GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Fiscal Year 2024 Budget Hearing

Testimony of
Wayne Turnage
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

Wednesday, April 5, 2023
9 a.m.
The John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning, Chairwoman 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 Fiscal Year 2024 (FY2024) Fair Shot Budget and Financial Plan for DHCF. As with previous years, the Mayor's commitment to funding critical health care services is evident in this budget, notwithstanding the fiscal challenges she faced – challenges which are discussed later in this section.

I am joined today by DHCF staff who played a central role in developing the agency's budget proposal for the Mayor's consideration. Much of the work in formulating DHCF's proposal to the Mayor was conducted by members of my Executive Management Team which includes both my Senior Deputy Director and Medicaid Director, Melisa Byrd, and our Senior Deputy Director of Finance, Angelique Martin, who due to an unavoidable conflict with a medical appointment cannot be here today. Angelique has assembled one of the most talented finance teams in the city, including James Simms, and our newly minted actuary Joseph Brennan – both of whom are in attendance at this hearing. Their discerning and penetrating insight is perfectly complimented by the comprehensive data analytical work conducted under the outstanding stewardship of senior staff member and Director of Data Analytics, April Grady.

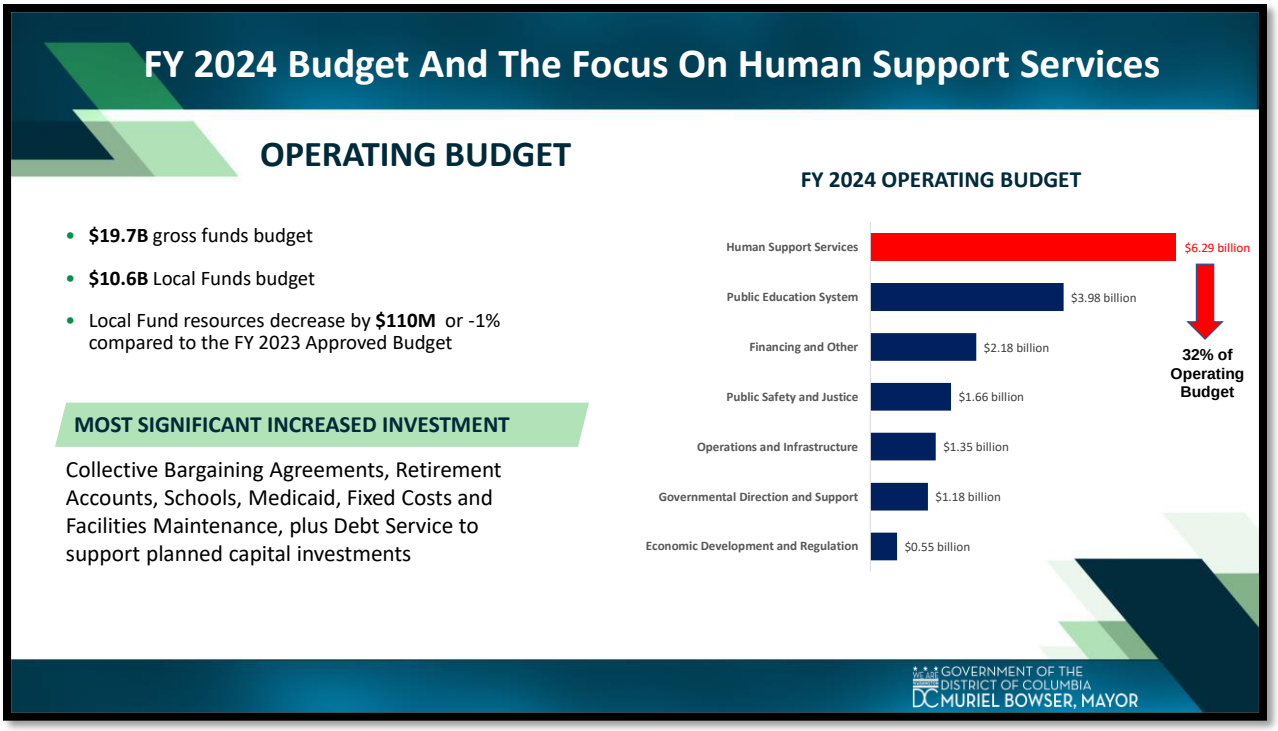
These two divisions – Reimbursement and Finance and Data Analytics – worked very closely with Darrin Shaffer, our Agency Fiscal Officer, and members of his talented staff to develop a proposal that is financially responsible while funding the broad sweep of health care programs delivered under the auspices of DHCF. Clearly, 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

At this time last year, Mayor Bowser submitted a record budget, buoyed by an economy that appeared ready to free itself from a two-year economic stranglehold of a devastating global pandemic. Unemployment was down, consumer spending was on the rebound, and the revenue losses from one of the District's leading economic indicators for the city – the restaurant industry – were significantly abated. But, one year later, the District's economic fortunes have become more complicated. Several revenue sources are trending favorably for FY2023, which prompted the Chief Financial Officer (CFO) to provide an upward revision in the expected revenue for the current fiscal year. However, over the remainder of the District's financial plan, through FY2027, a deteriorating commercial real estate market and more pessimistic expectations about the impact of the United States' monetary policy, caused the CFO to make significant downward adjustments in the city's out-year forecasts.

When these downward adjustments of more than $463 million are considered with the District's pre-forecast expenditure patterns, the projected financial plan was more than $1.7 billion out of balance. Because of the prominent role that health and human services agencies – especially DHCF – retain in the District's budget (see graph on page 4), the Mayor's efforts to solve a $1.7 billion problem across the financial plan has significant implications for DHCF. With reduced federal support and a declining real estate revenue base, the Mayor, nonetheless, put forth a FY2024 budget that is built on $19.7 billion in total operating dollars, with a local fund allocation of $10.6 billion.

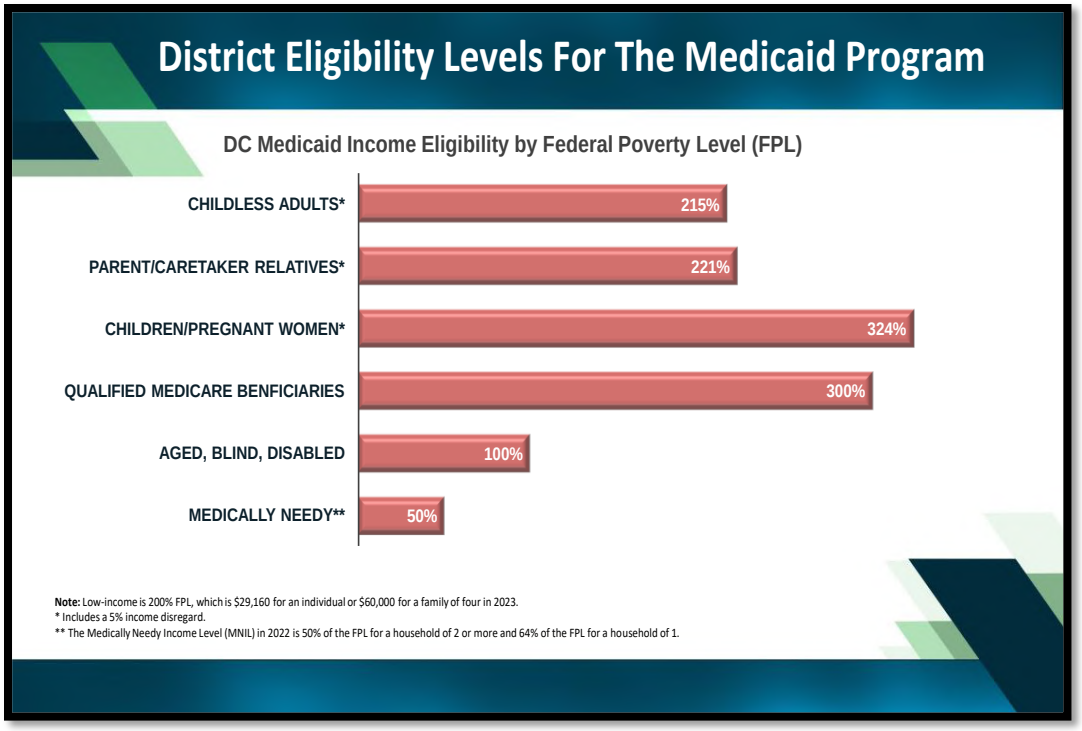
In the planning for this budget, the Mayor eschewed the use of virtual town halls to capture community input and returned to in-person budget town halls that were held on two



separate days. In these town halls, the deputy mayors outlined their cluster agencies' mission and goals before residents who were given the opportunity to weigh in on how they would allocate the city's resources among competing financial demands. This process provided communities across the city a window into the formulation process, giving them an opportunity to voice their views on how the city should spend residents' resources to address the many evident needs.

Overview of DHCF's Program Structure

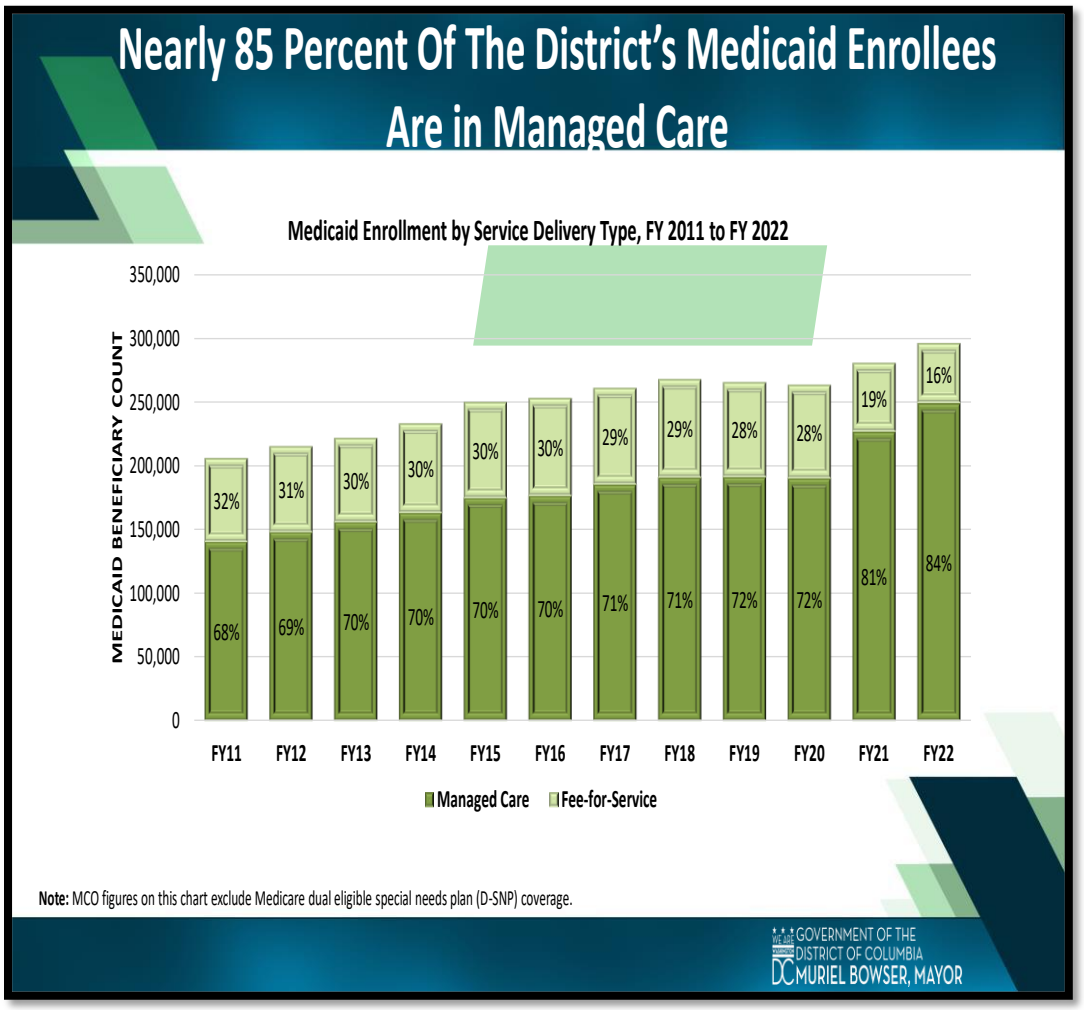
The Medicaid program is a federal-state program where mandatory eligibility groups and benefits are set by the federal government, while allowing states the flexibility for determining additional eligibility groups, benefits, and how care is delivered. In the District, we fund some of the highest eligibility levels in the country, making most low-income adults in the District eligible for the Medicaid program (see graph below). Additionally, many children and pregnant women, with low- or moderate-income levels, are also eligible.



Per federal guidance, we are now in the process of renewing health coverage for all Medicaid, Alliance, and ICP beneficiaries. This process started in July 2022 for Alliance and ICP beneficiaries and April 1, 2023, for Medicaid beneficiaries. As mentioned in the oversight hearing, our goal is to maintain enrollment and limit disruption of access to services for beneficiaries and families who remain eligible for these benefits.

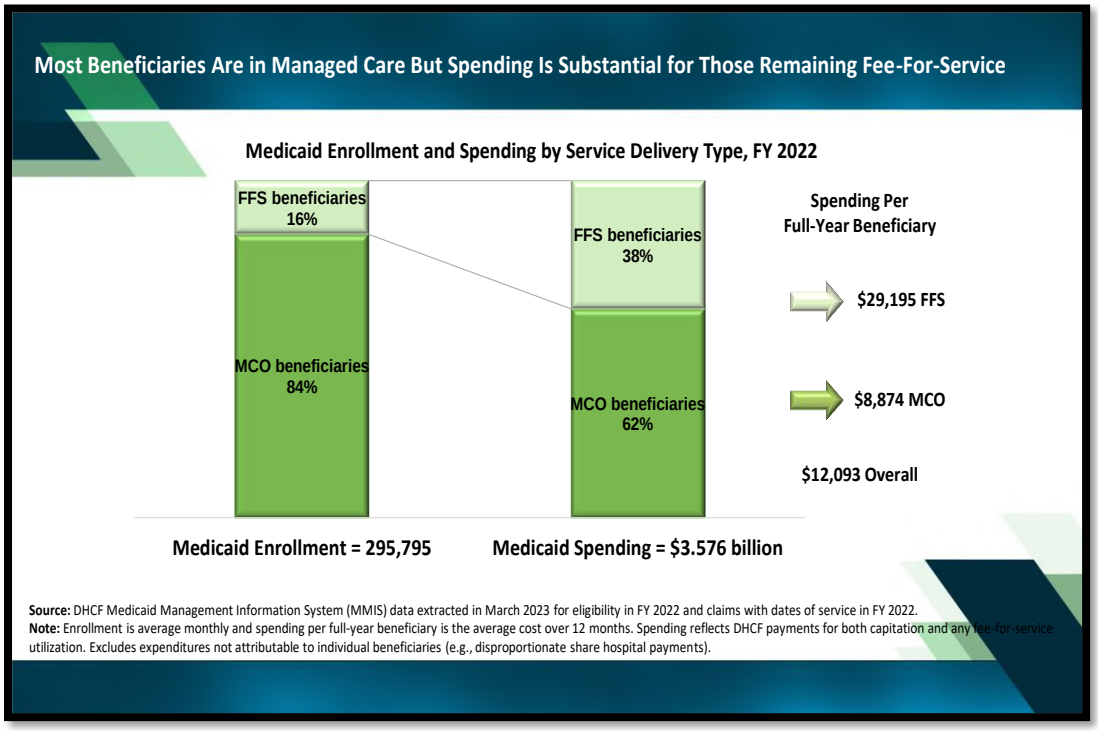
The array of benefits available through the Medicaid program consist of both federally mandated and optional services. We have broad flexibility to design a package of benefits for our Medicaid program within federal guidelines. Certain benefits, such as inpatient hospital and physician services, are mandatory, while others, such as prescription drugs and doula services, may be provided as a state option. We pride ourselves on a comprehensive service package and the proposed FY2024 budget maintains these benefits as a foundational component of our program.

DHCF's Bifurcated Program Structure. Most of our Medicaid beneficiaries access health care services through a managed care plan. Since FY2020, participation in managed care has grown from approximately 70 percent to nearly 85 percent in FY2022 (see graph below). The most recent increase in managed care is attributed to the February 2022 launch of the District Dual Choice program that serves individuals enrolled in both Medicare and Medicaid. The remaining beneficiaries receive care through the Medicaid Fee for Service (FFS) program, which is administered directly by DHCF, and we pay providers for the health care delivered to this non-managed care population.



This increase in managed care is purposeful – in 2019, DHCF announced its intent to transition a large share of FFS beneficiaries into the managed care program to increase these members access to coordination and case management services. These services are key components of the managed care program and are not widely available in fee for service program.

As shown by the graphic below, there are significant differences in the per-person spending in managed care compared to the FFS program. Specifically, on an annual basis, the per-beneficiary cost of managed care spending is approximately $8,800. Comparatively, the cost for FFS program is more than three times higher at nearly $30,000 annually. Our goal remains to move an even larger share of high-cost beneficiaries with more acute health problems, into managed care.



The Medicaid Funding Match. As a partner in the Medicaid program, the federal government funds both direct services and administrative functions. Federal dollars are allocated

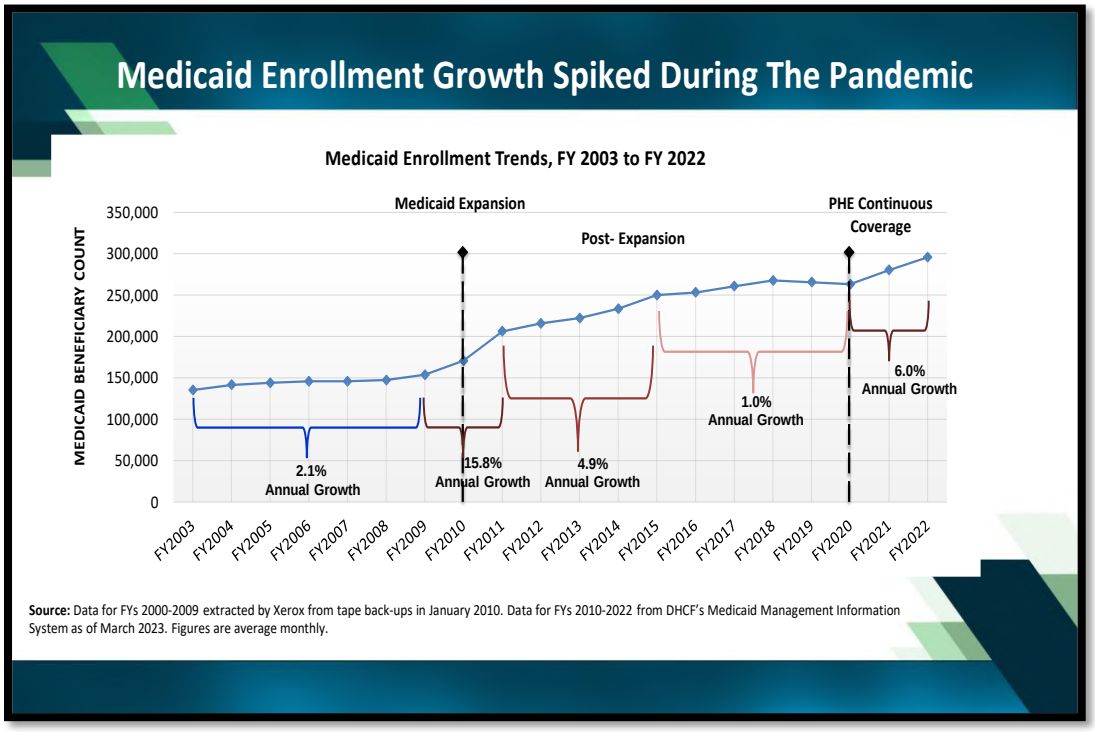
through a federal medical assistance percentage policy known as FMAP. The level of FMAP varies by state and, with few exceptions, is inversely related to a state's per capita income. Unlike other states, the District's FMAP is statutorily set at 70 percent and remains constant year over year. The 70 percent FMAP applies to direct services like physician and managed care services. Higher FMAP percentages are available for certain enrollment groups, and the federal government also subsidizes DHCF's administrative costs, and our technology system design and development projects. During the federal Public Health Emergency, the District benefitted from an increased FMAP of 6.2 percentage points, but this is now phasing out and will decrease each quarter until the end of the calendar year when it returns to 70 percent.

The Building Blocks For DHCF's Budget

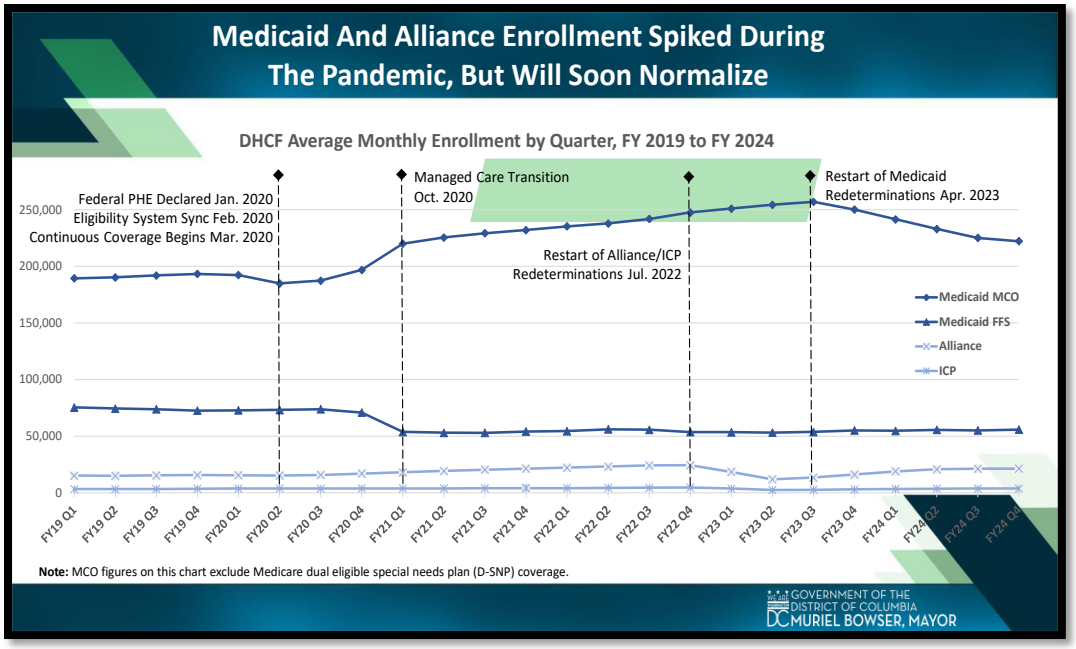
DHCF's budget formulation is driven by three key elements: 1) Medicaid and Alliance program enrollment; 2) service utilization; and 3) provider rates. Significant budget savings in the Medicaid program cannot be achieved without impacting one or more of these three areas. However, for part of the budget's financial plan, federal maintenance of effort requirements prohibit DHCF from making changes to eligibility levels or certain benefits. As we do each year, and with these limitations in mind, DHCF initiated budget formulation from the ground up – meaning we analyzed enrollment and utilization trends to project these outcomes for the coming year. Provider rates, including any rate changes, and expected policy changes are also appropriately factored into our estimation process to determine anticipated program costs.

Enrollment. It is important to note that as an entitlement program, a resident who is deemed eligible for Medicaid cannot be denied enrollment. Additionally, during the Public Health Emergency, Medicaid was under a continuous enrollment requirement – meaning no active beneficiaries could be disenrolled from the program, even if their income exceeded

allowable eligibility thresholds. The result is we have more people in the program than ever witnessed in the District. Notably, since 2020, the annual enrollment growth rate has been six percent compared to one percent for the immediate years prior (see graphic below). At a historical high, Medicaid now pays for the health care of just over 300,000 District residents. Thus, if all other variables remained constant, program costs would continue to increase simply because of increased enrollment.



The continuous enrollment requirement ended on March 31, 2023, and Medicaid eligibility renewals resumed for the first time since March 2020. Over the next 14 months, every Medicaid beneficiary will be required to recertify their eligibility. We expect some individuals will no longer be eligible for the program and that enrollment will normalize towards the end of Fiscal Year 2024, as shown in the figure on page 10. It is important to note that for purposes of this budget and financial plan, DHCF's enrollment projections extend through FY2025. Beyond that date, any projections would be unreliable, subject to wide error margins.



Service Utilization. In terms of utilization, at the beginning of the Public Health Emergency, we witnessed a precipitous decline in beneficiary utilization of Medicaid. Notably, many beneficiaries postponed or otherwise delayed health care treatment, especially during the first year of the pandemic for fear that they would contract the virus in a medical care setting. Once vaccines were identified and widely distributed, however, utilization began a return to historical norms and this trend is captured in our budget estimates for Medicaid and Alliance.

Provider Rates. The remaining variable that impacts DHCF's budget formulation is provider rates. In addition to eligibility flexibilities during the Public Health Emergency, DHCF was also able to increase provider rates, which drove payments up to levels that exceeded provider cost in many cases. Our ability to provide enhanced rates ends at the conclusion of the Public Health Emergency (May 11, 2023). We fully anticipate that some provider rates will return to normal by the end of May while others will phase out between May and November, 2023. These anticipated changes are fully reflected in the Mayor's proposed budget for DHCF.

Components of DHCF's Budget. DHCF's proposed budget is nearly $4.3 billion, and it reflects funding from multiple sources. The table below shows each funding source, the proposed FY2023 budget amount, and the year over year comparison from FY2023 to FY2024. Overall, a surge in inflation, an increase in federal Medicaid payments, and higher planned spending in federal grants are the key factors driving DHCF's proposed budget growth by 15 percent, despite key targeted reductions. Dedicated taxes which are used to defray managed care costs, and support staff salaries, grew by 9 percent. Local budget growth compared to the FY2023 approved budget, was comparatively modest at 3.3 percent – an increase of $31.9 million. The availability of enhanced FMAP through the first quarter of FY2024, likely dampened local fund growth.

DHCF's FY2024 Year Over Year Comparison by Appropriated Fund

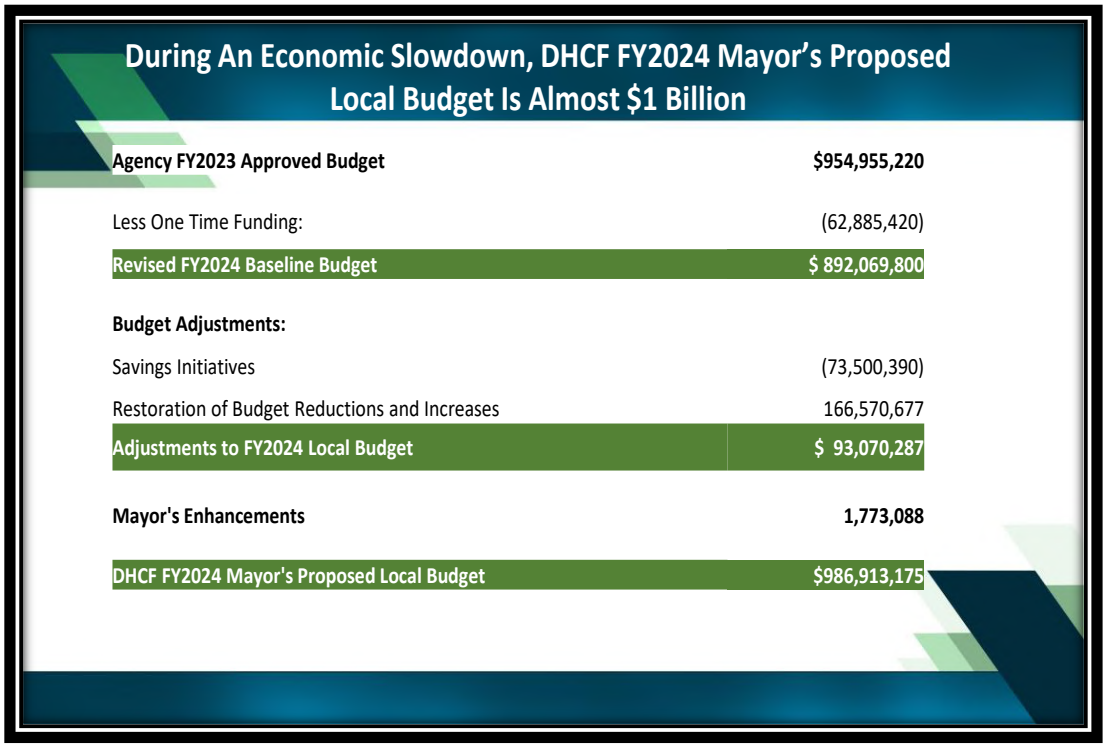
Appropriated Fund		FY 2023 Approved Budget	FY 2024 Proposed Budget	YoY Budget Change	% Change
0100	Local	954,955,220	986,913,175	31,957,954	3.3%
0110	Dedicated Taxes	105,105,077	114,535,958	9,430,881	9.0%
0150	Federal Payments	2,000,000	-	(2,000,000)	-100.0%
0200	Federal Grants	5,174,115	4,550,493	(623,622)	-12.1%
0250	Federal Medicaid Payments	2,663,283,089	3,180,056,342	516,773,254	19.4%
0400	Private Grants	365,701	100,000	(265,701)	-72.7%
0600	SPR Revenue (Type)	5,643,542	8,805,546	3,162,004	56.0%
0700	Intra Districts	-	-	-	0.0%
Grand Total		3,736,526,743	4,294,961,514	558,434,771	15.0%

Variance Explanation

- **Local:** Increase in local funds to support the Mayor's investments in health care and replace enhanced FMAP received in previous years due to the Public Health Emergency
- **Dedicated Taxes:** Alignment of budget to anticipated revenue collection to support provider payments and administrative cost. DHCF will use $10.1M in fund balance; available due to prior years of receiving EFMAP which required less dedicated tax (or local) match
- **Federal Payments:** The District ARPA funded projects were sunset at the end of FY23; The Transportation for Alliance Pregnant Mothers ($480k) and Practice Transformation Efforts ($1.5M) will be funded through other resources
- **Federal Grants:** the SUD grant expired in FY23; it is not accounted for in FY24 budget
- Federal Medicaid: The FY23 Approved budget assumed the EFMAP would sunset during FY22, the budget will be adjusted upward to align with the EFMAP reducing the delta between FY23 and FY24. FY24 aligns with anticipated Medicaid participation, including one quarter of EFMAP at 1.5% (or 71.5%)
- **Private:** DHCF did not awarded the grant in FY23
- **O-Type:** Alignment of budget to anticipated revenue collection and reflection of the utilization of fund balance in 3rd party Collections of $3.1M

Understanding the Local Fund Budget. The Mayor approved a number of actions to build the local fund budget. Under the current process, the Mayor's budget office initiates the process by establishing a baseline funding amount that is determined by the previous year's

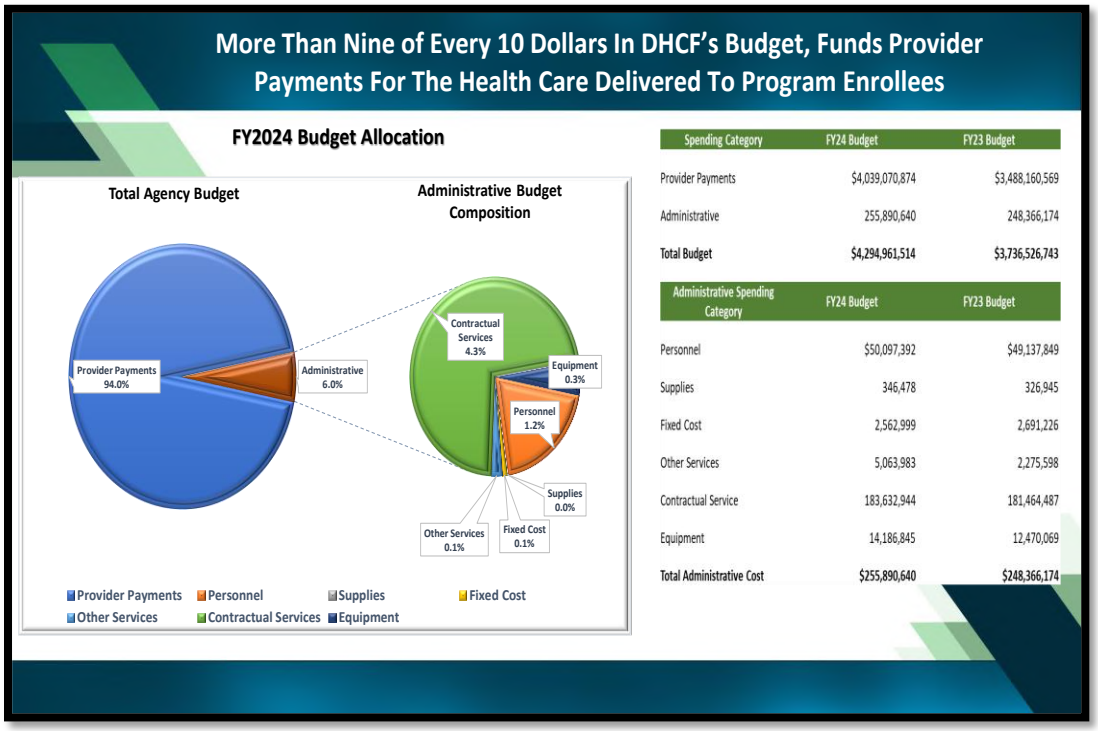
approved budget. For DHCF, this amount was $954.8 million – a figure that was adjusted downward by backing the one-time funding enhancements from FY2023 out of the baseline starting point. This 6.5 percent reduction generated the agency's budget target of $892 million (see table below).



DHCF staff then offered program reductions of $73.5 million but these savings initiatives were largely rejected by the Mayor, who ultimately restored $166 million to our budget – for a net adjustment of $93 million. After adding another $1.8 million in program enhancements to support Produce RX and the staff cost for long-term care eligibility processing – staff were transferred to DHCF from DHS – the agency's final proposed budget created a total local fund budget of $986.9 million.

Limited Administrative Spending. The local funds in DHCF's budget are sufficient to draw down $3.1 billion in federal Medicaid payments, creating a total fund budget of $4.3 billion. Yet, despite this considerable budget, DHCF remains an extraordinarily lean operation.

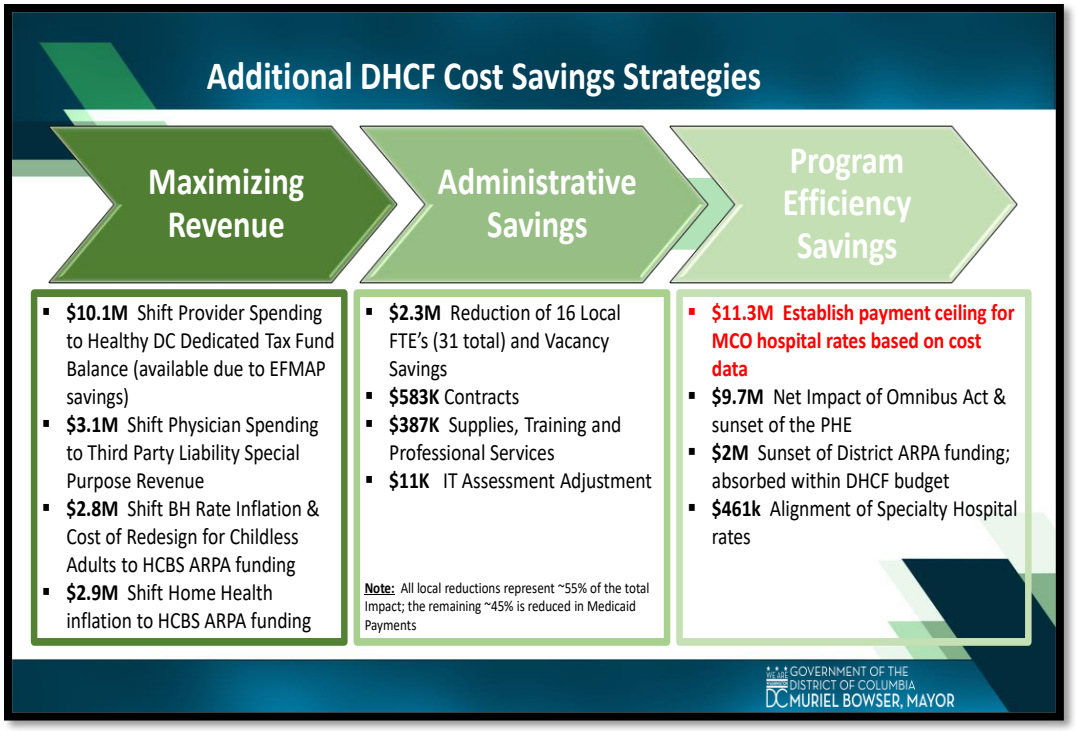
Fully 94 percent of these funds are dedicated to provider payments. The remaining six percent is allocated for administrative cost and most of these resources are paid to vendors for contract services. Only 1.2 percent of DHCF's budget is allocated for agency staff (see graphic below).



Spending Category	FY24 Budget	FY23 Budget
Provider Payments	$4,039,070,874	$3,488,160,569
Administrative	255,890,640	248,366,174
Total Budget	**$4,294,961,514**	**$3,736,526,743**

Administrative Spending Category	FY24 Budget	FY23 Budget
Personnel	$50,097,392	$49,137,849
Supplies	346,478	326,945
Fixed Cost	2,562,999	2,691,226
Other Services	5,063,983	2,275,598
Contractual Service	183,632,944	181,464,487
Equipment	14,186,845	12,470,069
Total Administrative Cost	**$255,890,640**	**$248,366,174**

Key Savings Reduction. The Mayor's proposal for DHCF is built on strategic cost shifting, administrative savings, and program efficiencies. Through cost shifting, we saved nearly $19 million in local spending. The largest savings was generated by using available fund balance from the Healthy DC Dedicated Tax to offset $10.1 million in managed care costs (see graphic on next page). The surplus in the funds was generated by savings from the enhanced FMAP received by the District. Similar cost shifts were executed to pay for physician cost (using Special Purpose Revenue), and behavioral health and home health rate inflation (using federal ARPA funds for Home and Community-Based Services). Together, these strategies generated $8.8 million. Also, as



with other agencies, DHCF's most significant administrative savings were generated by a sweep of 16 staff positions which generated $2.3 million in savings.

Capping Managed Care Hospital Costs. Two years ago, DHCF established a requirement that every health plan in the program, must contract with every acute care hospital in the city. The penalty for failure to comply could result in a termination of the relevant health plans' contracts if we determine that they did not negotiate with the hospitals in good faith. We developed this policy to give Medicaid and Alliance managed care members equal access to each hospital in the city, regardless of the managed care plan in which they were enrolled. This policy can mitigate the problem of adverse selection – a situation where members with more severe medical conditions decide to disproportionately enroll with a given plan – but, it also has the unintended effect of weakening the negotiating leverage of the health plans. While hospitals face the same penalties for non-compliance, it can be imprudent to remove a hospital from the

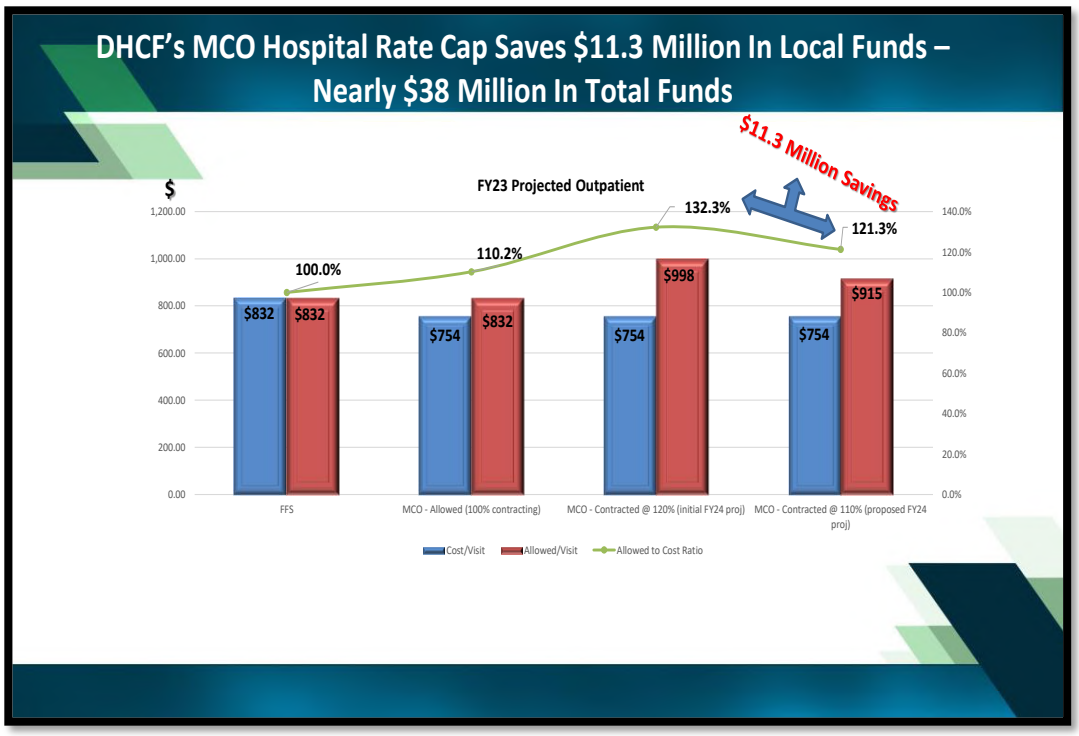
entire Medicaid program, especially if the doctors in the relevant facility deliver care to a large portion of Medicaid enrollees.

In addition to the requirement of universal contracting, DHCF employs a reimbursement policy that establishes a minimum floor for managed care hospital rates. The health plans are not permitted to pay hospitals below this floor which is set at 100 percent of FFS hospital cost. Because the FFS population has higher acuity levels and receive certain more expensive benefits, such as transplants, that the individual health plans' populations do not, the baseline managed care hospital rates which are tied to FFS cost, are inflated above the expected cost experiences for health plans before the contract negotiating process is initiated.

This is demonstrated in the graphic on the next page which reports FFS and managed care (MCO) cost per visit, allowed cost per visit, and an allowed cost to ratio. As shown by the bar on the far-left side of the graphic, the FFS cost per visit is $832, which is also the FFS allowed cost per visit. This, however, is higher than the $754 MCO *actual* hospital cost per visit. This means that MCO hospital baseline rates paid at 100% of FFS cost, compute to an allowed MCO hospital cost to ratio of 110 percent of MCO hospital actual cost per visit. In other words, when MCOs pay hospitals the minimum rate allowed by DHCF, the resulting payment is still higher than the MCOs' actual cost per visit at 110%

For budget formulation, DHCF used the actuarially proposed FY2024 MCO contracting adjustments to estimate the cost of the outpatient hospital rates without a cap. As shown, we initially projected the MCO hospital contracting rates at 120 percent of the allowed FFS cost without a cap. This creates an MCO hospital rate that is 132 percent of

cost. This is not acceptable for a public plan and is likely not sustainable long-term, even in periods of less fiscal stress.



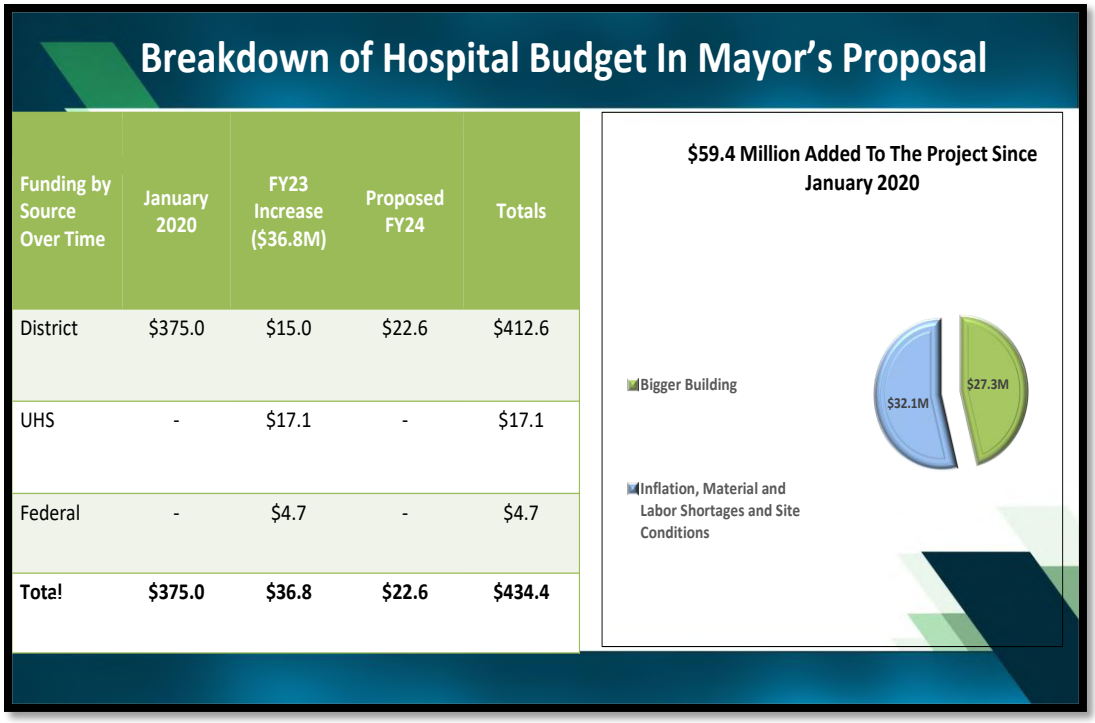
Therefore, to address this problem, the Mayor's budget establishes the Medicaid Hospital Provider Reimbursement Act of 2023 in the Budget Support Act. This subtitle requires DHCF to fund Medicaid MCO hospital care rates at a level that ensures outpatient hospital reimbursement has a minimum floor of 100 percent of the FFS rate and a maximum level of 110 percent of the fee-for-service outpatient methodology set forth in the Medicaid State Plan. It is important to note that this range is above the MCO hospital cost per visit and, most of the hospitals in the Medicaid program, already operate within this range.

For inpatient rates, the language imposes a minimum floor of 98 percent of costs and a maximum equal to the negotiated rates in place as of March 31, 2023. The goal, of

course, is to tap down any upward pressure on inpatient rates during this period of fiscal stress.

Budget Allocation For Cedar Hill Hospital

Madam Chairwoman, the final item to be covered in my testimony is the Mayor's budget proposal for the new hospital. As the table below indicates the Mayor's has added $22.6 million to the hospital budget, bringing the project total to $434.4M. Thus, $59.4 million have been added to the project since January 2020. Of this new amount, $27.3 million were added to make the facility bigger, while $32.1 million were allocated to offset the higher costs due to continued inflation, raw material and labor cost increases, medical equipment, computer chip shortages, and unanticipated construction and design issues. With these investments the hospital remains on schedule and keeps our cost increases to less than half the national average over the last 3 years – a significant accomplishment in these historically challenging economic times. Barring the emergence of future unforeseen costs, the resources proposed in the Mayor's FY2024 budget are sufficient to ensure that hospital's construction is completed on-time in December 2024 and the facility can open to patients in early 2025.



Conclusion

Madam Chairwoman, this concludes my testimony for today. There can be little question about the difficult financial environment in which the Mayor's FY2024 Fair Shot budget was crafted. Despite the negative revenue growth in the out years of the District's financial plan, the Mayor preserved the key features of the health care programs administered by DHCF – high eligibility levels, an expansive system of benefits, and provider reimbursement rates that do not threaten access to care. We look forward to working with you and other members of the Committee to address any questions that have surfaced since the Mayor's budget submission.

Thank you.