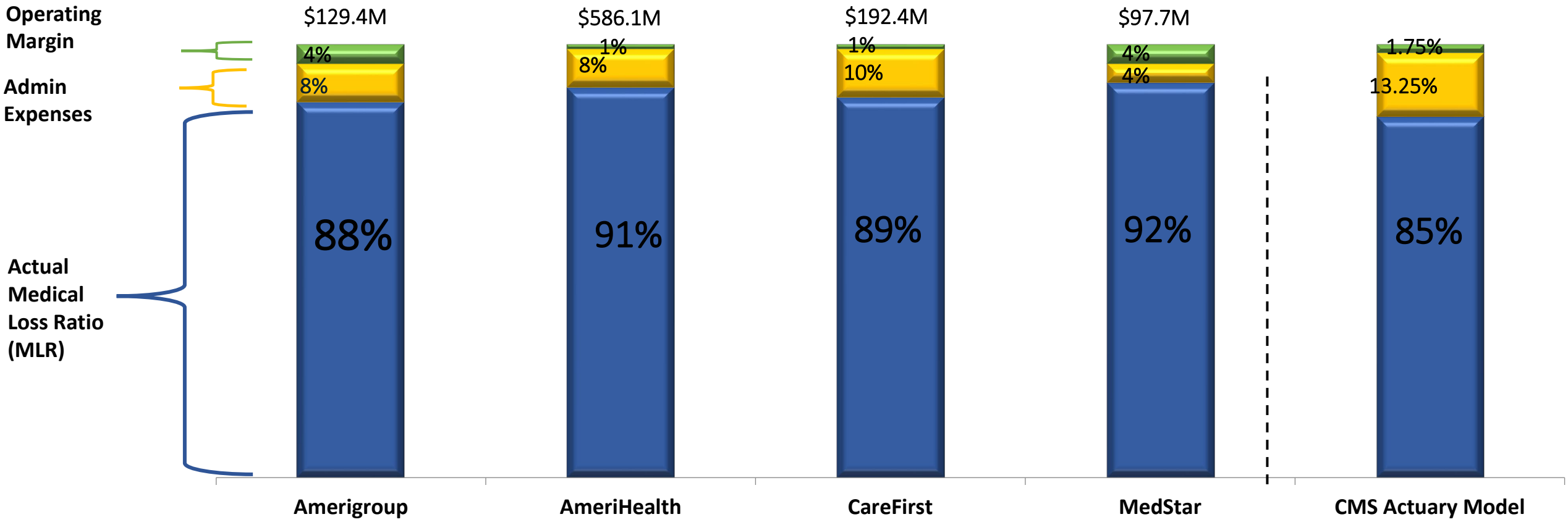
	1 Qtr. PHE & Post Transition of FFS to MCO	12 Months PHE and 1st Yr. Transition of FFS to MCO	9 Months PHE and Pre Transition
Services	**FY22 Proposed Budget**	**FY21 Approved Budget**	**FY20 Expenditures**
Alliance	112,947,242.31	101,713,378.03	90,274,253.98
Behavioral Health	163,511,745.66	162,597,482.49	134,591,760.46
Clinic Services	**46,446,501.99**	**24,949,669.34**	**73,339,305.14**
Home Health Services	**14,945,428.84**	**17,639,376.78**	**19,451,471.85**
Hospital Services	**191,495,043.60**	**222,249,939.33**	**383,152,108.51**
Long Term Care	1,059,286,055.68	969,560,039.38	1,036,172,171.92
Managed Care	**1,475,657,863.23**	**1,514,929,613.18**	**1,170,570,990.23**
Other Services	217,600,315.01	218,435,853.62	208,026,800.28
Pharmacy	**27,177,198.25**	**29,545,756.50**	**48,848,466.83**
Physicians and Nursing	**17,201,773.13**	**31,045,562.92**	**49,730,484.16**
Public Provider	73,329,100.00	41,369,100.00	54,673,747.60
Hospital Support	8,000,000.00	-	8,750,000.00
Grand Total	**3,407,598,267.70**	**3,334,035,771.57**	**3,277,581,560.96**

- 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

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

With Transfer of FFS Population To Managed Care DHCF Will Be Mindful Of MCOs' Cost Experience Compared To CMS Actuary Model*

Actual MCO Revenue for January 2020 to December 2020

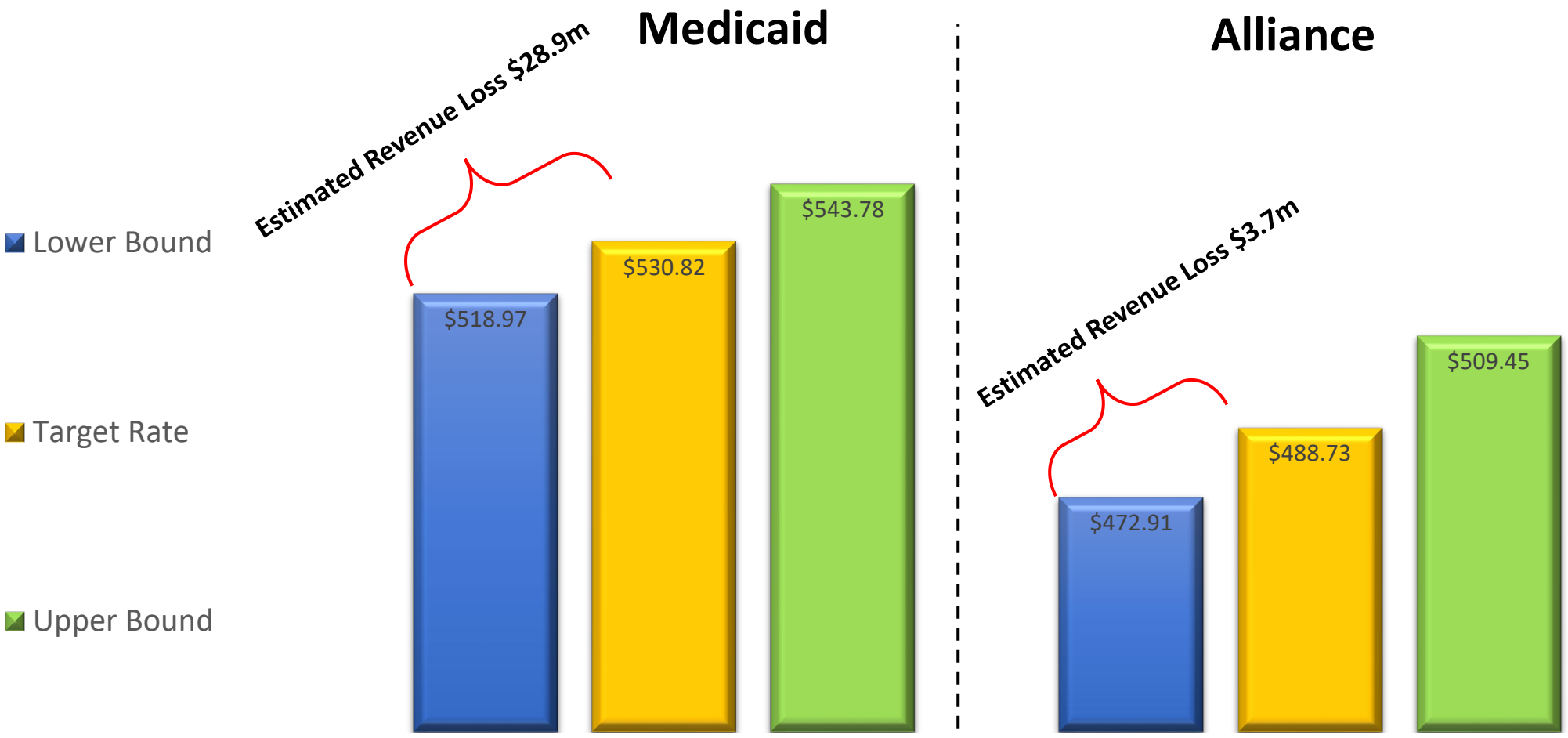


Source: MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the four full-risk MCOs that operated during 2020.

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.

Mayor's Budget Pays Managed Care Plans At Target Rate – Moving To Lower Bound Would Reduce Plan Revenue By $32.6 Million

Managed Care Rate Range For Medicaid And Alliance Programs, FY2022



Managed Care Contracts Under Protest And Review By Council

- MCO contracts were re-procured in 2020 to address the problem of adverse selection – which leads to financial ruin for some plans and unjust profits for others. New contracts with program and financial safeguards were awarded to AmeriHealth, CareFirst, and MedStar Family Choice

- Amerigroup, which finished 4th in the competitive range, raised several complaints of the award to MedStar -

  - Points received for technical merits of proposal were too high due to absence of documentation for 2 staff positions

  - Score for past performance was too high based on the use of 2 versus 3 references

  - Score for past performance reflected a more favorable treatment of Medstar than Amerigroup for similar problems, though MedStar proposed a new solution to address the problem.

  - Amerigroup also requested documents on MedStar's CBE plan submission to examine whether it was compliant with CBE law on the technically narrow question of timeliness – the so-called Conduent ruling.

- As required by the Contracts Appeals Board, DHCF's technical panel has initiated a revaluation of its scoring.

- However, because the Contract Officer for OCP is now required to apply the Conduent ruling to the managed care procurement, MedStar's proposal and those of two other unrelated procurements, by law, must be treated as non-responsive, thus eliminating any further review

- The Mayor's bill before Council will allow the revaluation for all proposals to DHCF procurements that were submitted prior to August 2020 to go forward in the evaluation process – the bill does ***NOT*** supplant the Contract Appeals Board final ruling on DHCF's scoring of the proposals

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Conclusion

- Mr. Chairman this concludes my testimony on DHCF's proposed budget for FY2022

- As has been demonstrated, the Mayor continues to fund health care through the Medicaid and Alliance programs at levels that support expansive coverage to promote critical access, as well as comprehensive services to ensure the enrollees receive the full range of preventive, diagnostic, emergency, specialty care and acute services

- My team and I are happy to address any questions from you and others on the health committee. Thank you for this opportunity to testify

Questions and Comments

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