June FY25 Medical Care Advisory Committee (MCAC) Meeting

June 3, 2025 | 5:30 PM – 7:30 PM ET

Virtual Meeting

Housekeeping

- **Introduce yourself in the chat:**
  - Name
  - Organization (if applicable)
  - MCAC member or non-member
- **Keep yourself muted unless speaking**
- **You can add questions to the chat or use the "Raise Hand" function**
- **This meeting will be recorded**
  - DHCF will post a recording of the meeting on the MCAC webpage after the meeting

Agenda

- Welcome and Roll Call
- DHCF Budget Update
- Public Announcements

DHCF Budget Update

Presentation to the MCAC

Budget Overview for FY 2026

Department of Health Care Finance

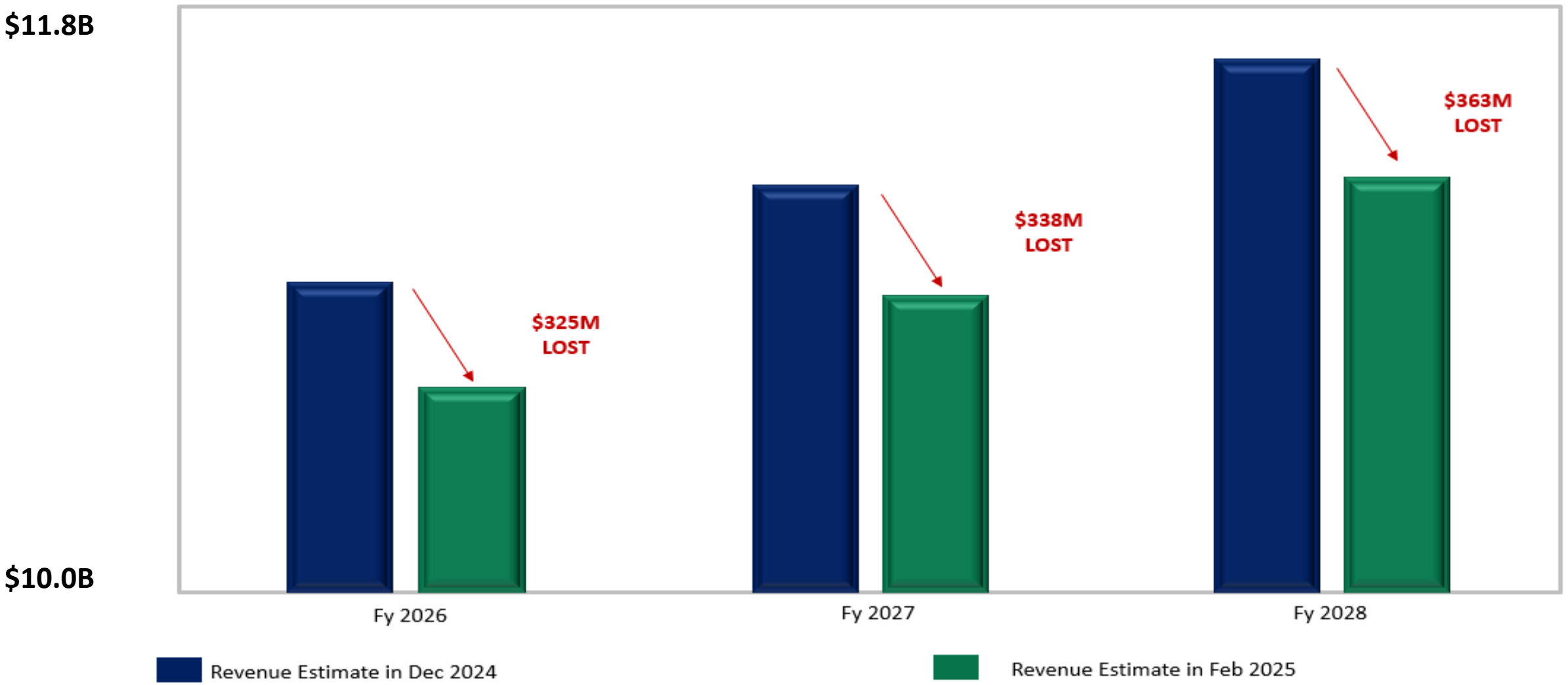
Introduction

Introduction

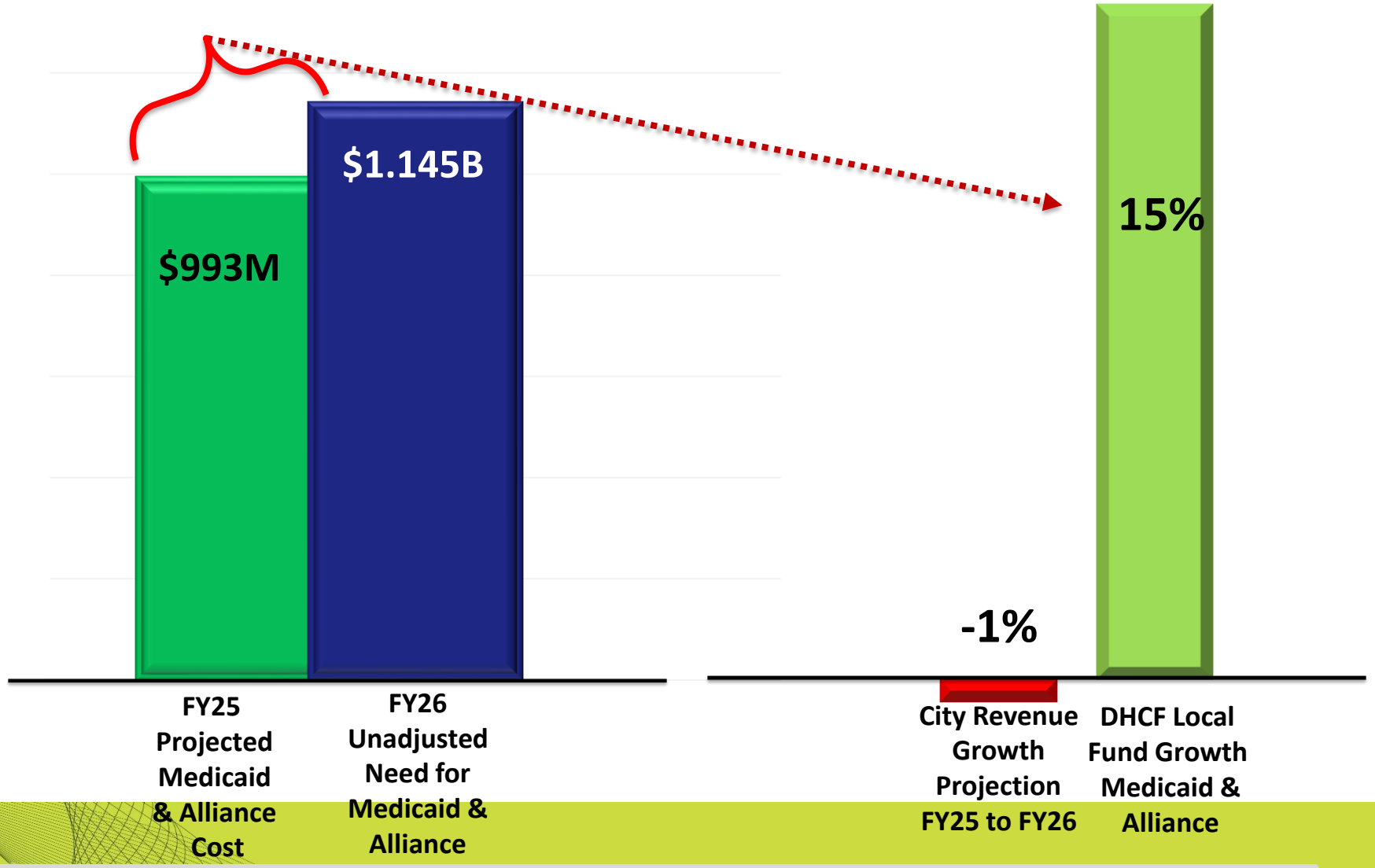
- Today's FY2026 Budget Overview focuses on:
  - The financial environment in which we formulated DHCF's budget and the countervailing cost growth trends for both the Medicaid and Alliance programs;
  - The framework employed by DHCF to slow the growth in funding for Medicaid and Alliance – both of which 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; and
  - The program changes proposed to reform and reduce the financial footprint of the locally funded Alliance program

Revenue Picture For The District And DHCF Cost Trends

Loss Of Federal Employment For DC Residents, Reduced Income and Consumer Spending, And A Continued Softening of the Commercial Office Market Have Reduced Predicted Revenues For The City By More Than $1 Billion

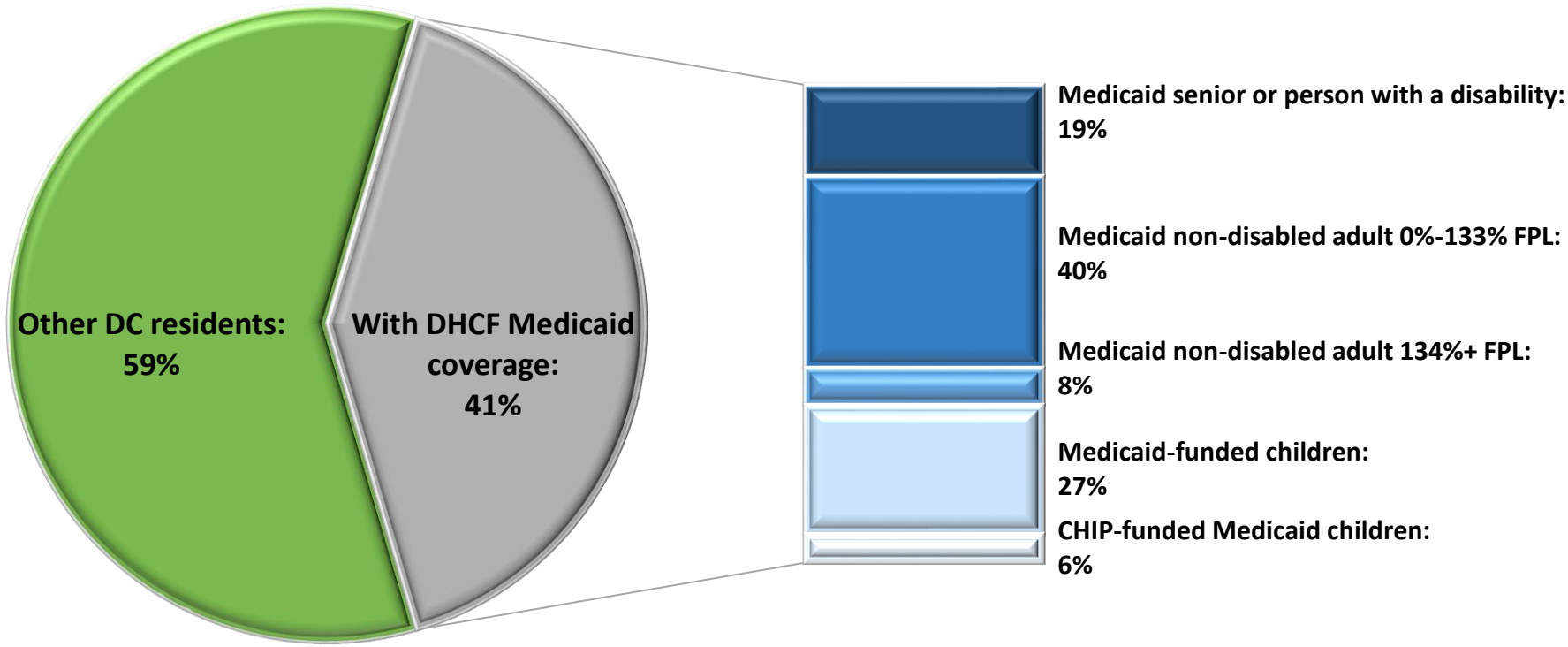


While District's Revenue Growth Rate Flattens, Medicaid And Alliance Enrollment and Utilization Changes Are Driving Double Digit Projected Local Fund Growth



In FY2024 Over 40% of District Residents Received Health Care Through the Medicaid Program And Only 8% Have Incomes Above 133% of The Federal Poverty Level

Proportion of DC Residents with Medicaid/CHIP Coverage, FY 2024

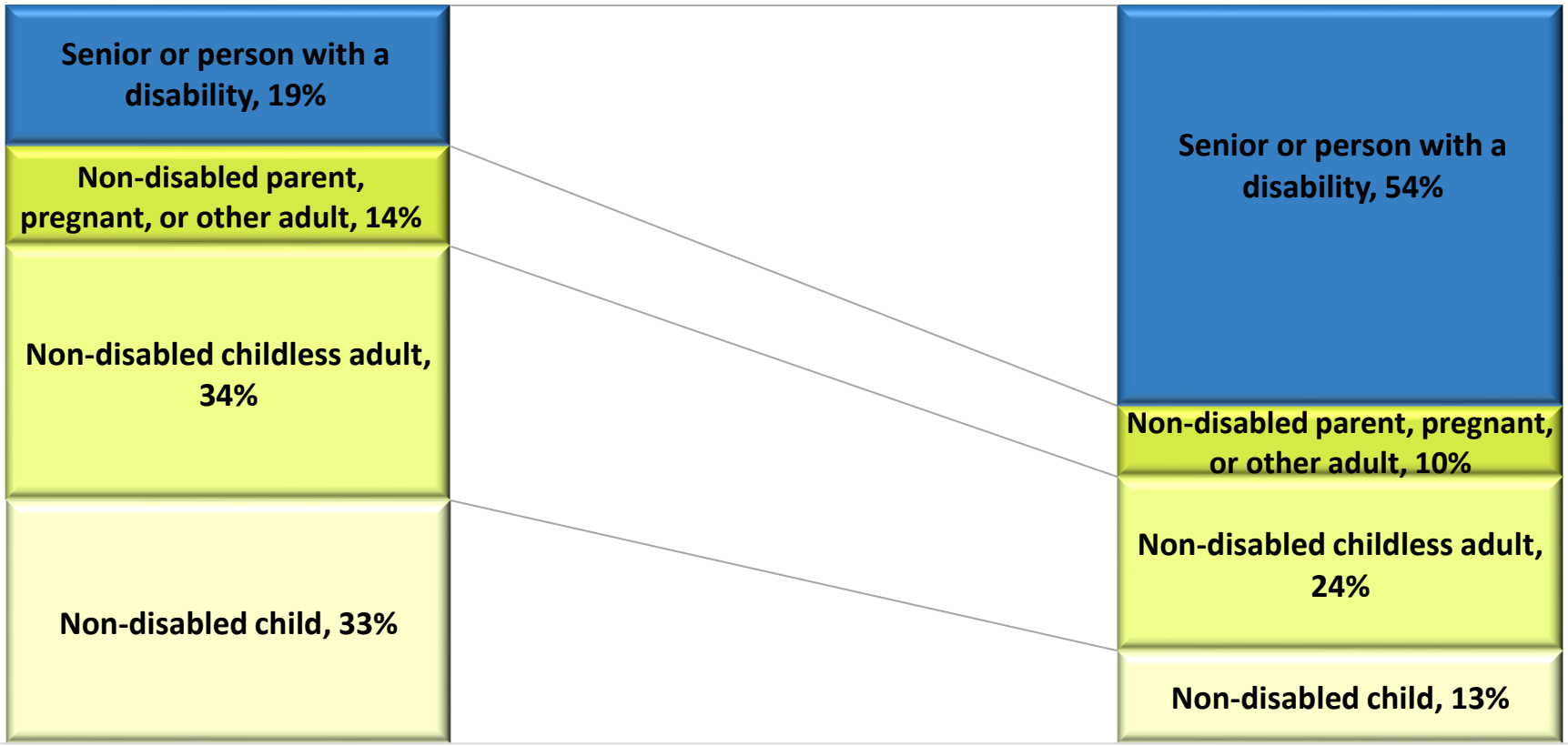


Total District of Columbia Residents = 702,250

Source: District population reflects the U.S. Census Bureau's estimate as of 7/1/2024 from NST-EST2024-POP. Medicaid data reflect FY 2024 average monthly enrollment as of May 2025 from DHCF's Medicaid Management Information System.
Note: Sum of components may not equal total due to rounding and 5% income disregard is not included i

Seniors and Persons with Disabilities Reflect About 20% of Enrollment; But Nearly 60% Of Medicaid Spending

Medicaid Enrollment and Spending by Eligibility Group, FY 2024



Medicaid Enrollment: 287,303

Medicaid Spending: $3.845 billion

Source: DHCF Medicaid Management Information System (MMIS) data extracted in May 2025 for eligibility in FY 2024 and claims with dates of service in FY 2024.

Savings Approach For Medicaid

Significant Savings In Medicaid Can Only Be Achieved By Reductions To One Or More Of The Three Foundational Building Blocks Of The Program

Framework for District Medicaid	**Since the establishment of Home Rule, the District's Medicaid program has been developed on three foundational principles.**
1. Eligibility – Leverage Federal Match	**Eligibility.** Leverage favorable federal match rates to cover almost as many low-income District residents as federal law permits – result is some of the highest Medicaid eligibility rates in the country.
2. Expand Program Benefits	**Benefits.** Fund a robust set of benefits allowing low-income residents access to nearly the same array of health care benefits of their higher income neighbors, while ensuring access to long-term health care services for persons with disabilities – DC Medicaid benefits are among the most expansive nationwide.
3. Establish Fair Provider Reimbursement Rates	**Provider Reimbursement.** Develop a fair and reasonable system of reimbursement that pays providers significant rates for treating people whose payor is the government.

DHCF Generated $332 Million in Local Fund Savings And The Mayor Authorized An Offsetting $142.1 Million In Investments – Net Savings = $191 Million. Largest Reductions Were Made In Beneficiary Eligibility

Projected Medicaid Savings for FY2026

FY2026 Budget Adjustments At-A-Glance

Category	Savings	Investment	Net Change
Eligibility	(291,558,800)	124,801,321	(166,757,480)
Efficiencies	(24,519,924)	175,000	(24,344,924)
Services	(2,681,076)	2,573,740	(107,336)
Provider Rates	(13,837,488)	14,503,996	666,508
Total	**(332,597,288)**	**142,054,057**	**(190,543,231)**

Percent Reductions By Category

Eligibility

Efficiencies, Rates & Services

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
LOCAL FUND	$ 1,070,804,358	$ 1,043,110,088	$ 1,051,730,425	$ 8,620,337	172	175
DEDICATED TAXES	240,409,641	240,409,641	267,714,097	$ 27,304,456	7	7
SPECIAL PURPOSE REVENUE FUNDS	7,008,261	7,008,261	5,491,817	$ (1,516,444)	16	15
FEDERAL GRANT FUND - FPR	10,712,509	5,136,131	10,399,776	$ 5,263,645	5	8
FEDERAL MEDICAID PAYMENTS	3,572,144,949	3,572,144,949	4,080,659,923	$ 508,514,974	178	184
	$ 4,901,079,718	$ 4,867,809,070	$ 5,415,996,038	$ 548,186,968	377	389

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 Care 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

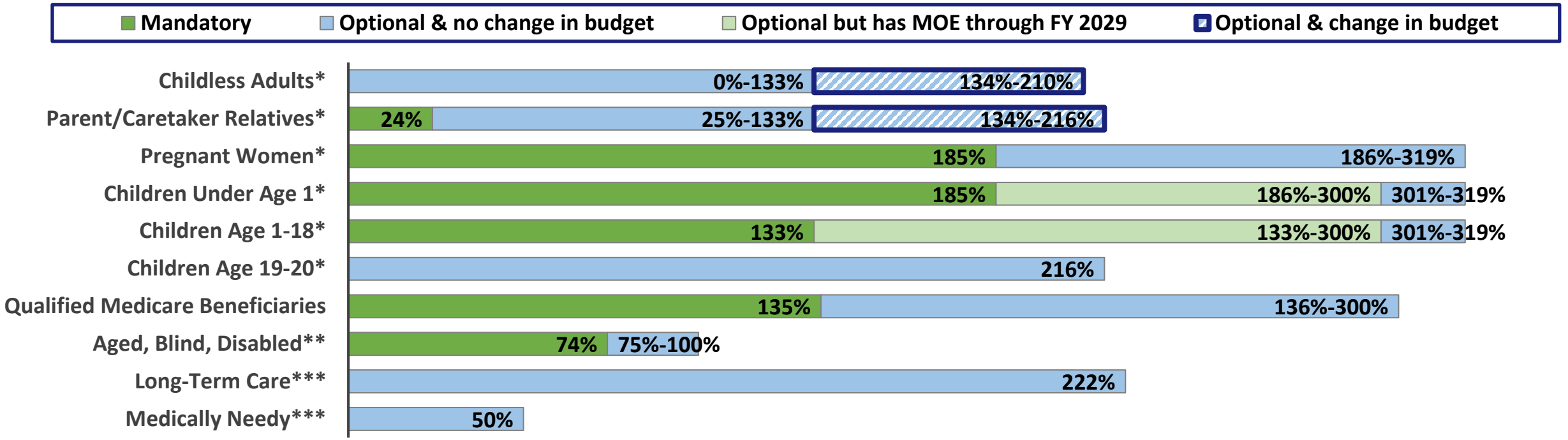
All Other Funds: Cost allocation shifts and increase in 2 FTEs across the agency

Medicaid Eligibility Changes

The Administration Pursued Several Goals In Reducing The Eligibility Cost For Medicaid

Goal	Description
Focus Reductions On Optional Populations	**Mandatory vs. Optional**. Medicaid "optional groups" describe low-income individuals and families that the District has the option to enroll in the program. These optional groups are typically distinguished from mandatory beneficiaries only by the amount of income they earn, and in one case the category of eligibility – Medically Needy – that they represent. The District has nine optional groups.
Target Those Beneficiaries On The Higher End Of The Eligibility Thresholds	**Income Range.** The District has the highest Medicaid income eligibility levels in the country for most beneficiary groups. The levels for several optional groups exceed the national average.
Focus Reductions on Persons Who Have Other Insurance Options	**Offer Alternative Coverage Options.** By working with the District's Health Insurance Exchange, develop alternative insurance options for persons at the high end of DC's Medicaid eligibility thresholds who are removed from the program in Fiscal Year 2026.

DC Medicaid Mandatory and Optional Income Eligibility by Federal Poverty Level (FPL)



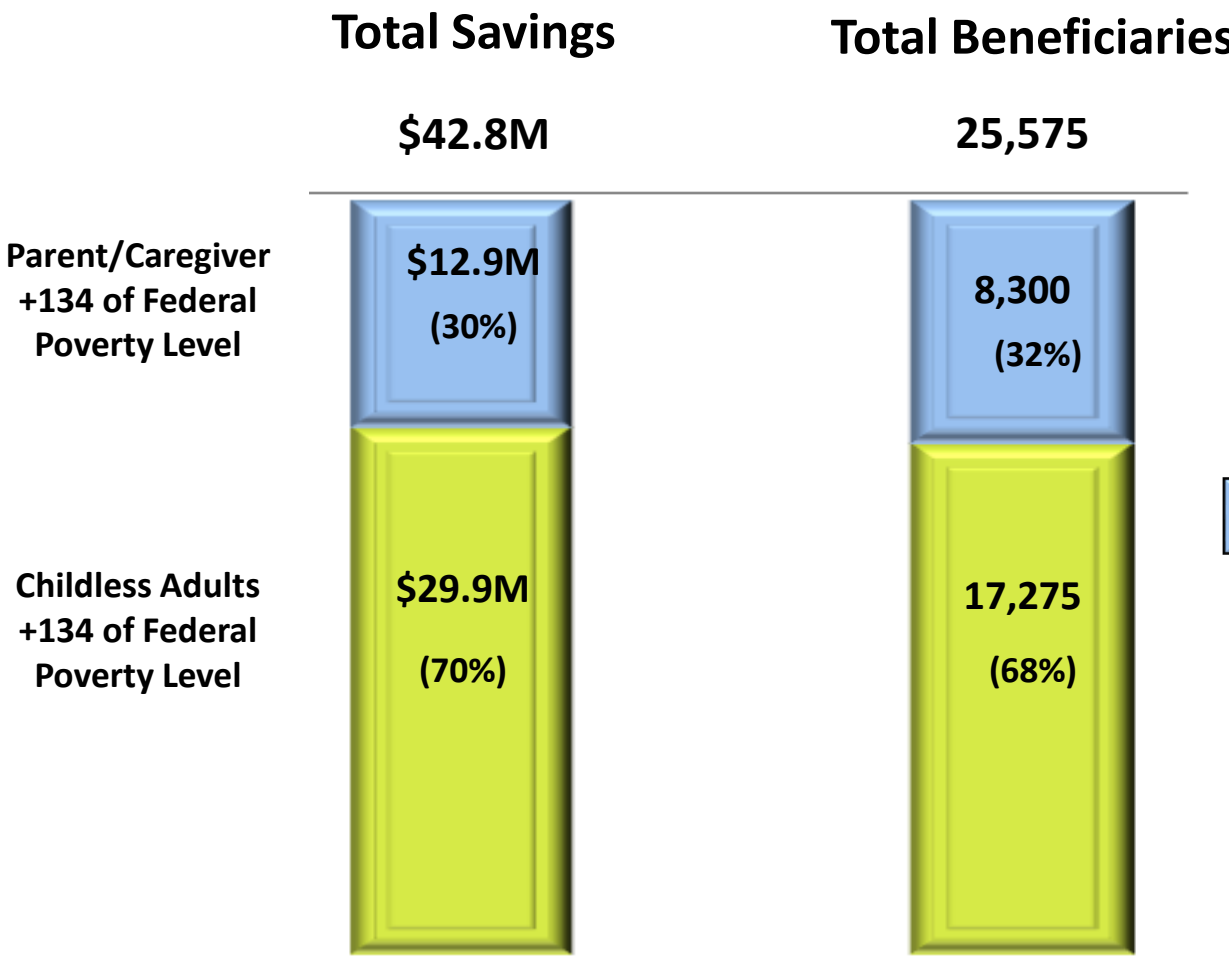
Note: 200% FPL is $30,120 for an individual or $64,300 for a family of four in 2025. MOE is maintenance of effort.

* Medicaid eligibility determinations for these groups include a 5% income disregard when calculating the effective upper FPL limit. The limit shown here excludes the disregard.

** Must be receiving Supplemental Security Income (SSI) cash assistance to qualify for mandatory coverage; the 74% FPL shown is for an individual and the limit for a couple is 82% FPL.

*** Long-term care eligibility is limited to individuals who require an institutional level of care and the upper limit is 300% of the SSI federal benefit rate, which translates to 222% FPL for an individual. The medically needy level (MNIL) in 2025 is 50% of the FPL for a household of 2 or more and 64% FPL for an individual.

Two Optional Groups of Beneficiaries Will Receive Insurance Through The District's Exchange Or The Federal Basic Health Plan



Notes: While subsidies are available, there is a cost related to co-pay and pharmacy, and for some, premiums for those who earn more than 100 FPL. Except for specific populations, services can be denied. Emergency, family planning, and pregnancy-related services are exempt from cost sharing

New Coverage

- Shift from Medicaid MCO to Basic Health Plan, or to a Qualified Health On The State Exchange Market place
- Designed and managed by HBX

Basic Health Plan (BHP)

Eligibility

- 133-200% of federal poverty level (FPL)
- Residents who are lawfully present, but are not citizens due to the 5-year bar
- Not on Medicaid or Children's Health Insurance Program

Services

Includes a minimum of 10 essential benefits specified in ACA

- Modest premiums and cost-sharing – designed by plan administrator

Funding

- Federal funding equals 95% of the premium tax credit

Qualified Health Plan (QHP)

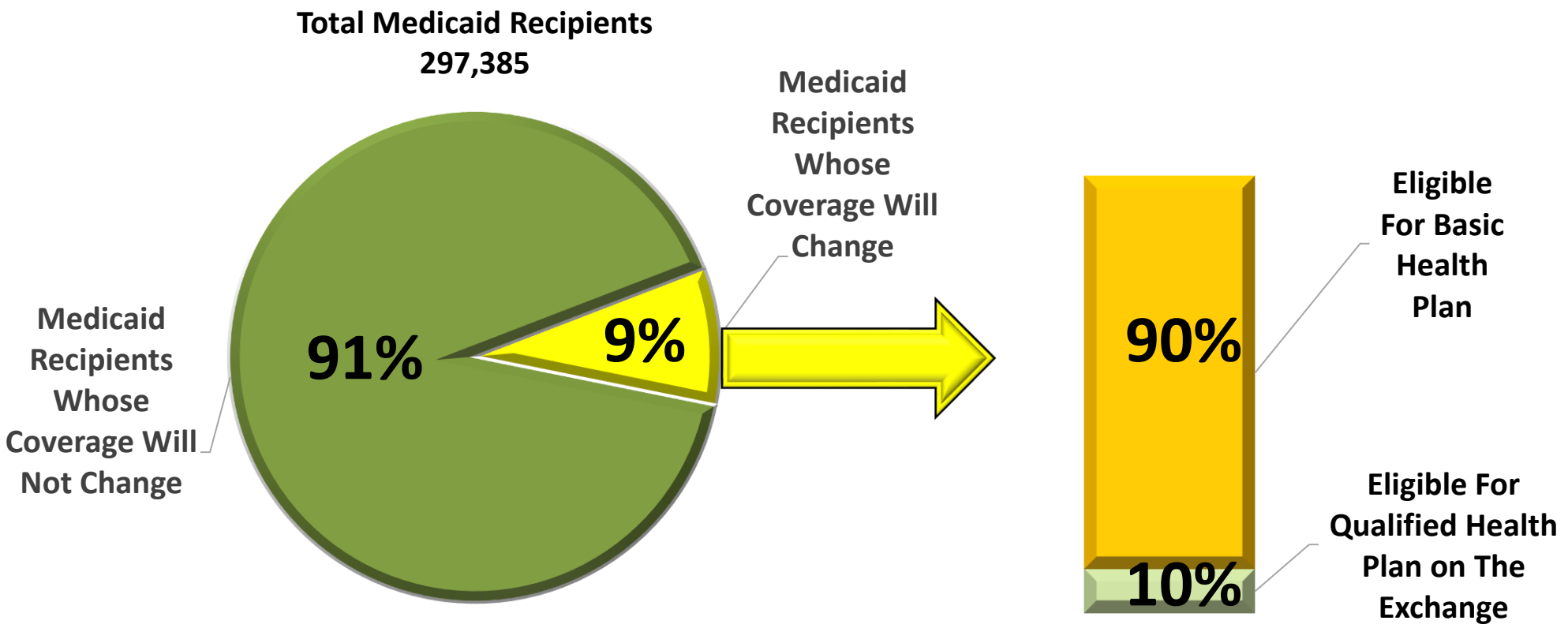
Eligibility

- US citizens and people in the United States lawfully as well as those subject to the 5-year bar
- Not eligible for Medicaid and the Children's Health Insurance Program

Services

- Includes a minimum of 10 essential health benefits specified in the Affordable Care Act
- Available premium assistance if income exceeds federal poverty level

The Coverage For Approximately 9% Of Medicaid Recipients Will Be Transferred Under This Proposal, And 90 Percent of This Group Will Be Eligible For The Basic Health Plan With Limited Cost Sharing



Source: DHCF projections for FY 2026 budget formulation.
Note: Total Medicaid shown here reflects projected enrollment in the first quarter of FY 2026. The change in coverage would be effective in the second quarter of FY 2026.

Childless Adults and Parents/Caretakers Who Are Shifting To The Health Benefits Exchange Or Basic Health Plan Have Less Acute Health Care Needs

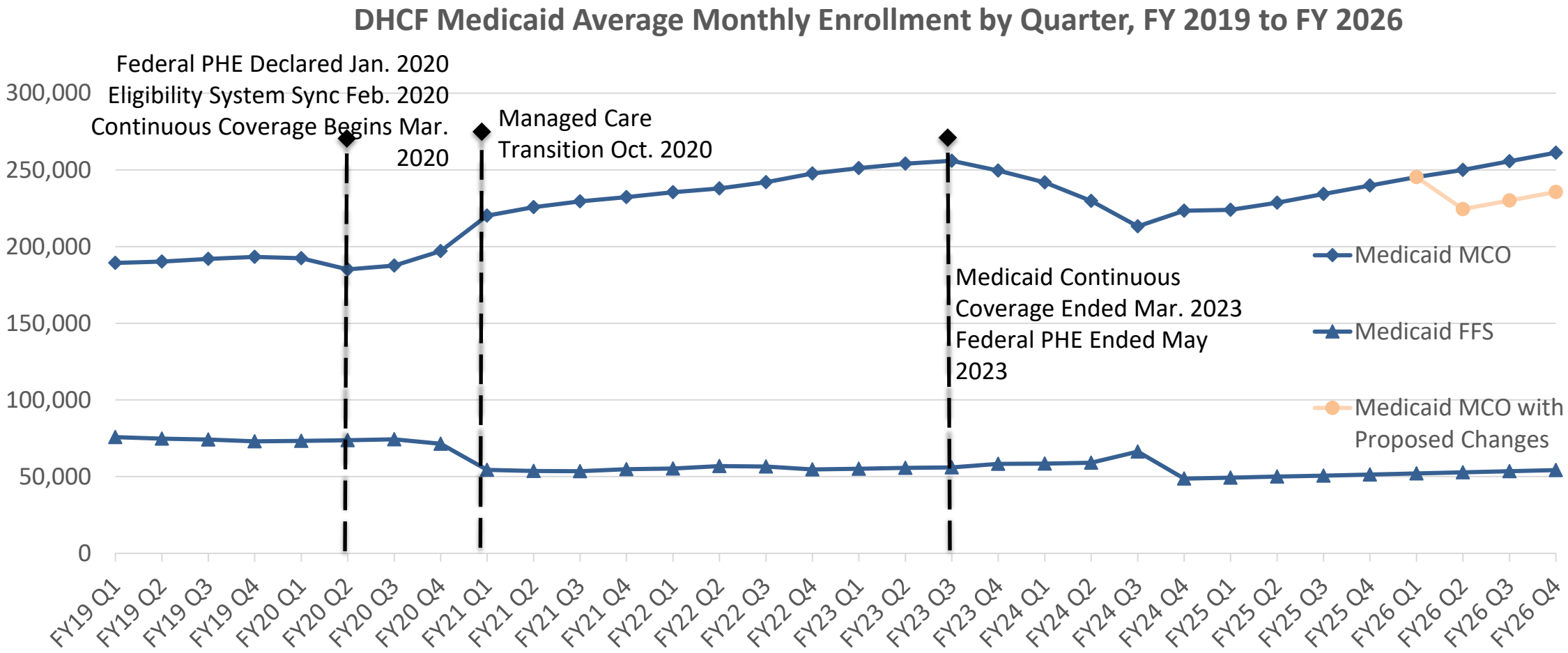
- **DHCF continues to cover the highest risk beneficiaries in Medicaid**
  - In reviewing the October through December 2024 DCHFP risk scores, childless adults and parents/caregivers with FPLs above 138% had lower historical risk when compared to other cohorts within the Temporary Assistance for Needy Families (TANF) population

	All	Remain in Medicaid	Shift to HBX
Scored TANF	93.6%	78.7%	14.9%
Total Risk Score	1.0715	1.0814	1.0193
Childless Adults	1.1137	1.1264	1.0476
Parent/Caretakers	1.0032	1.0136	0.9579

- **Risk scores are around 6% higher for population remaining in Medicaid which underscores their higher acuity and need**

- **Population shifting to HBX have lower historical risk and cost, and can more easily be absorbed into product offerings through DC's Health Benefit Exchange (HBX)**

Medicaid Eligibility Changes Will Reduce Enrollments In FY2026 And Beyond



Source: DHCF projections for FY 2026 budget formulation.

Note: Managed care organization (MCO) figures on this chart exclude Medicare dual eligible special needs plan (D-SNP) coverage, which is grouped with fee-for-service (FFS).

Medicaid Program Efficiencies

DHCF Has Identified More Than $24 Million Local In Savings Due To Reforms and Efficiencies

Reform

Durable Medical Equipment (DME): Reduce waste by a minimum of 10% through utilization review and election requirements **($316K)**

LTC Reform: Quality-based payment structure focused on quality not quantity; ensuring correct services are offered in the right place at the right time **($1M)**

Efficiencies

MCO Targeted Efficiency Levels (TEL): Quality measure that reduces MCO capitation rate for avoidable cost based on LANE quality measures as well as others **($5M)**

Maximizing Drug Rebate Opportunities: Savings for eligible drug rebates for prescriptions paid through providers other than a pharmacy (ie Outpatient hospitals) **($9.1M)**

Cost Shift

Shift End Stage renal Disease cost to Medicare: Medicaid is currently covering persons with End Stage Renal Disease (ESRD); however Medicare will support total cost **($5.1M)**

Emergency Transportation: Include service within Emergency Medicaid **($3.3M)**

Provider Rates

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 enhancement of $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 million 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**	

In Addition To Funding Service Utilization Growth, DHCF Has A Net Increase To Support Three Initiatives To Support Children and People Diagnosed With Sickle Cell Anemia

- The increases are required to support services required by CMS to enhance care access and align with current federal opportunities that DHCF has received funding for to design quality care
- DHCF will continue to establish a Maternal Health Reform Model, which includes opportunities to include various services that will support in-home care for expecting families

Continuous Eligibility For Kids	Pre- Release Services for Youth	Cell & Gene Therapy	Remote Patient Monitoring
• Program began in FY2025; FY2026 is for a full year • Kids 19 and under will maintain coverage 12 months after the redetermination without interruption • **$131K**	• CMS mandated coverage for youth exiting the judicial system • 30-days prior to release, they will receive case management and have access to certain services • Focus is to have access to health care and plan established and implemented prior to release • **$225K**	• Required coverage due to FDA Approval • Provides coverage of prescription and treatment • Current focus is on sickle cell • Potential special funding from CMS through CGT Access Model • Eligible for Drug Rebates • **$2.2M**	• Maternal Health reform is currently being reviewed by DHCF • Focus is to determine the most effective service array and payment methodology to support improved outcomes • **($1.7M)**

DHCF Is Maximizing Federal Grants To Support Efforts In Establishing Care Models That Drive Quality Of Care And Promote Cost Efficiencies

FY25 Efforts Yielded Significant Federal Funds to Support Whole-Person Care in FY26

1

Maternal Health: Approved for $17 million in federal funds over 10 years for maternal health innovation

- *A 100% federal grant to implement the Transforming Maternal Health (TMaH) model over 10 years to develop and implement payment and care delivery initiatives to support whole-person maternal health over the perinatal care period, up to 1 year post birth*
- *The funds will support provider incentive payments for infrastructure, provider technical assistance, and new staff at DHCF*

2

Justice-Involved Re-Entry: Approved for $2.8 million in federal funds over 4 years for youth justice-involved re-entry

- *A 100% federal grant to support implementing a new federal requirement to provide targeted case management (TCM) and screening and diagnostic services to post-adjudicated juveniles prior to release from detention and TCM for at least 30 days post-release*
- *The funds will support providers with technical assistance, technology, and new staff at DHCF, DYRS, and DOC*

3

Sickle Cell Disease: Applied for $7 million in federal funds for cell and gene therapy (CGT) for sickle cell disease

- *A 100% federal grant to support the implementation of a new CMS model to* address challenges of CGTs for sickle cell disease, including negotiating outcomes-based arrangements
- *The funds will support public awareness, care coordination, data dashboards, and new staff at DHCF*

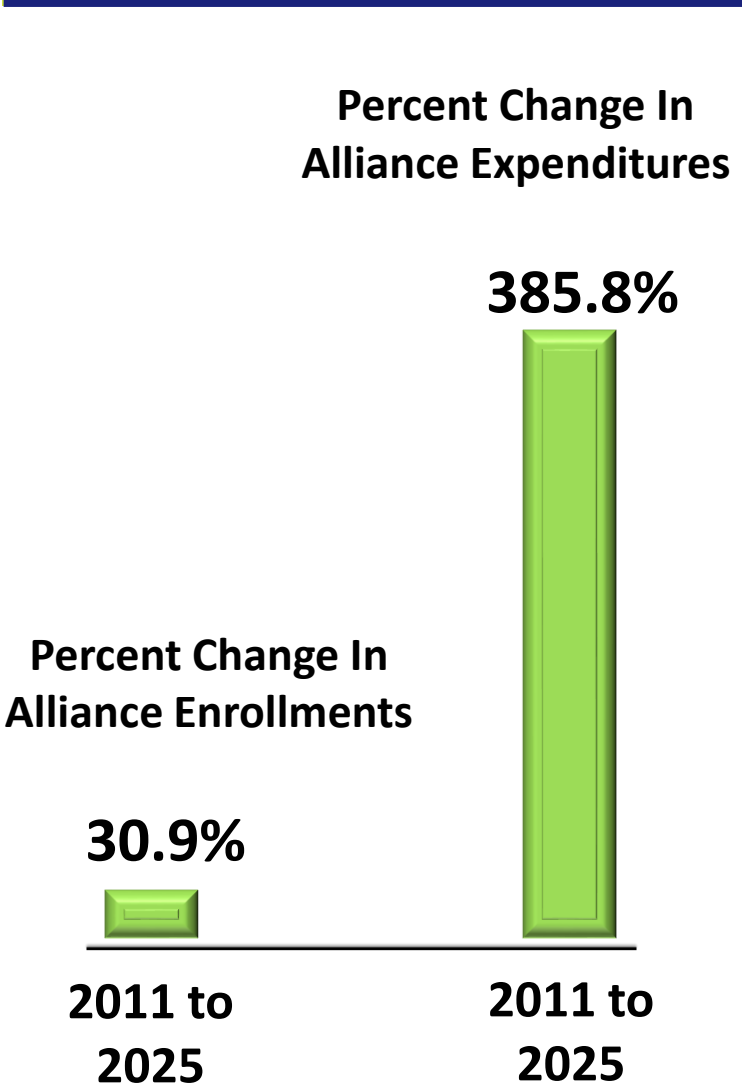
4

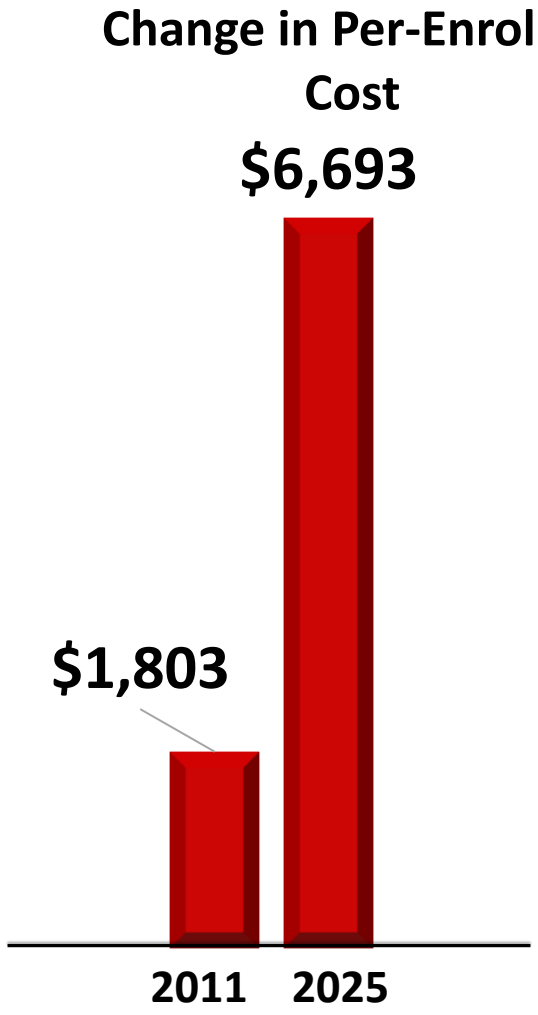
Digital Health: Pursuing $9.3 million (total computable) to support whole-person care via digital health innovations

- *Requesting federal approval for a 20% increase in total computable funding for digital health innovations, but a 14% decrease in local spending*
- *The funds will support critical DC Health Information Exchange (HIE) infrastructure, providers with electronic health record (EHR) data quality improvement, and continued enhancements to population health analytics and care coordination tools*

Alliance Changes

Since 2011, Alliance Expenditure Growth Has Significantly Outstripped Enrollment

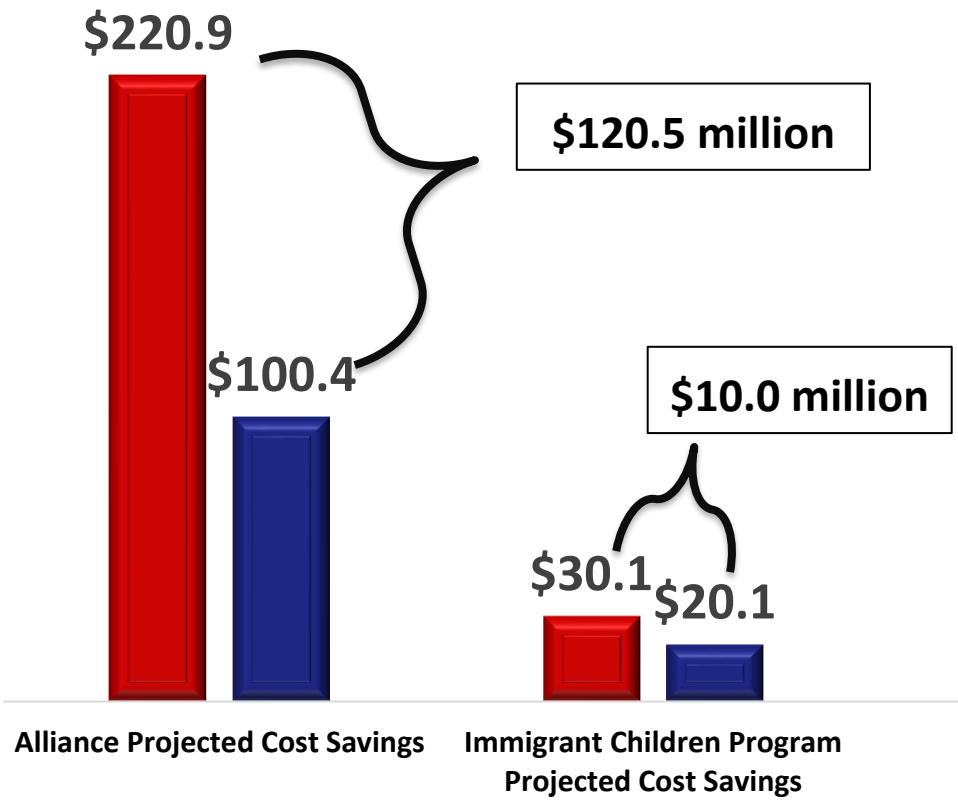




Alliance Growth Trends

- In 2011, there were 28,282 adults and immigrant children in the locally funded Alliance and ICP program.
- The cost of the program in this year was $51 million, producing a per-beneficiary cost of $1,803.
- By 2025, the were 37,024 adults and immigrant children in the program
- The cost of the program increased to $247 million, producing a per-beneficiary cost of $6,693.

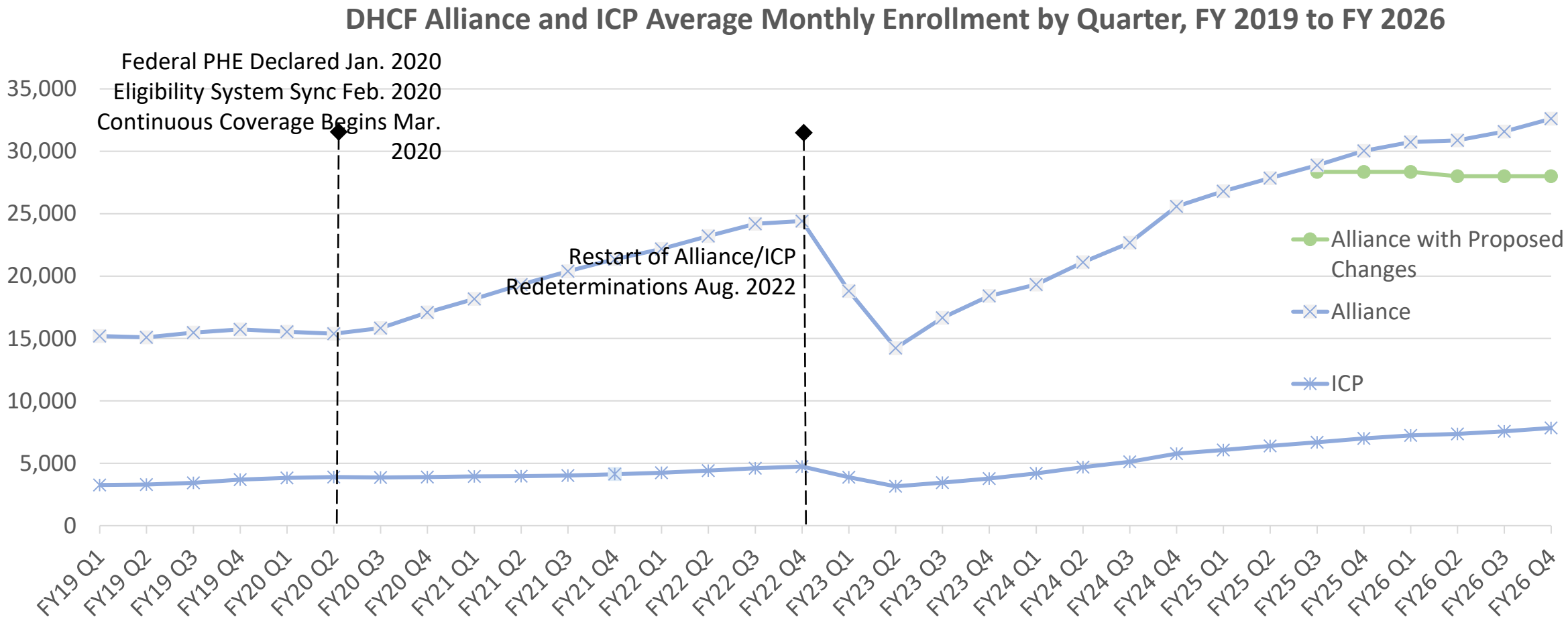
Savings Initiatives Will Reduce cost of Alliance and Immigrant Children's Program By $130.5M By FY2026



Descriptions of Cost Savings Initiatives

- Shift program from managed care to fee-for-service, effective October 1, 2025 and limit benefit package.
  - No monthly capitated payment – pay per episode of care
  - Benefits are Pharmacy, Primary Care, Hospital-based care, and Non-Emergency Transportation
- Establish hard enrollment cap, effective August 1, 2025.
  - Cap is set at forecasted enrollment of 28,000 or August 2025 enrollment level, whichever is less.
- Adopt face-to-face recertifications every six-months, effective March 1, 2026.
  - 90-day grace period to recertify after lose of coverage
- Program eligibility level reduced to 134 percent of federal poverty level, effective October 1, 2025.
- Children age out of coverage after their 21st birthday.

Enrollment For The Alliance Program Will Decline By Approximately 14 Percent In FY2026



Source: DHCF projections for FY 2026 budget formulation.

Note: The restart of Alliance/ICP eligibility redeterminations corresponded to the end of the District's local public health emergency.

Conclusion

- Recap
  - The financial environment in which we formulated DHCF's budget and 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; and
  - The program changes proposed to reform and reduce the financial footprint of the locally funded Alliance program.

- The strategies put forth were thoughtfully deliberated and crafted in a manner to minimize the loss of access to quality health care.

- Key Dates:
  - Thursday, June 5th: Public Testimony for DHCF's FY26 Budget Proposal
  - Monday, June 9th: DHCF Testimony for the FY26 Budget Proposal

Questions and Answers

Public Announcements

Get Involved and Make Sure You're Getting Updates

The next meeting will be July 30, 2025, at 5:30PM

If you (or other community members and partners) are not already receiving MCAC meeting invites, you can email the newly established dhcfMACandBAC@dc.gov and we will add you to the list.

DHCF will be releasing applications for MCAC openings soon – please share with your networks!