FY 2022 PROPOSED BUDGET AND FINANCIAL PLAN

PRESENTATION TO THE COUNCIL OF THE DISTRICT OF COLUMBIA

A FAIR SHOT
Mayor Muriel Bowser’s Proposed FY 2022 Budget

The Department of Health Care Finance
June 7, 2021

Wayne Turnage
Director of Department of Health Care Finance
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
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
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
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

- **2020**
  - New MCO contracts (16,700 FFS transition to MCOs)
  - Implement PACE

- **2021**
  - Carve-in Behavioral Health Services to managed care contract

- **2022**
  - Issue new MCO RFP with additional populations and enhanced program requirements (universal contracting), and financial safeguards.
  - Expand Medicare/Medicaid Alignment via Highly-Integrated Dual Eligible Special Needs Plan (HIDE-SNP)

- **2023**
  - Implement new MCO contract with MTLSS
  - Fully integrate Medicare/Medicaid (FIDE-SNP)

- **2024**
  - Issue new MCO RFP to include managed long-term services and supports (MLTSS)

- **2025**
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

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY2019</th>
<th>FY2020</th>
<th>% of Total Pymt</th>
<th>% of Total Pymt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Total</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Children's Natl Medical Ctr</td>
<td>74,455,397</td>
<td>58,365,160</td>
<td>132,820,557</td>
<td>62,554,050</td>
</tr>
<tr>
<td>George Washington Univ Hosp</td>
<td>92,017,564</td>
<td>30,665,085</td>
<td>122,682,650</td>
<td>101,217,743</td>
</tr>
<tr>
<td>Georgetown Univ Hosp</td>
<td>28,135,070</td>
<td>10,519,742</td>
<td>38,654,813</td>
<td>32,256,241</td>
</tr>
<tr>
<td>Howard Univ Hosp</td>
<td>73,281,309</td>
<td>37,268,317</td>
<td>110,549,626</td>
<td>75,791,776</td>
</tr>
<tr>
<td>Sibley Mem Hosp</td>
<td>5,039,983</td>
<td>6,191,684</td>
<td>11,231,667</td>
<td>6,044,552</td>
</tr>
<tr>
<td>United Medical Ctr</td>
<td>22,860,500</td>
<td>16,299,085</td>
<td>39,159,585</td>
<td>24,714,755</td>
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<tr>
<td>Washington Hosp Ctr</td>
<td>133,661,787</td>
<td>57,953,761</td>
<td>191,615,548</td>
<td>136,439,184</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>432,233,262</td>
<td>231,267,034</td>
<td>663,500,296</td>
<td>439,018,301</td>
</tr>
</tbody>
</table>

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

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

*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

**FFS - Inpatient Acute Hospital Quarterly Trends**

- Avg. Pay per Stay
- Data is based on date of payment
- Overall increase in the average expenditure per stay.
- Continuous decrease in the # of FFS stays, while MCO 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.

**MCO - Inpatient Acute Hospital Quarterly Trends**

- Avg. Pay per Stay
- PHE
- Transition Adults to MCO

**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

Quarterly outpatient hospital trends beginning Oct 1, 2018 and ending December 31, 2020 (Q1 FY 2019 thru Q1 FY 2021)

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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  - 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
The Building Blocks Of DHCF’s 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 FY20 Inflation**
- ($378k)

**FQHC’s Rate Increase held at FY20 Inflation**
- ($116k)

**Inpatient/Outpatient Rate Increase held at FY20 Inflation**
- ($790k)

**DCAS Eligibility System O&M**
- $9.6M

**MMIS Operating Impact of Capital**
- $2.9M

**Net Enrollment Adjustments**
- $3.2M

**Alliance Cost Growth**
- $1M

**Hospital Support**
- $8M

**PHE Enhanced Rates & DSNP Transition**
- $9.6M

**Alliance 6-Month Recertification by Phone**
- $5.3M

**Implementation of Neurobehavioral Health Service**
- $698k

**Implementation of Doula Services**
- $75k

**Practice Transformation Collaborative**
- $1.5M (ARPA Grant Funds)
Some Provider Payment Budgets Decrease Due To Declining Enrollment in FY22, But 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>
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<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/ID & 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
With Transfer of FFS Population To Managed Care DHCF Will Be Mindful Of MCOs' Cost Experience Compared To CMS Actuary Model*

<table>
<thead>
<tr>
<th>MCO</th>
<th>Actual MCO Revenue for January 2020 to December 2020</th>
<th>Operating Margin</th>
<th>Admin Expenses</th>
<th>Actual Medical Loss Ratio (MLR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>$129.4M</td>
<td>4%</td>
<td>8%</td>
<td>88%</td>
</tr>
<tr>
<td>AmeriHealth</td>
<td>$586.1M</td>
<td>1%</td>
<td>8%</td>
<td>91%</td>
</tr>
<tr>
<td>CareFirst</td>
<td>$192.4M</td>
<td>1%</td>
<td>10%</td>
<td>89%</td>
</tr>
<tr>
<td>MedStar</td>
<td>$97.7M</td>
<td>4%</td>
<td>4%</td>
<td>92%</td>
</tr>
<tr>
<td>CMS Actuary Model</td>
<td>$1.75%</td>
<td>13.25%</td>
<td>4%</td>
<td>85%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Program</th>
<th>Lower Bound</th>
<th>Target Rate</th>
<th>Upper Bound</th>
<th>Estimated Revenue Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$518.97</td>
<td>$530.82</td>
<td>$543.78</td>
<td>$72.6 million</td>
</tr>
<tr>
<td>Alliance</td>
<td>$472.91</td>
<td>$488.73</td>
<td>$509.45</td>
<td>$28.9 million</td>
</tr>
</tbody>
</table>

Estimated Revenue Loss:
- Medicaid: $28.9 million
- Alliance: $3.7 million
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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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