DHCF Proposed FY2021 Budget, Including Medicaid and Alliance Spending Trends

Presentation for:

Medical Care Advisory Committee

(MCAC)

May 2020

Department of Health Care Finance

Washington DC

Presentation Outline

- [x] Overview Of District's Budget For FY2021
- [ ] DHCF Budget Development
- [ ] DHCF Program Overview
  - *Priorities*
  - *Health Care Transformation from Fee-For-Service to Managed Care*
  - *Building Infrastructure to Support Program Value and Accountability*
    - *DC Access System Eligibility System*
    - *Health Information Exchange*
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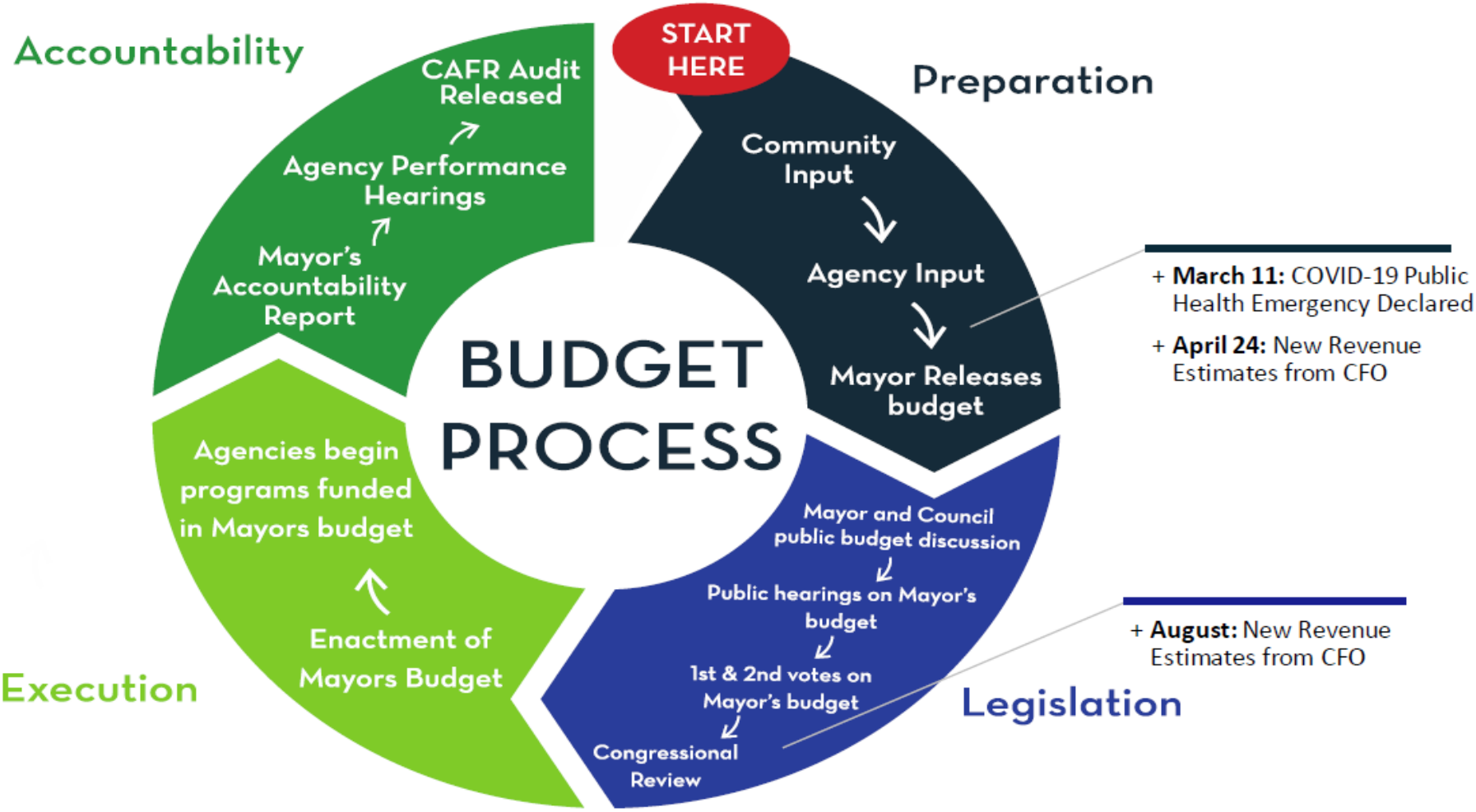
- [ ] DHCF's Response to COVID-19 Public Health Emergency
- [ ] Conclusion

Budget Process



Historic Pandemic Impacts District Budget Planning

- District finances were roiled by the worst pandemic experienced in this country more than 100 years

- Response to pandemic designed to slow rate of transmission of the coronavirus, COVID – 19
  - Large social gatherings were prohibited
  - Schools and non-essential businesses were closed
  - 60 percent of District employees were ordered to telework
  - Stay-at-home order issued

- These restrictions echoed through the local economy creating a cascading effect that produced a significant loss of employment

- Several weeks into the Public Health Emergency, the District's Chief Financial Officer (CFO) forecasted that nearly 100,000 jobs would be lost in a retracting DC economy

- The CFO further predicted that employment levels would not fully recover until the summer of 2021

Historic Pandemic Impacts District Budget Planning (continued)

- Restrictions have been effective in minimizing viral spread in the city, saving thousands of lives

- Unavoidably, commerce and business income in the city have been dampened in the process
  - The predicted effect of business closures and substantially higher levels of resident unemployment, have triggered a sharp loss of revenue for the District of Columbia.

- This negative financial impact of COVID - 19 required the Mayor and her budget team to make significant sacrifices

- Steps were taken early in the process to reduce spending in the current (FY2020) budget
  - Hiring and spending freezes across government.
  - Actions were carried forward in FY2021 that reduced the largest portion of the budget hole for the upcoming fiscal year, compared to any other gap closing initiatives

- FY2021 Budget went through several additional iterations following the CFO reforecast, and some spending plans were either reduced or completely eliminated

District of Columbia's Unique Budget

While the District is similar to other localities and states in that its budget must be balanced—expenditures cannot exceed revenues—the District's budget is unique in that it must be balanced over four years.

This means revenue declines today have a multi-year impact on the budget.

District of Columbia's Reserve Funds

The District has four reserve funds designed to provide flexibility during difficult financial times. Three are already in use.

IN USE:

✓ **Cash Flow Reserve - $775M**
Provides daily operating cash to pay employees, meet contract payments, and cover daily supplies.

*The **Cash Flow Reserve** is providing daily operating cash to pay employees, meet contract payments, and cover daily supplies. The cash flow reserve is expected to be at its lowest point in August as several significant obligations are due.*

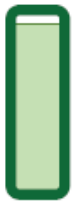
✓ **Contingency Cash - $299M**
Available for unanticipated, non-recurring needs that arise. Funds must be replenished within 1-2 years.

*The District has used $236.4M of its **Contingency Cash Reserve**, mostly for COVID-19 response.*

✓ **Fiscal Stabilization - $213M**
May be used to cover revenue shortfalls experienced by the District government.

*The full $213M **Fiscal Stabilization Reserve** was used to balance the 4-year financial plan, and is budgeted to be replenished over the life of the plan.*

✗ **Emergency Reserve - $149M**
Available for extraordinary unanticipated, non-recurring needs, such as a natural disaster or calamity. Typically used only after Contingency Cash has been exhausted.



*We preserve the **Emergency Reserve** in case we have a second wave of COVID19 or another unforeseen emergency.*

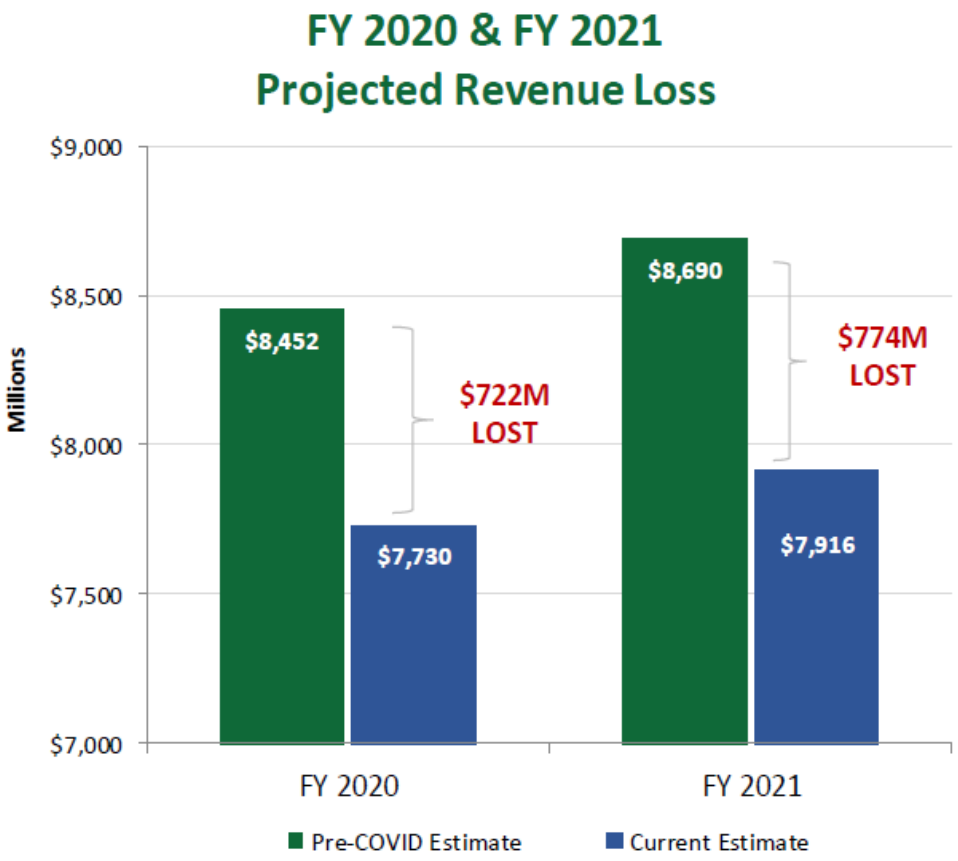
Revenue Losses Are Significant

What does it mean to cut $700M+ from the operating budget?

- Hypothetically speaking… cutting the combined local budgets of the Departments of Human Services, Disability Services and Parks and Recreation—and then some

What does it mean to cut $1.2B from the capital budget?

- Hypothetically speaking… cutting all local capital for both DDOT and DCPS and cutting 3 years of fleet
- Hypothetically speaking… cutting all DMPED capital projects plus the new St. Elizabeths Hospital plus all fleet for 3 years



Local Funds Budget by Cluster

Local Fund Expenditures by Appropriation Title

*Dollars in millions

Mayor Bowser's Priorities for the FY21 Budget

- Maintain core government functions that focus on the health, well-being and safety of DC residents and businesses
- Maximize resources available for the immediate public health response to COVID-19
- Maximize resources available for those in our community hardest hit by the COVID-19 public health emergency
- Maintain stability for District Government workforce
- Don't lose ground on key District priorities

Healthcare Improvements

- **$4.2M** to support 5 new ***Centers of Excellence*** at Howard University Hospital and **$25M** to support the development of a new Howard Hospital, to be completed by 2026 (plus future tax abatements of **$225M**)
- **$4.8M** to implement recommendations from the Mayor's Commission on Healthcare Systems Transformation to reduce reliance on emergency care and improve health outcomes
- **$35M** in additional funds to support increased enrollment in Medicaid as a result of the public health emergency
- **$1.4M** in grants for developmental disability service providers & increased Stevie Sellows fees to provide **$1.6M** for intermediate care facilities to pay increased wages to their staff

$365M for a new, state-of-the-art hospital and ambulatory center at St. Elizabeths

The 136-bed center will provide maternity services and newborn deliveries and help address inequalities in health outcomes and provide a comprehensive network of care to meet Ward 7 and Ward 8 residents' needs

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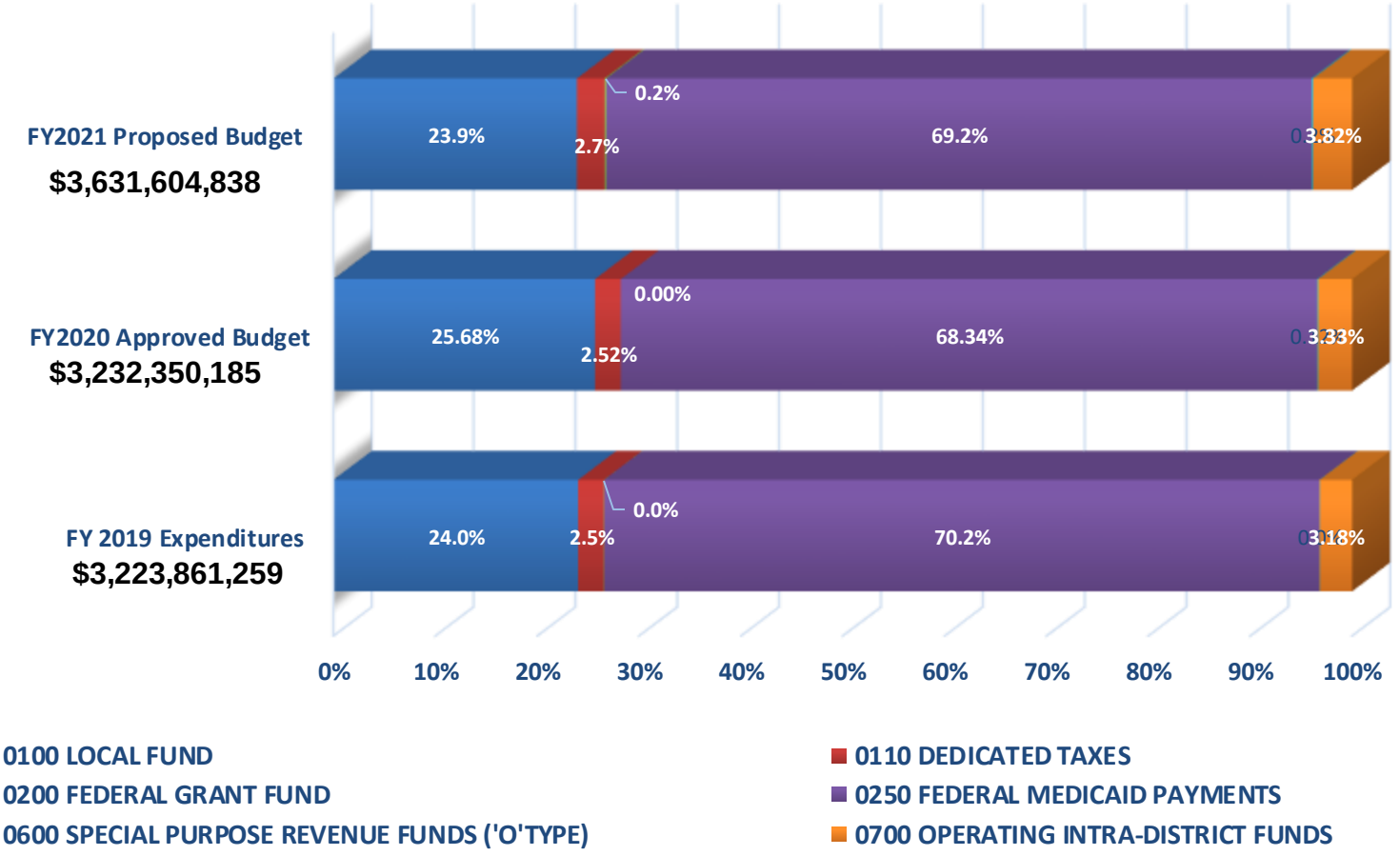
69% of DHCF's Budget is Supported by Medicaid Entitlement Payments in FY21

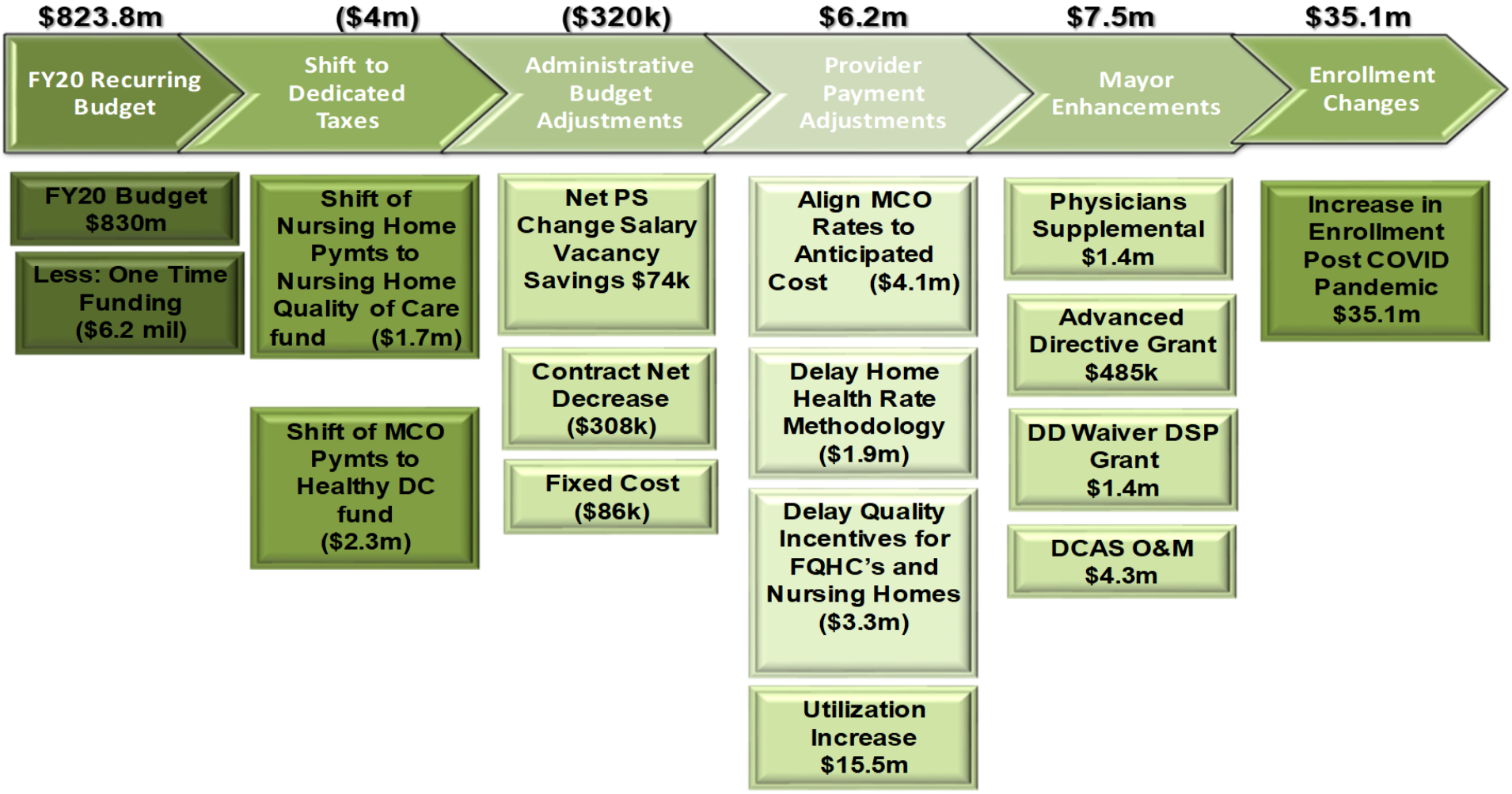
Federal Participation Remains Constant Over the Last Three Years



DHCF FY2021 Local Budget Snapshot

FY20 Approved Budget	**830,015,717**
Removal of One-Time Funding	(6,220,802)
FY20 Recurring Budget	**823,794,915**
Shift to Dedicated Taxes	(4,017,333)
Net Administrative Adjustments	(319,913)
Net Programmatic Changes	6,215,303
Total Budget Adjustment	**1,878,057**
Mayor Enhancements	7,531,000
Enrollment Increase	35,080,177
Additional Funding	**42,611,177**
FY2021 Budget	**868,284,149**

The Building Blocks to DHCF's $868.2 Million Local Fund Budget



The Mayor Invested $7.5 mil Local Funding in Enhancements

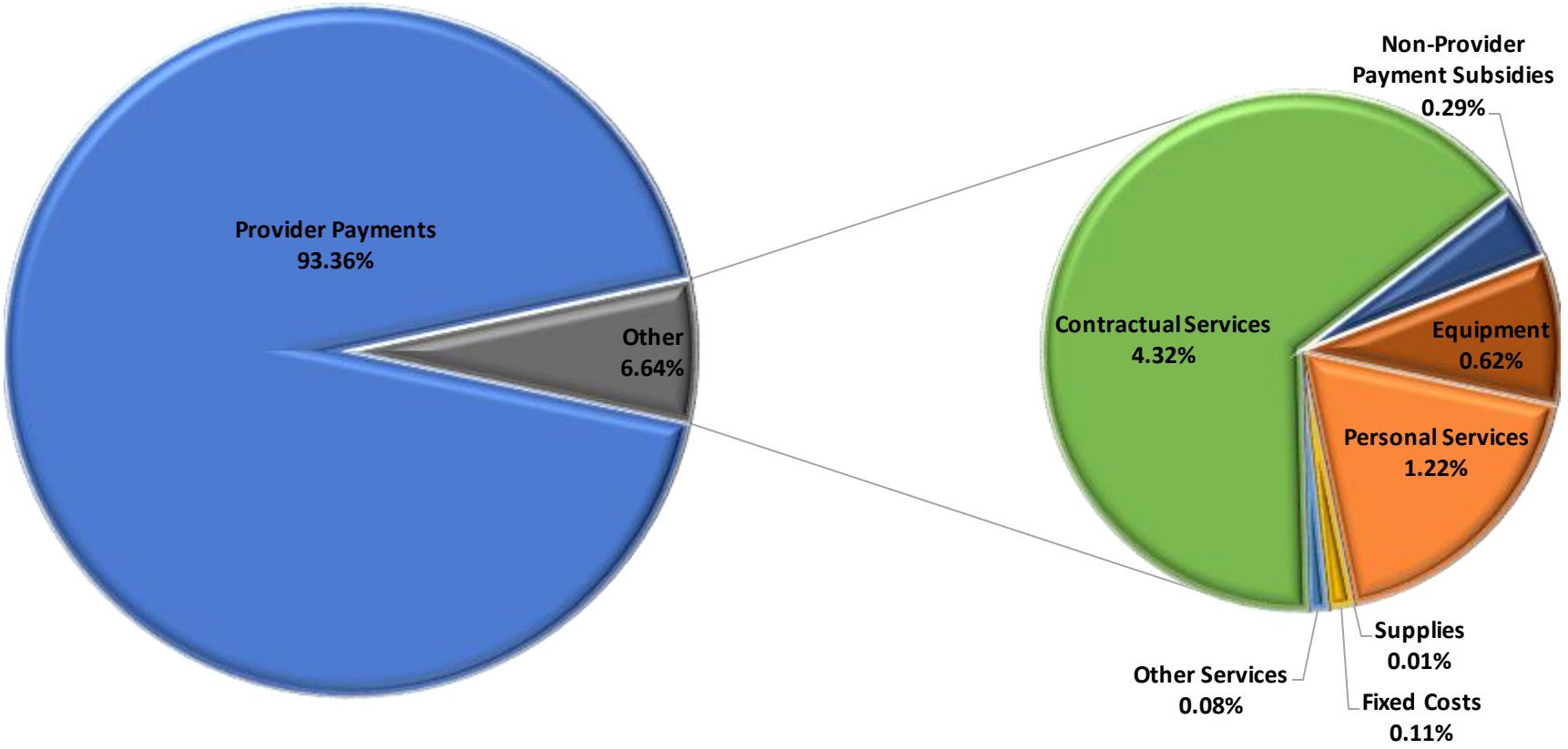
- **Physicians Supplemental Payment ($1.4 mil):** DHCF would make quarterly supplemental Medicaid payments of $1,125,000 to a physician group practice enrolled in DC fee-for-service Medicaid that has entered into an agreement with the only publicly owned acute care hospital in Wards 7 & 8 to provide inpatient / hospitalist, emergency department, and intensive care physician services at the hospital. The supplemental payments would be for services rendered to fee-for-service Medicaid beneficiaries in the same quarter. Medicaid Entitlement Payment will match the local share with 70% participation.

- **DCAS Operations and Maintenance ($4.3 mil):** The additional funding will provide the necessary staffing, software, and other associated contracts required to have proper Operations and Maintenance (O&M) of the DCAS eligibility system. Typical to any large-scale IT project, as more features and functionality are developed for DCAS, the need to continuously maintain the existing functionality along with the newly developed functionality requires additional resources along the way. Given the current roadmap for the program, the anticipated date completion of the Design, Development, and Integration (DDI) work that will allow for all Medicaid functionality to be contained within DCAS is Fall 2021. Medicaid Entitlement Payment and federal funding will match the local share.

- **Advanced Directives (AD) Grants ($485k):** The grant opportunity is to support efforts through the Commission on Health recommendations to build advanced directives into the Health Information Exchange (HIE). AD's provide a legal way to document what a patients wants in a medical emergency or if they are sickly, such as a living will or Power of Attorney. This grants will make patients AD's available across the provider network using the DC HIE

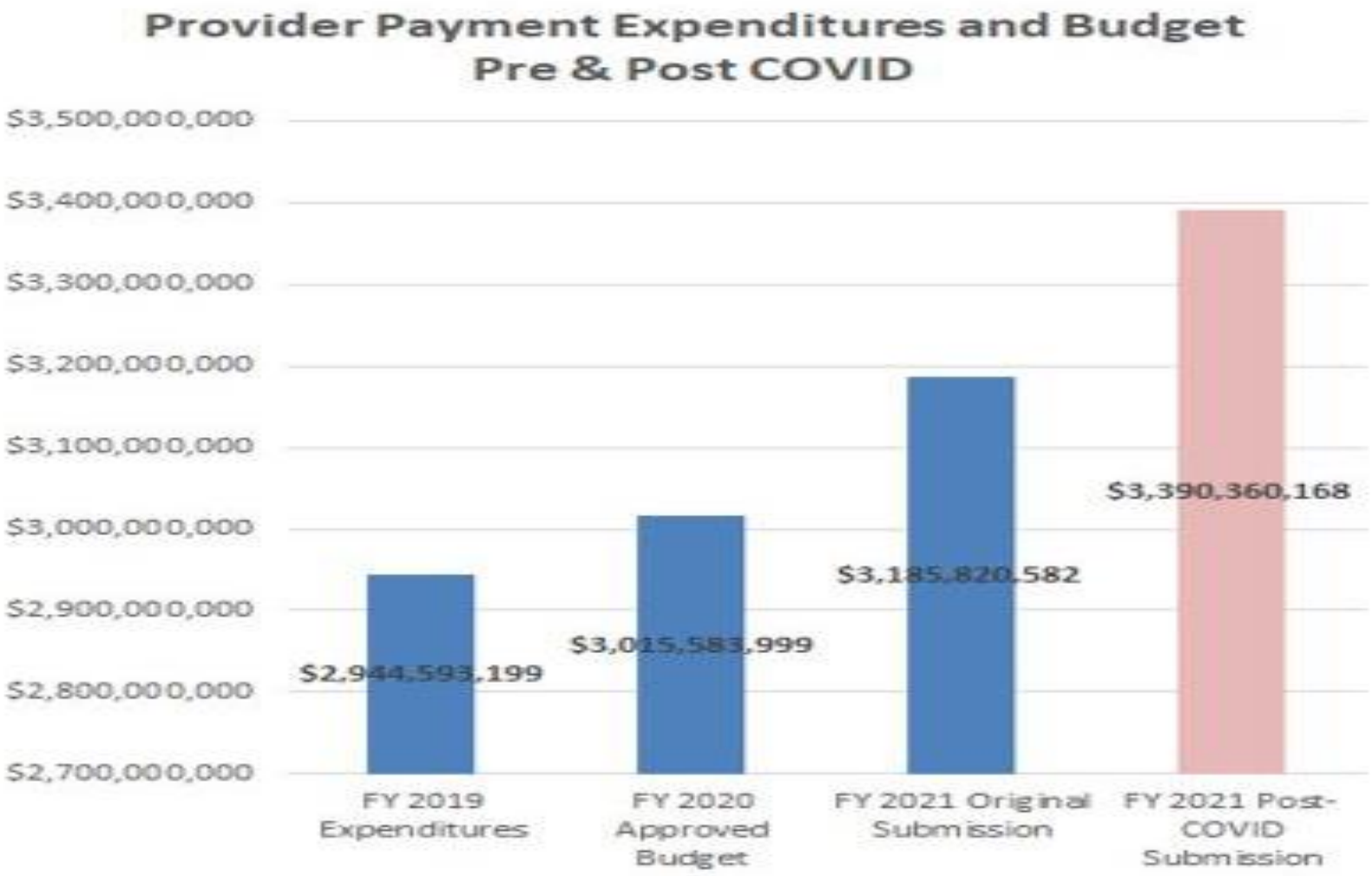
- **Grants to Support DSP Workers in Developmental Disabled waiver homes ($1.4 mil):** the funding is available to assist DD Waiver providers the ability to provide enhanced rates for Direct Services Professionals (DSP). Note: ICF providers received similar funding support through Dedicated taxes.

93% of FY21 DHCF Budget Supports Direct Care Services for District Residents

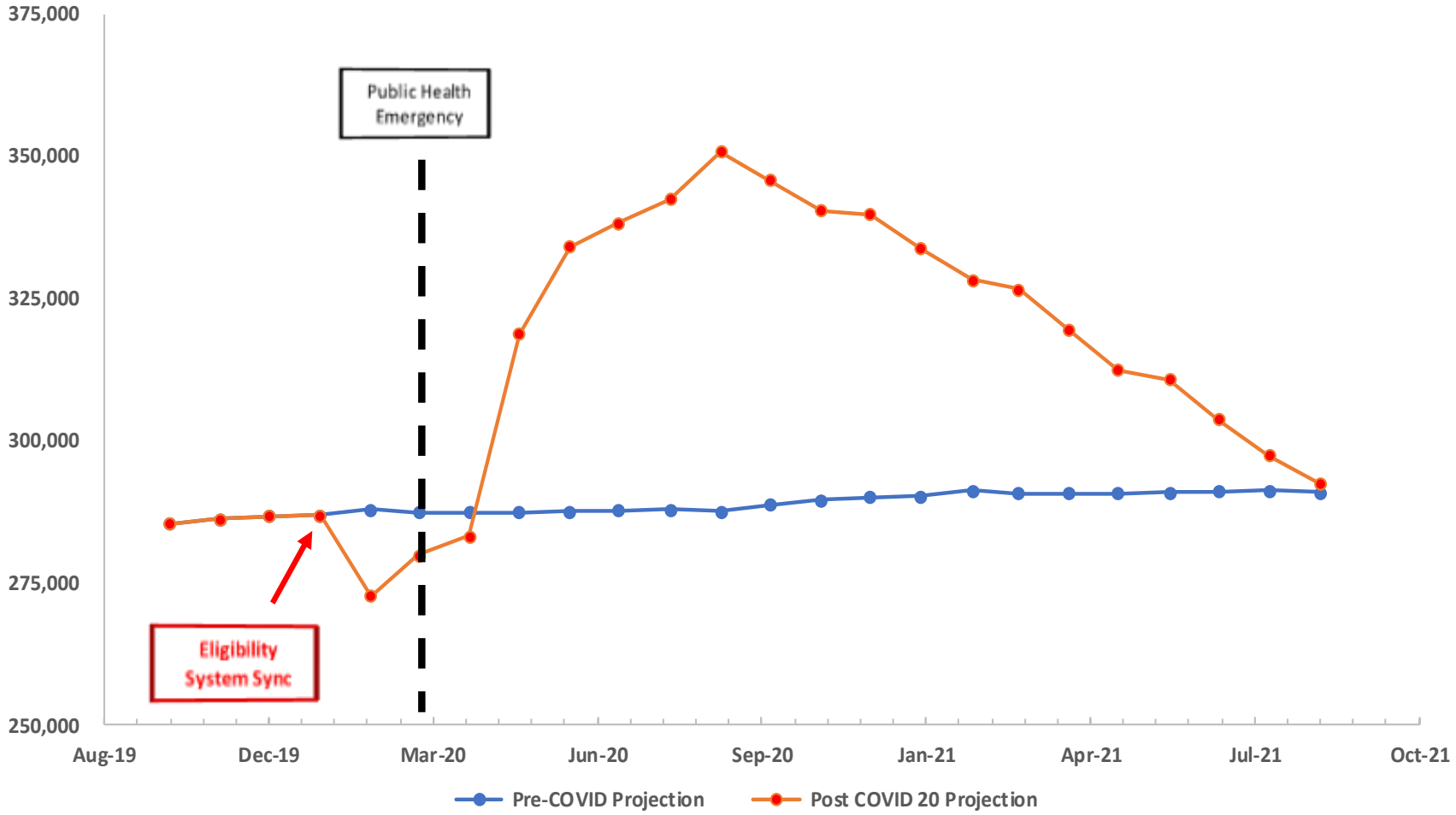


Source: Data is based on the FY21 Mayor's Budget Submission.

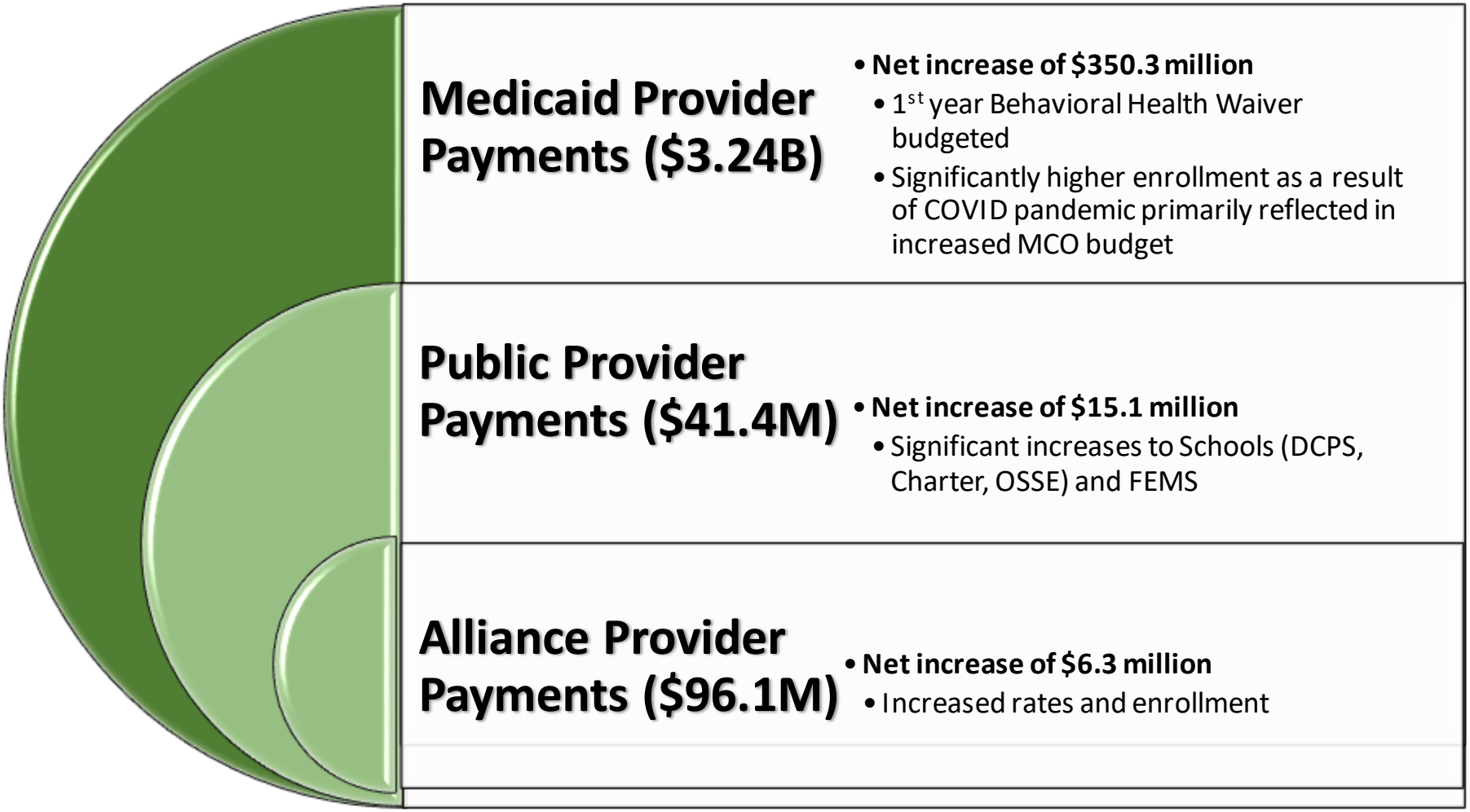
Due to the Public Health Emergency, Provider Payments Anticipated Expenditures Increase Dramatically from Original FY21 Projections



Due to the Public Health Emergency Enrollment Increases Dramatically from Original FY21 Enrollment Projections



From FY20 to FY21, Medicaid Spend Increases 12.5%; Alliance Spend Increases 7%



Source: Data is based on the FY21 Mayor's Budget Submission.

DHCF Budget Request For Mandatory Medicaid Services

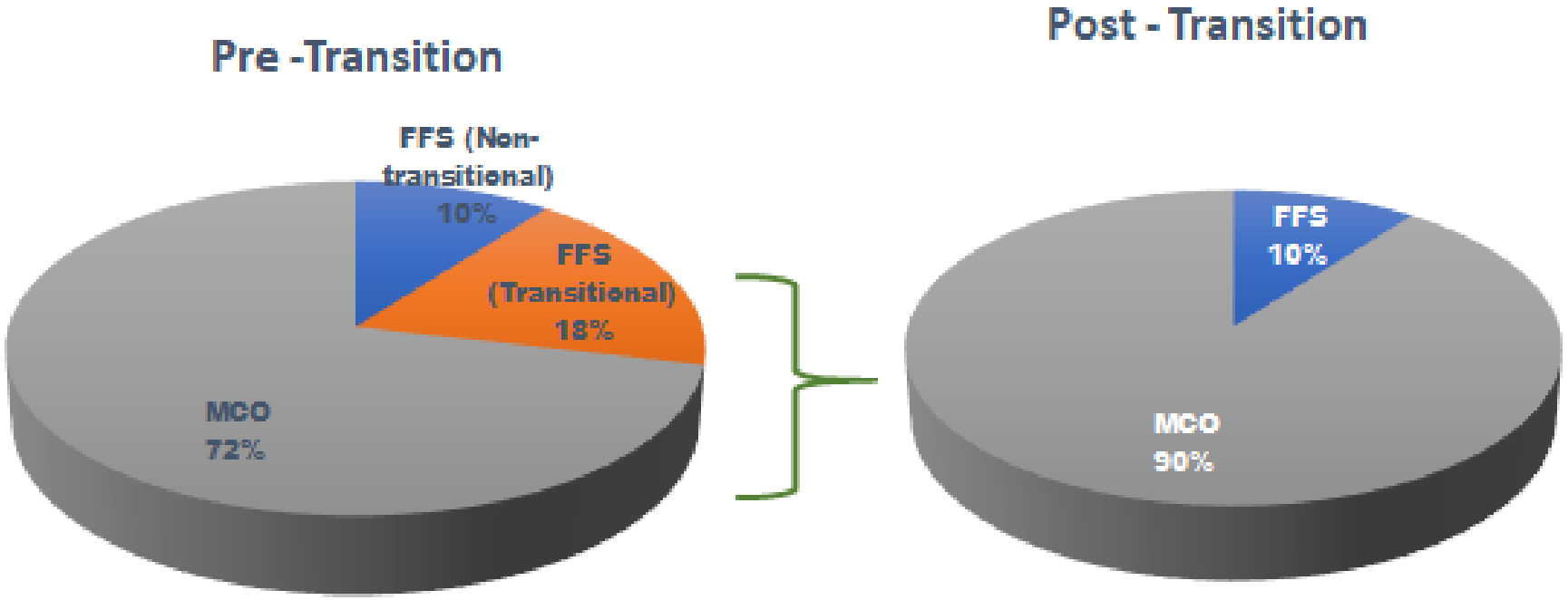
(figures in millions)

Medicaid Mandatory Service	FY19 Expenditures	FY20 Approved Budget	FY21 Proposed Budget	Percent Change from FY20 to FY21
Managed Care Services	1,140.74	1,129.97	1,561.78	38%
Inpatient Hospital	301.30	254.11	200.35	(21%)
Nursing Facilities	284.76	292.56	294.71	1%
Intermediate Care Facility (ICF)	91.97	101.182	98.583	(3%)
Physician Services	40.77	47.25	25.25	(47%)
Outpatient Hospital, Supplemental & Emergency	48.54	55.01*	16.72	(70%)
Durable Medical Equip (including prosthetics, orthotics, and supplies)	26.37	28.32	23.02	(19%)
Non-Emergency Transportation	30.01	37.69	32.51	(14%)
Federally Qualified Health Centers	50.37	63.98	16.03	(75%)
Lab & X-Ray	16.30	17.67	6.74	(62%)

Source: FY20 Budget does not reflect updates as a result of the Public Health Emergency. FY21 is based on the FY21 Mayor's Budget Submission.

* Outpatient FY20 budget reflects adjustment to include full Medicaid Entitlement Payment portion

90% of Outpatient Cost is Estimated to be in Managed Care in FY2021 as the District Begins Shift to an MCO Care



DHCF Budget Request For Key Optional Medicaid Services

Medicaid Optional Services	FY19 Expenditures	FY20 Approved Budget	FY21 Proposed Budget	Percent Change Between FY20 and FY21
IDD Waiver (all FY 2019-21 includes intra-district funds)	254.99	246.01	299.45	22%
Personal Care Aide	209.05	146.88	101.18	(31%)
EPD Waiver	108.56	102.31	164.14	60%
Pharmacy (net of rebates)	48.18	27.78	29.55	6%
Mental Health (includes PRTFs & DBH intra-district for MHRS)	97.05	102.61	113.59	9%
Adult Day Health	8.58	10.70	9.17	(14%)
Home Health (Skilled Care)	10.82	18.74	13.89	(26%)

Source: FY20 Budget does not reflect updates as a result of the Public Health Emergency. FY21 is based on the FY21 Mayor's Budget Submission.

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DHCF Priorities Focus on Whole Person Care, Value, and Accountability

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

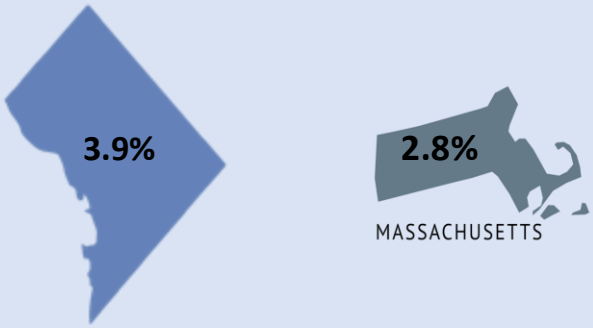
PRIORITIES
DHCF has three priorities for the programs we administer:

1. Building a health system that provides whole person care
2. Ensuring value and accountability
3. Strengthening internal operational infrastructure

DHCF Programs Provide Health Care Coverage to 40% of District Residents – Supporting Near Universal Coverage in DC

Near universal coverage

DC has the second lowest uninsured rate

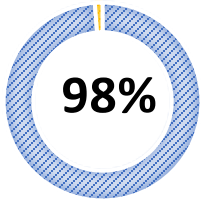


DHCF covers more than 280,000 people

On average during FY 2019, more than **265,000** in **Medicaid**; among those not eligible for Medicaid, **15,000** in the **DC Healthcare Alliance** and **4,000** in the **Immigrant Children's Program**

4 out of 10 District residents

7 out of 10 children



Of all eligible DC children are enrolled in Medicaid (highest rate in the US)

Health challenges remain despite coverage

12th in the nation For 911 call-volume in the country

10% Residents report delaying care due to not being able to get an appointment soon enough

- **Source:** U.S. Census Bureau, 2018 American Community Survey 1-year estimates; DHCF Medicaid Management Information System (MMIS) data extracted in March 2020; Haley et al., "Improvements in Uninsurance and Medicaid/CHIP Participation among Children and Parents Stalled in 2017," May 2019.

DHCF Embarking on Transformation of Public Health Care Delivery System

Building on Reform Efforts to Improve Health Outcomes: The Next Five Years

The Goal: Improve health outcomes so that District residents can live their best lives

The Path to Improve Outcomes:

More value over volume: increase expectations for value-based purchasing through managed care

- Increased access to care: require universal contracting for key providers (acute care hospitals and FQHCs)
- More coordinated care: transition FFS Medicaid population to managed care organizations (MCOs)

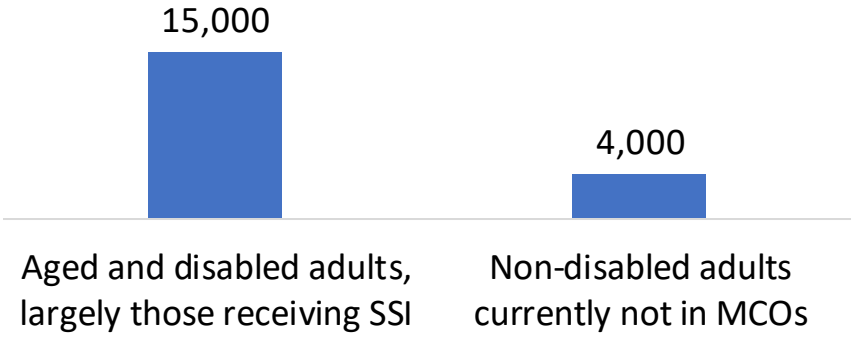
Managed Care as the Vehicle:

- Access to care coordination and case management:
- Increased program flexibility promotes innovation
- Utilize plan (Medicaid and Medicare) expertise
- Strengthen program oversight

FY 2021 First Transition to Managed Care:

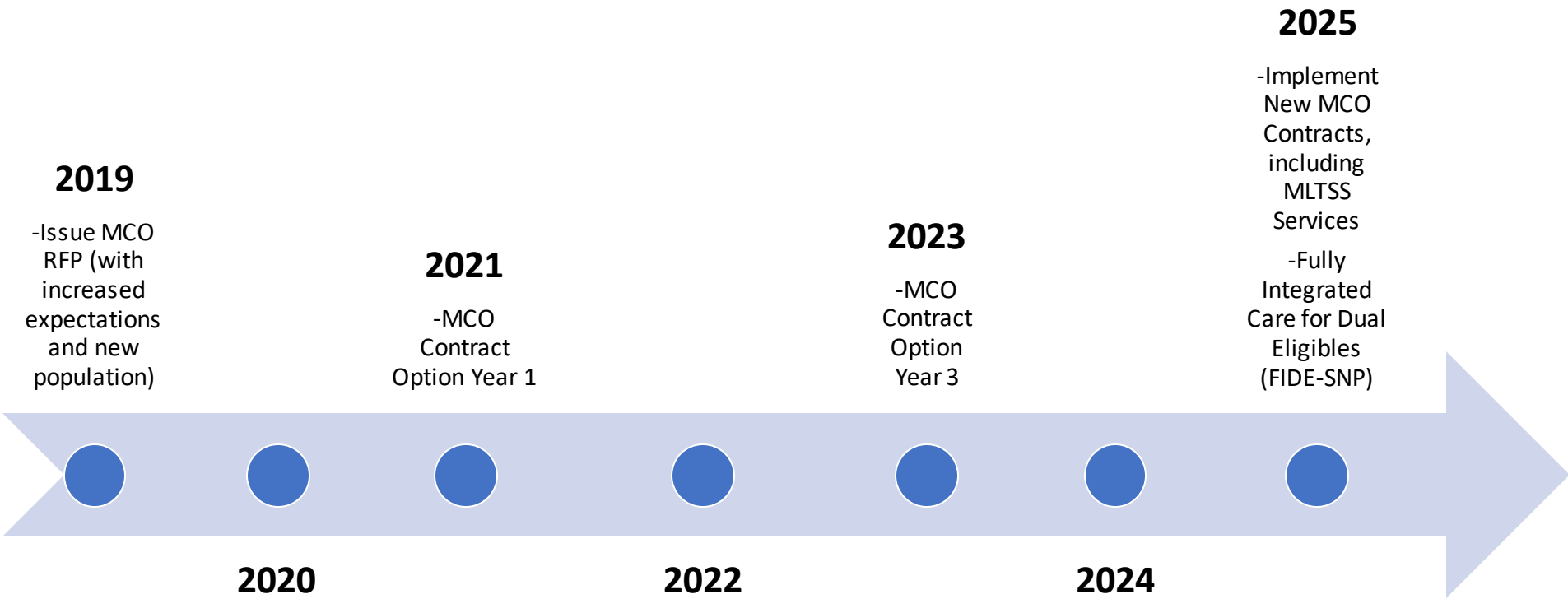
- Supplemental Security Income (SSI) Adults
- MCO Opt Outs

Approximately 19,000 Expected to Transition to MCOs in FY 2021



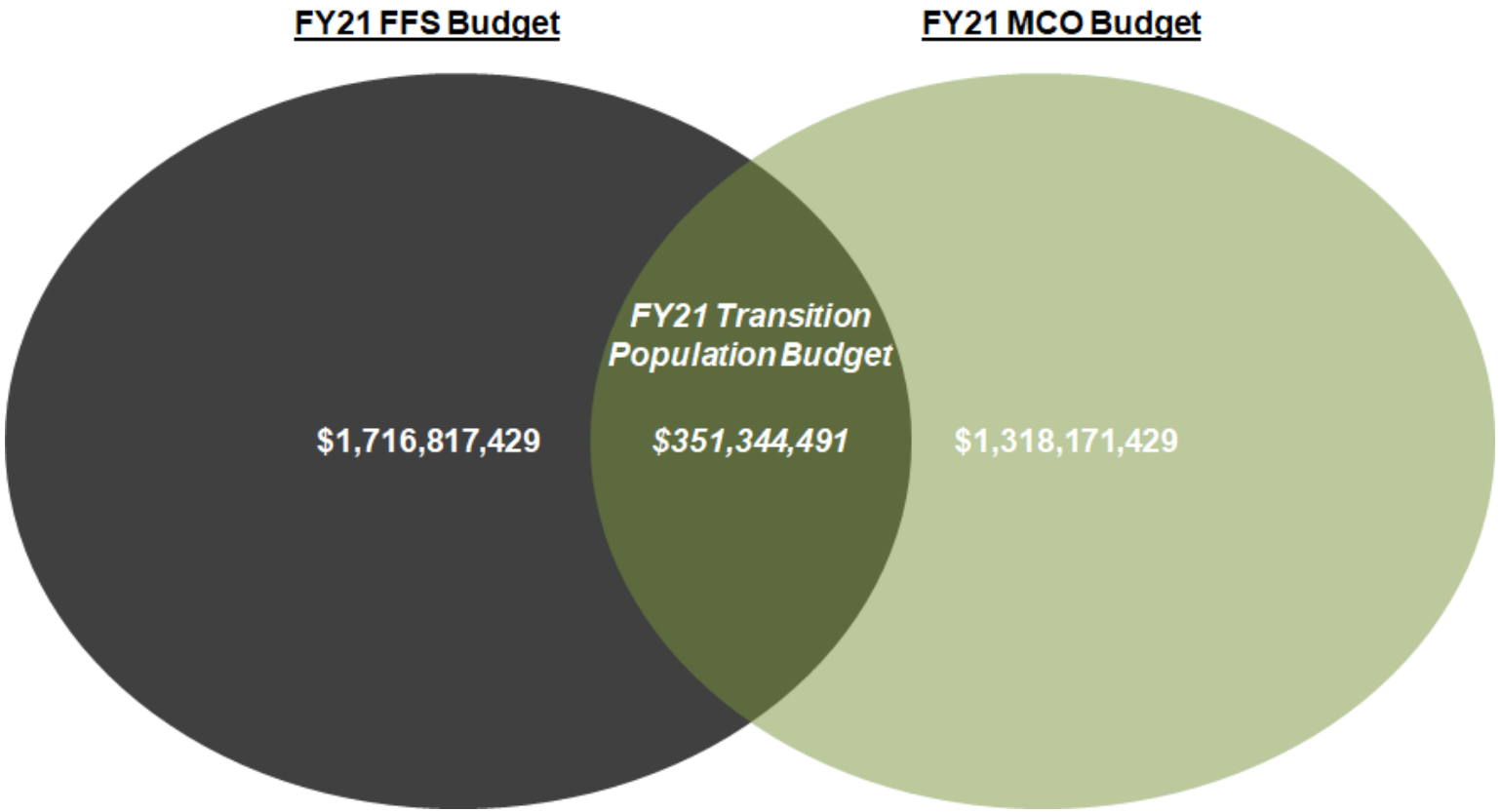
Note: Beneficiaries who are dually eligible for Medicare, those who require an institutional level of long-term care, and certain other populations are excluded from the FY 2021 transition. Approximately, 6,000 participants have shifted to MCO's in FY20

DC Medicaid Reform Milestones Include FY 2021 Transition of Beneficiaries From FFS to MCOs



- **Note:** FFS = fee-for-service; MCO = managed care organization; MLTSS = managed long-term services and supports; PACE = Program of All-Inclusive Care for the Elderly; RFP = request for proposal.

The Population Transitioning From Fee For Service (FFS) is Estimated Will Shift $351M to Managed Care (MCO)



*MCO Budget includes Alliance and Immigrant Children

2020 Reform Milestone is the Implementation of New Managed Care Contracts To Strengthen the Program

- ❑ Equal distribution of beneficiaries across plans
- ❑ Universal contracting for certain core providers, including:
  - District acute care hospitals *(Howard University Hospital, Medstar Washington Hospital Center, Medstar Georgetown Hospital, Children's National Hospital, United Medical Center, Sibley Hospital, George Washington Hospital)*
  - Hospital-related Provider Groups
  - Federally Qualified Health Centers (FQHCs) that receive funding under a Public Health Service Act 330 grant and FQHC look-alikes.

DHCF Will Implement Universal Contracting For Key Providers To Prevent Adverse Selection

- Mandated requirement for MCOs to contract with all identified hospitals, FQHCs, and hospital-related physician groups
- Targeted providers who participate in the FFS program will be required to also participate in the managed care program. The FFS provider agreement will be revised to include this requirement
- While DHCF will establish rate floors, these will ***NOT*** exist as a default rate should the negotiations deadlock – they simply reflect the minimum payment rate that are permissible as the result of a negotiated agreement
- DHCF reserves the right to terminate this Provider Agreement and also the managed care contract, if we determine that either the providers or the managed care plan have refused to negotiate in good faith within 90 days of the effective date of this agreement

DHCF Continues Building Infrastructure to Support Increased Program Value and Accountability

- Integrated eligibility system development and implementation continues
- Advancements in health information exchange (HIE)

The Development of DCAS Is Organized In Three Separate Phases

Release 1

***BENEFIT PROGRAMS**:

Assisted Insurance:

MAGI Medicaid

QHP (Premium Tax Credits)

Unassisted Insurance:

SHOP

Individual Market

SOFTWARE PRODUCT:

HCR Caseworker Portal

HCR Citizen Portal

Release 2

***BENEFIT PROGRAMS**:

Food Benefits:

SNAP; ESNAP; TSNAP; DSNAP

Energy Assistance:

LIHEAP

Cash Benefits:

TANF; POWER; GC; IDA; RCA; Burial Assistance.

SOFTWARE PRODUCT:

CGISS Caseworker Portal

Release 3

***BENEFIT PROGRAMS**:

Medical:

Non-MAGI Medicaid

Alliance

Immigrant Children's Program

Economic Services Programs:

SNAP & TANF Enhancements

SOFTWARE PRODUCT:

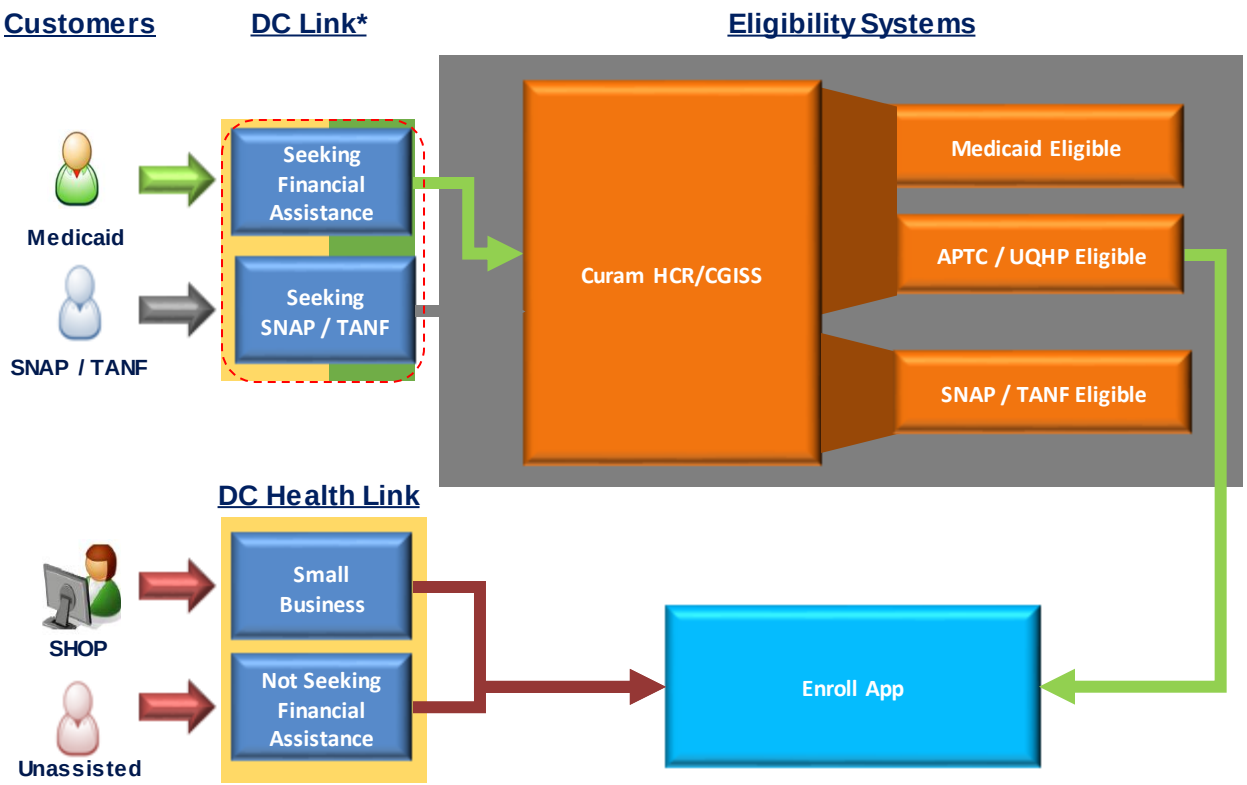
CGISS Caseworker Portal

CGISS Citizen Portal

HCR Caseworker Portal

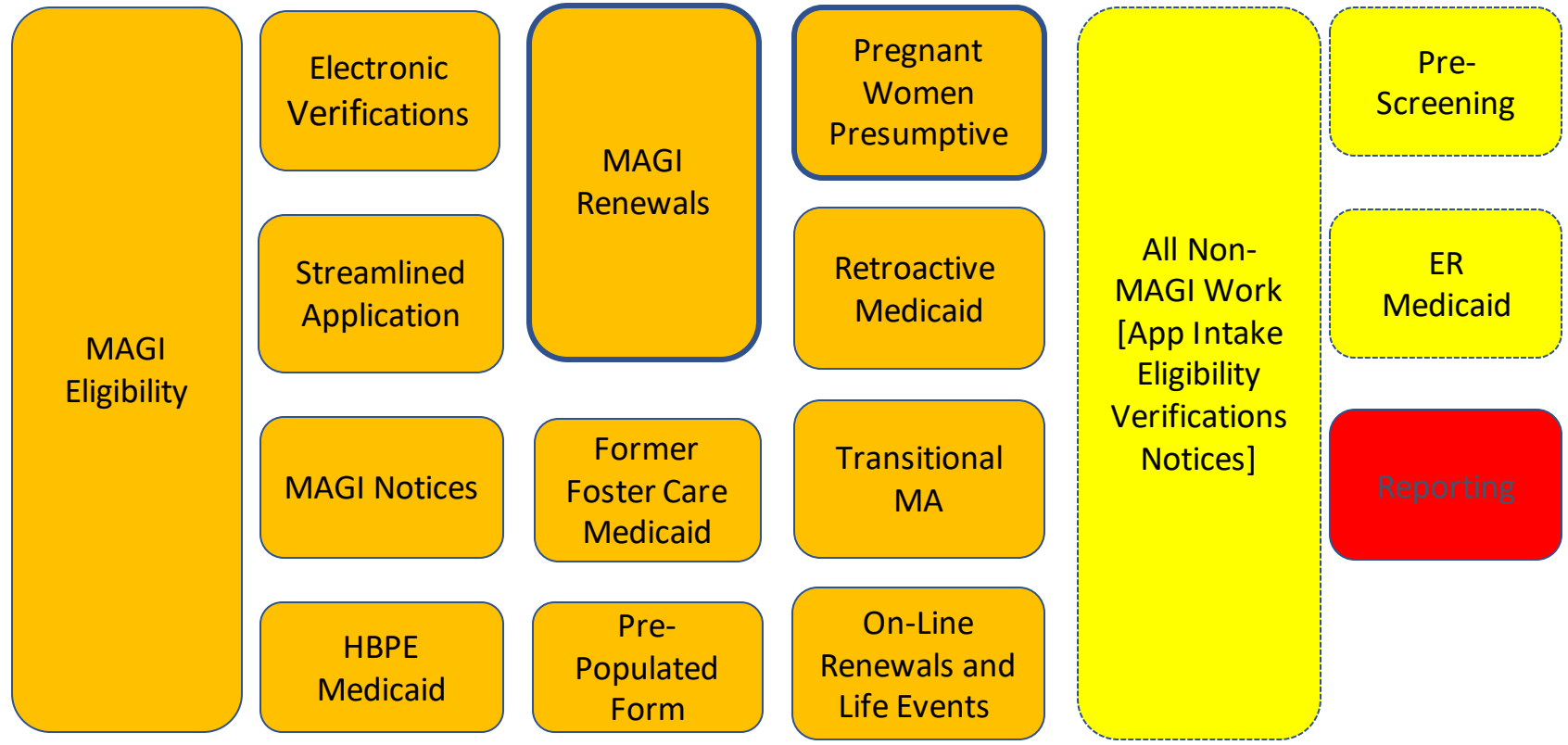
HCR Citizen Portal

DCAS Is Designed To Assist Persons Seeking Publicly-Financed Health Care Insurance, Private Insurance With and Without Subsidies, And Public Assistance Benefits



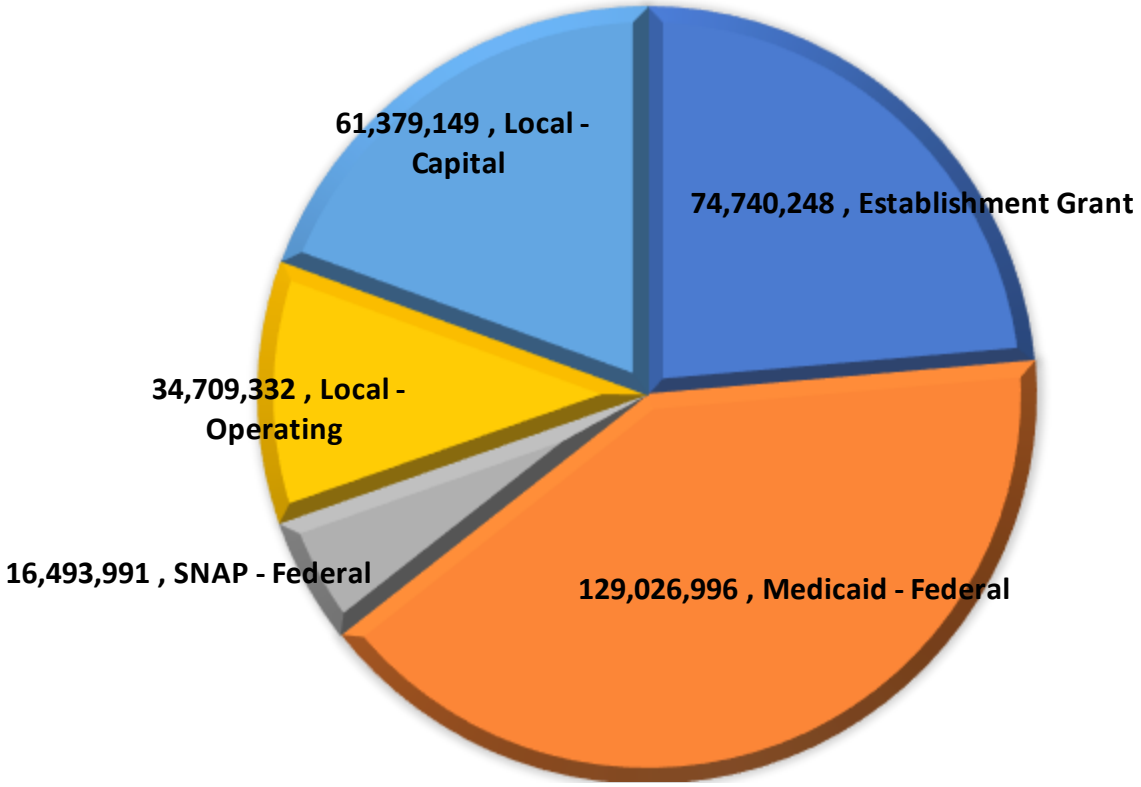
*Name Pending

DCAS Release 1 Functionality Is Nearly Complete With the Final Phase Addressed in Release 3

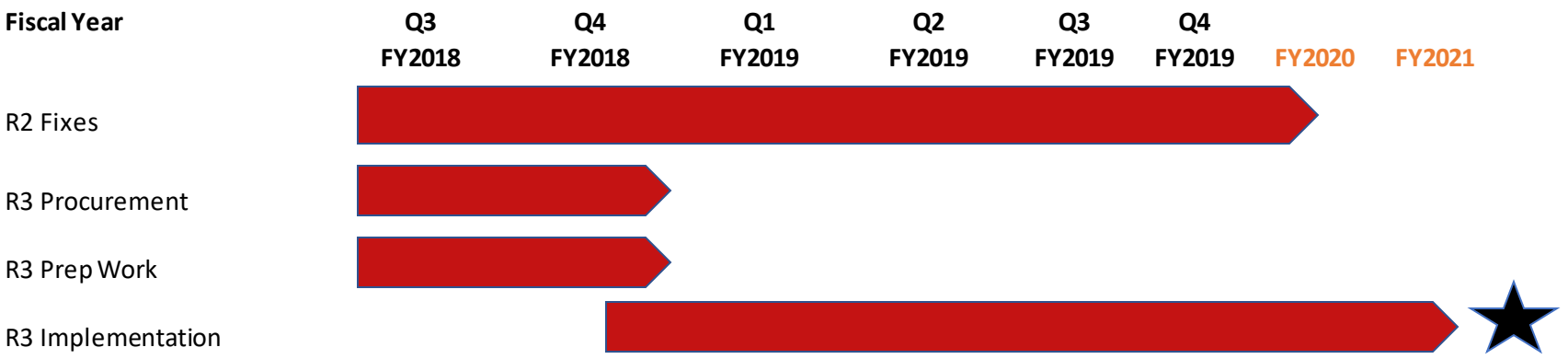


Prior Years DCAS Spending
FY12 – FY18

Total $316,349,747



DHCF is going through Release 3 – The Last Phase of the DCAS Project



R3 Projected Spending				
Funding Type	**FY 19 Budget**	**FY 20 Budget**	**FY 21 Budget**	**Total**
Federal	88,769,385	98,006,575	87,099,090	273,875,049
Local	17,232,749	17,899,883	16,124,246	51,256,879
Total	**106,002,134**	**115,906,458**	**103,223,336**	**325,131,928**

Source: FY19 from APD budget and FY20-FY21 from Capital plan.

DHCF Launches the DC HIE a Regulated Marketplace for HIE Services

- **Established** July 2019 through rulemaking
- **Formalizes** partnerships to facilitate a more direct level of cooperation between DHCF and HIEs operating in the District (i.e. clearly define who participates in The DC HIE)

District Designated HIE Entity

***A District Registered HIE Entity has been selected and will be publicly announced in the next few weeks*

Meets additional requirements and is the partner to DHCF for maintaining and sustaining HIE services in the District

District Registered HIE Entity

Meets core-minimum privacy/security and business operations requirements to participate in the DC HIE

CRISP

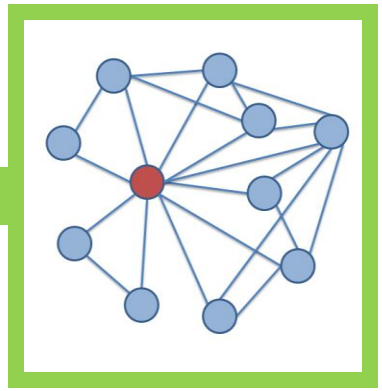
DCPCA DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

Why does the DC HIE Regulation matter for the District?

For **patients**, the DC HIE means having more informed providers who meet their needs and preferences in the delivery of high-quality, high-value health care. Their providers will communicate more regularly, and they won't need to "tell their story" by faxing or carrying copies of their medical records.

For **providers**, the DC HIE means having timely access to vital patient health information available when and where it is needed. This health information will help providers make better-informed decisions that improve care and safety for their patients.

For **HIE entities**, the DC HIE means a level playing field and a citywide governance structure to help exchange health information and meet customer's needs.



DHCF Is Investing In Six HIE Core Capabilities For Medicaid Providers

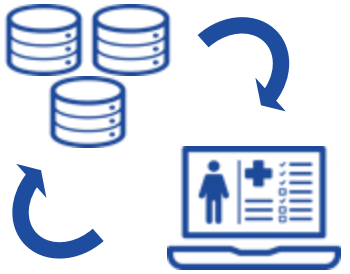
Clinical Patient Lookup

Simple and Secure Digital Communications Among Providers

Advanced Analytics for Population Health Management

Electronic Clinical Quality Measures (eCQM) Calculation and Review

SDOH Screening, Exchange and Referral (Under Development)



Specialized Registry Submission through EHRs

The DC HIE

The DC HIE Rule *(Chapter 87 District of Columbia Health Information Exchange of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations)* formalizes partnerships to facilitate more cooperation between DHCF and HIE entities.

District Registered HIE Entities

CRISP

DCPCA DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

- Is a HIE entity that **meets or exceeds privacy, security, and access requirements** for health information exchange.
- Receives **key opportunities** to engage in discussions with other DC HIE entities.
- The District Registered HIE Entity status is awarded for a term of **three (3) years.**

The DC HIE Registration Application is accepted on a rolling basis

District Designated HIE Entity

CRISP

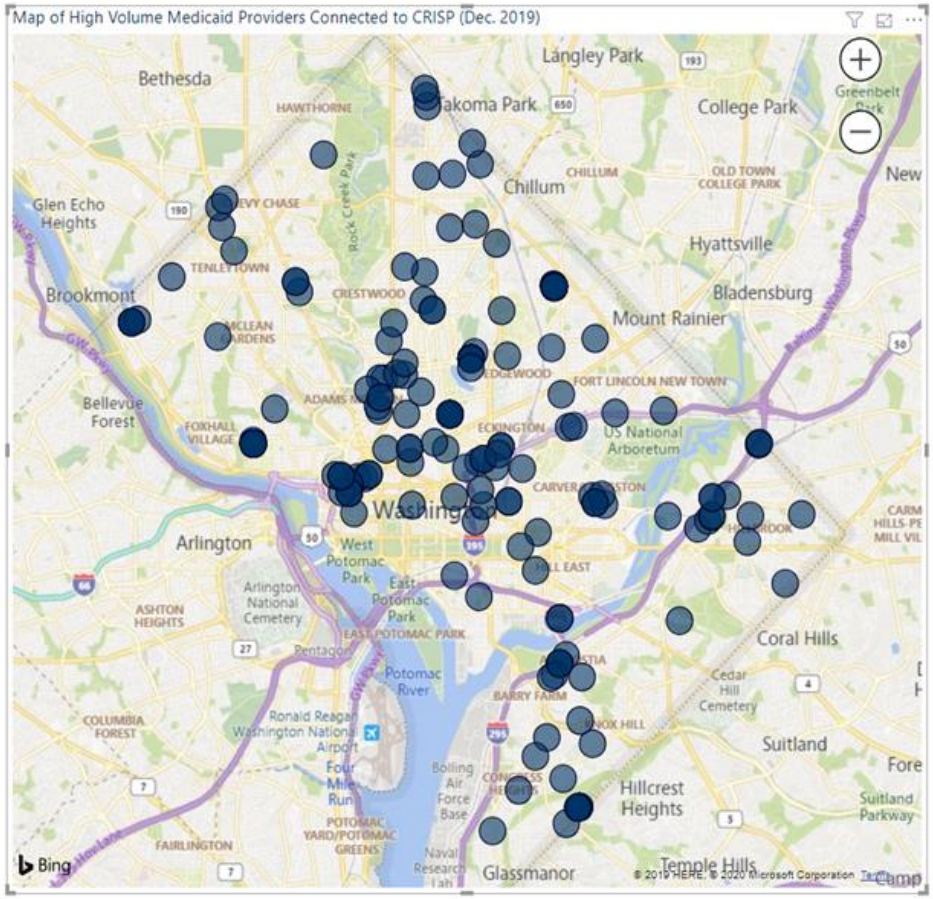
- Is a District Registered HIE Entity that **meets or exceeds the consumer education and auditing requirements** in the DC HIE Rule.
- Is a key partner to DHCF, the District Designated HIE Entity **supports the ongoing maintenance and operation of the DC HIE infrastructure or services.**
- The District Designated HIE Entity status is awarded for a term of **five (5) years.**

The DC HIE Designation memorandum of agreement was signed April 13, 2020.

Health Information Exchange Enables DHCF to Connect a Disconnected Health Care System

- 100% of the following providers have access to CRISP services:
  - Acute care hospitals
  - FQHCs
  - Nursing Facilities
- More than 4 in 10 high-volume Medicaid providers (those with 100+ claims) already participate in HIE
  - Increasing participation by behavioral health providers
- Approximately 490,000 DC patients see providers who receive real-time hospital alerts from CRISP DC
  - Includes all Medicaid beneficiaries
- In collaboration with DC Health, enables providers to receive notifications on COVID-19 test results for their patients.

CRISP Unified Landing Page is Accessible to 9,300+ Users Located Throughout the District



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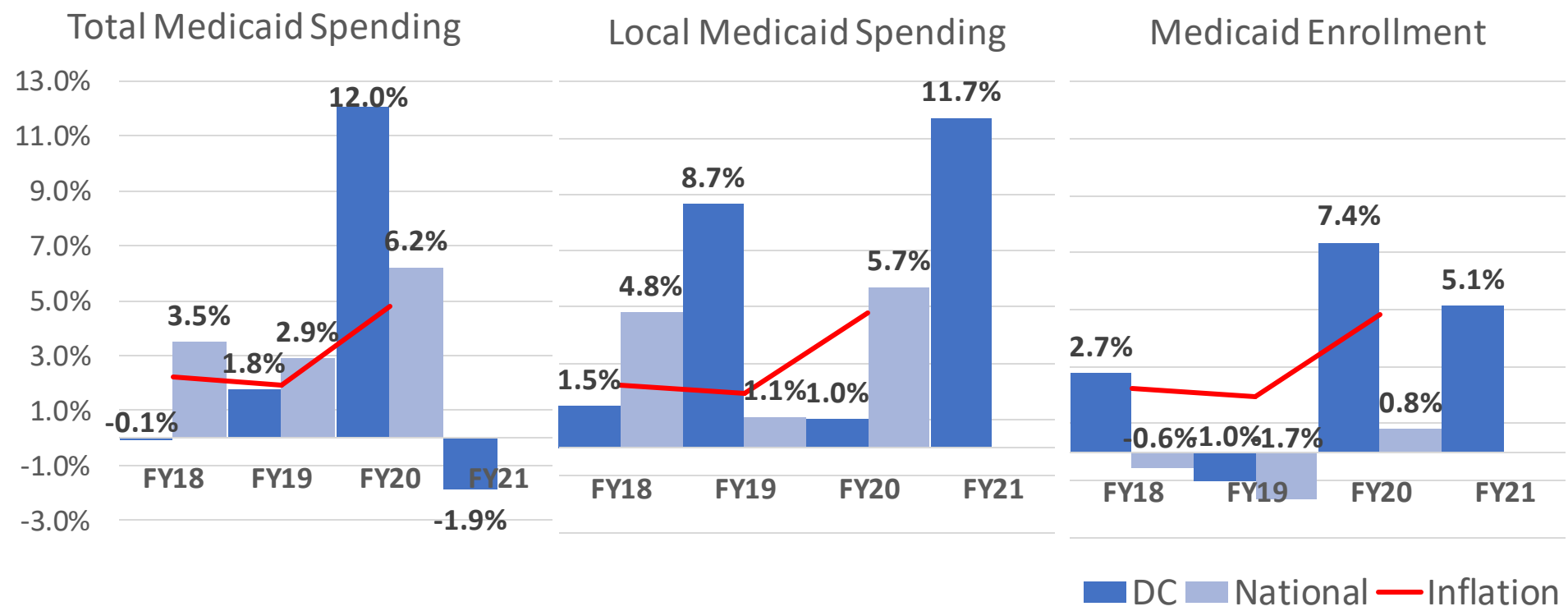
- ❑ Conclusion

Both Total and Local Medicaid Spending and Enrollment Grew Sharply in FY20; Local Spend and Enrollment Continue to Grow in FY21

DC and National Medicaid Spending and Enrollment Growth Rates: FY2018-19 (Actual), FY2020 (Approved), FY2021 (Submission)

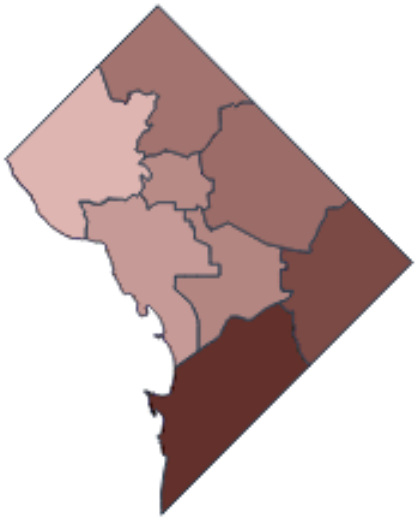


Sources: DC spending trends are based on SOAR data; DC enrollment trends are based on data from DC MMIS. National data are from the Kaiser Family Foundation's issue brief "Medicaid Enrollment & Spending Growth: FY2019 & 2020"; Inflation data are annual average monthly Medical CPI for the Fiscal year, projected for FY21 using an exponential smoothing method which accounts for seasonality and gives recent data points more weight.

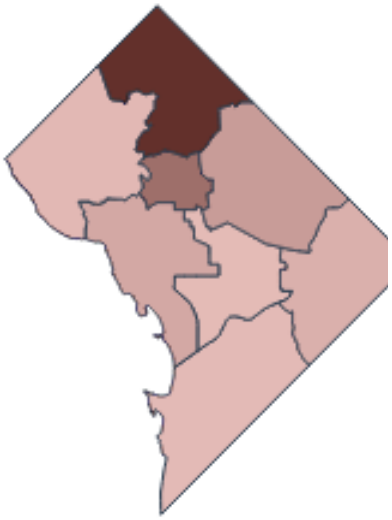
Most Medicaid Beneficiaries Live in Wards 7 and 8, While Most Alliance and ICP Beneficiaries Live in

Ward Distribution by Program Type, FY 2019

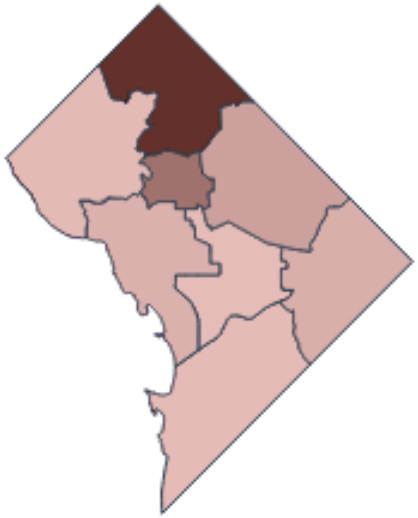
Medicaid by Ward



Alliance by Ward



ICP by Ward

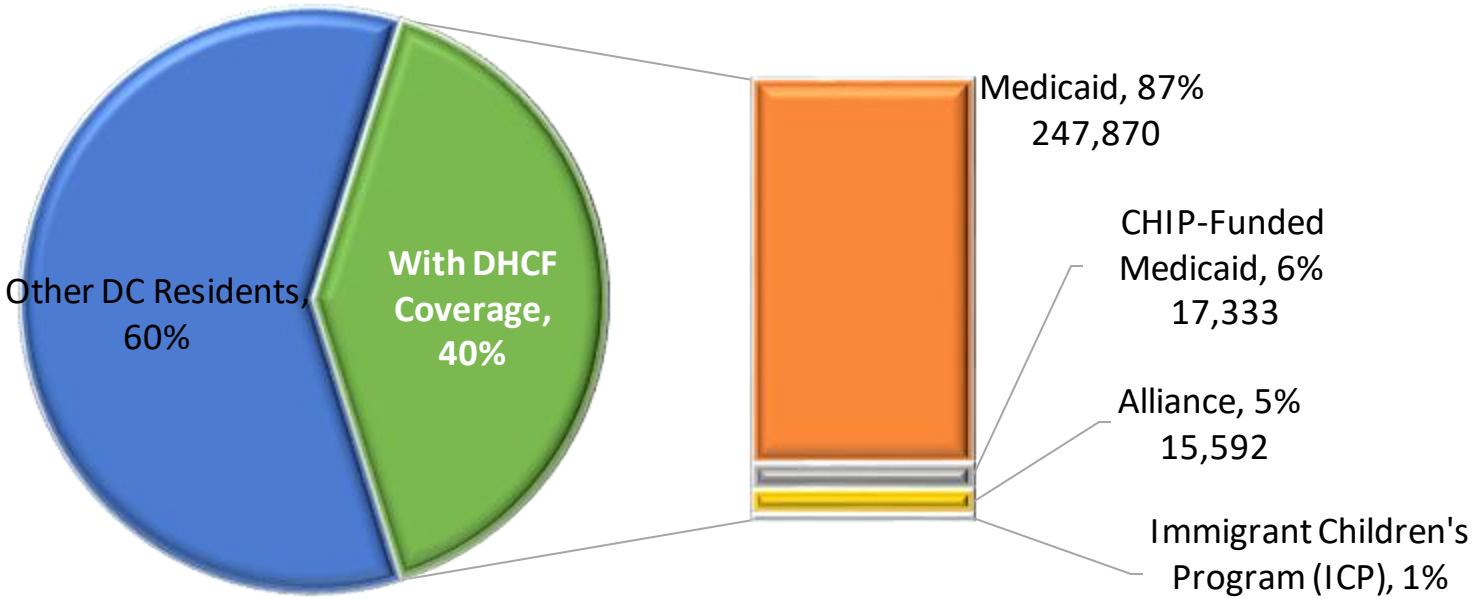


Ward	Medicaid	Alliance	ICP
1	9%	26%	26%
2	7%	7%	5%
3	2%	2%	2%
4	13%	46%	49%
5	14%	11%	10%
6	10%	2%	1%
7	20%	5%	5%
8	25%	2%	1%

- **Source:** Medicaid data reported from DHCF's Medicaid Management Information System (MMIS) for FY 2019.
- **Note:** Based on average monthly enrollment. ICP = Immigrant Children's Program.

Nearly 4 in 10 District Residents Rely on DHCF-Funded Health Care Coverage – Most in Medicaid

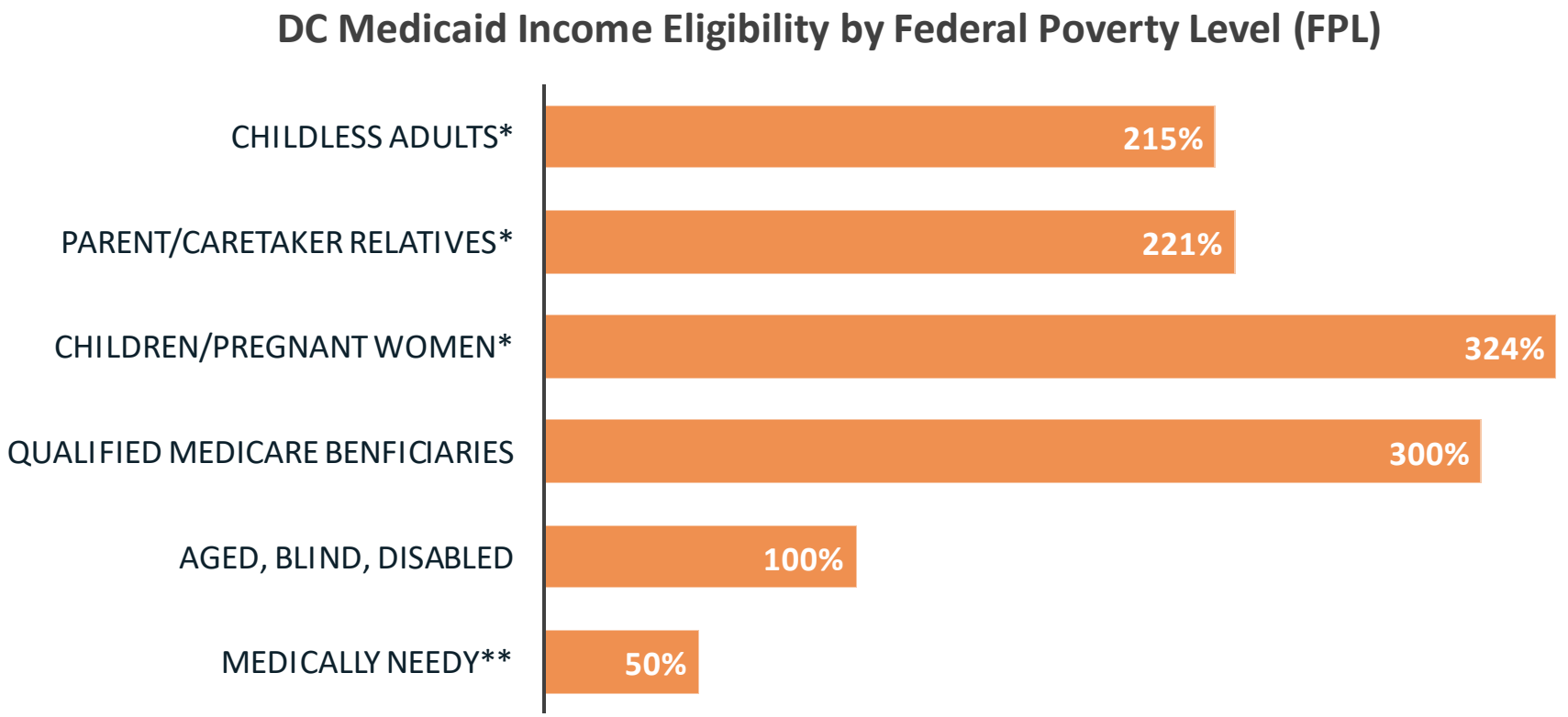
Proportion of DC Residents with DHCF-Funded Coverage, FY 2019



Total District of Columbia Residents = 705,749

- **Source:** District population estimate reflects July 1, 2019, from U.S. Census Bureau. Medicaid, Alliance, and ICP data reflects average monthly enrollment in FY 2019, DHCF's Medicaid Management Information System (MMIS).
- **Note:** The District resident total may undercount certain individuals (e.g., those who are not US citizens) and thus the percentage with DHCF coverage may be overstated.

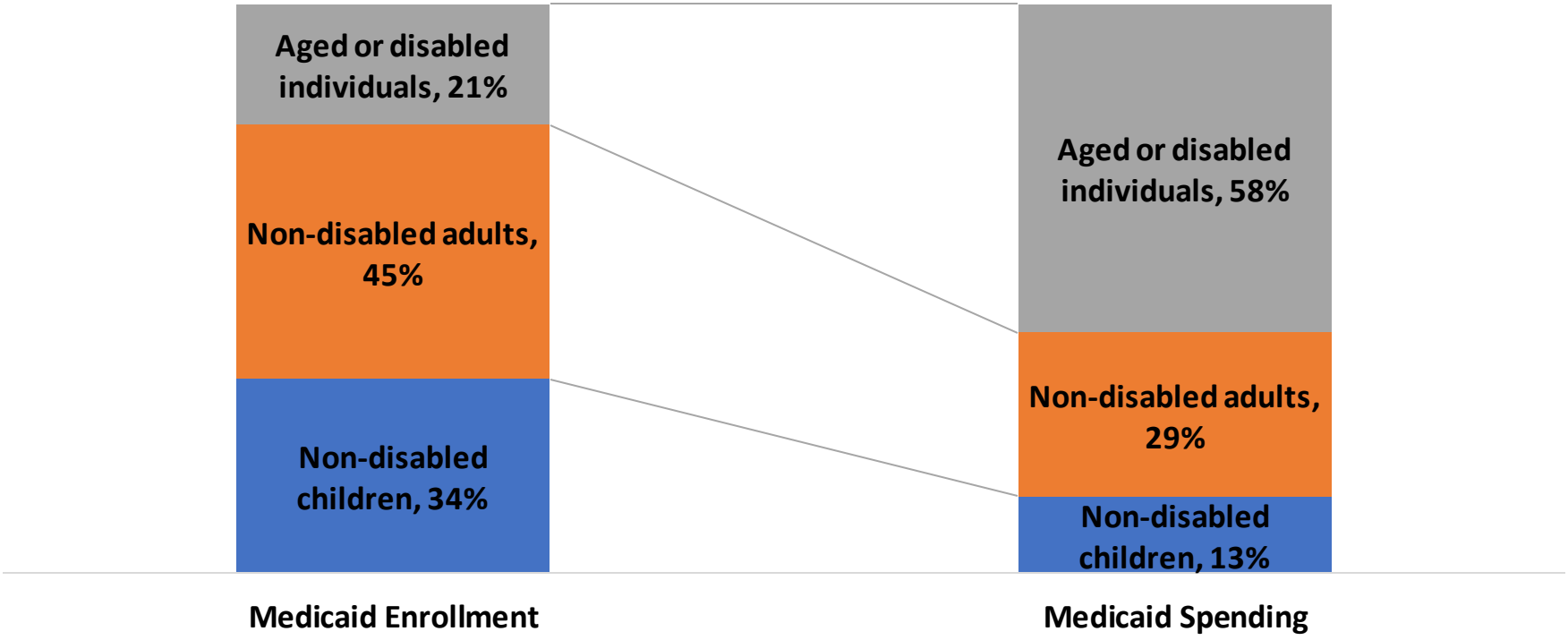
In the District, Most Low-Income Non-Elderly Adults Are Medicaid-Eligible



- **Note:** Low-income is 200% FPL, which is about $25,520 for an individual or $52,400 for a family of four in CY 2020.
- * Includes a 5% income disregard.
- ** The Medically Needy Income Level (MNIL) for a household of 2 or more is 50% of the FPL, but for a household of 1 the MNIL is 95% of the MNIL for a household of 2.

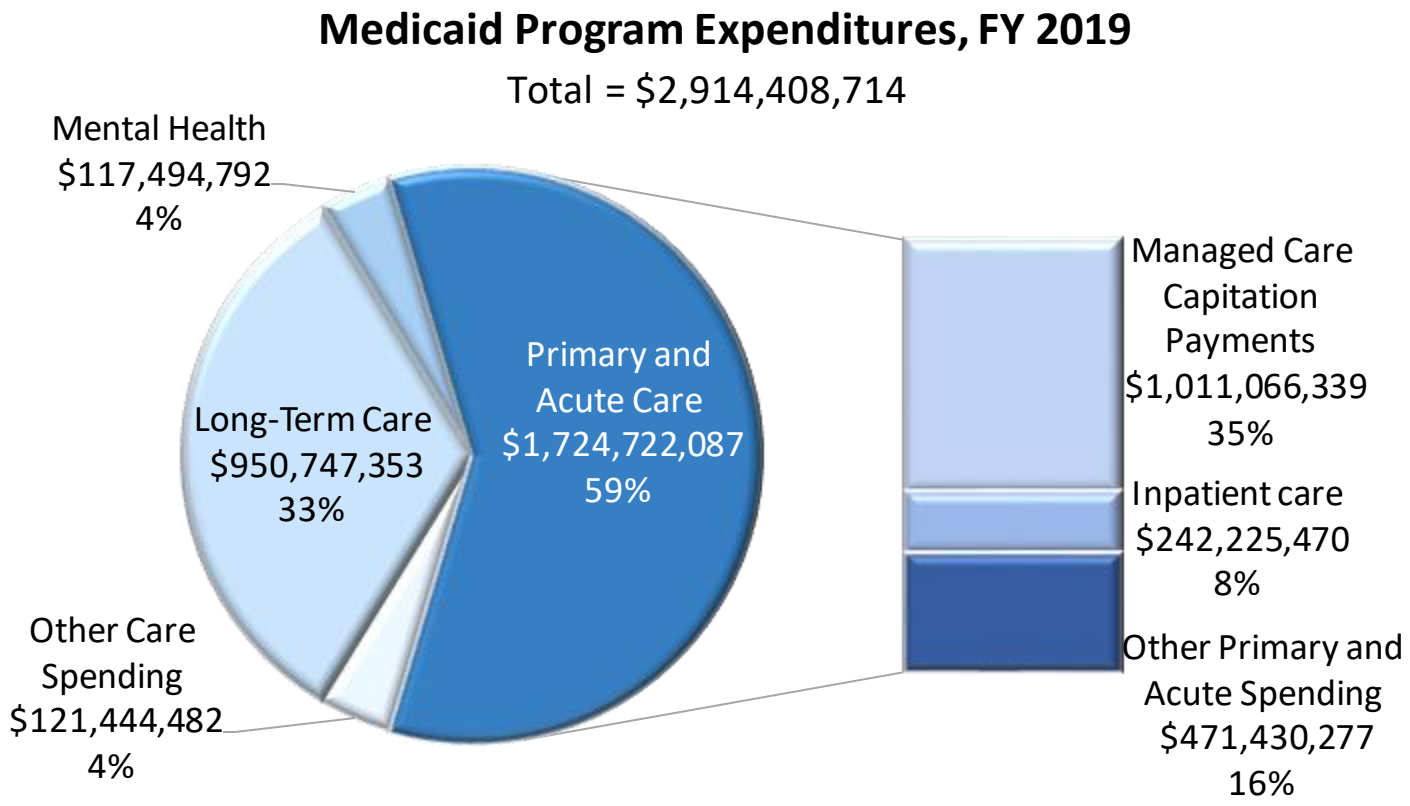
Aged and Disabled Beneficiaries Account for About 20% of Enrollment, But Nearly 60% of Spending

Medicaid Enrollment and Spending by Eligibility Group, FY 2019



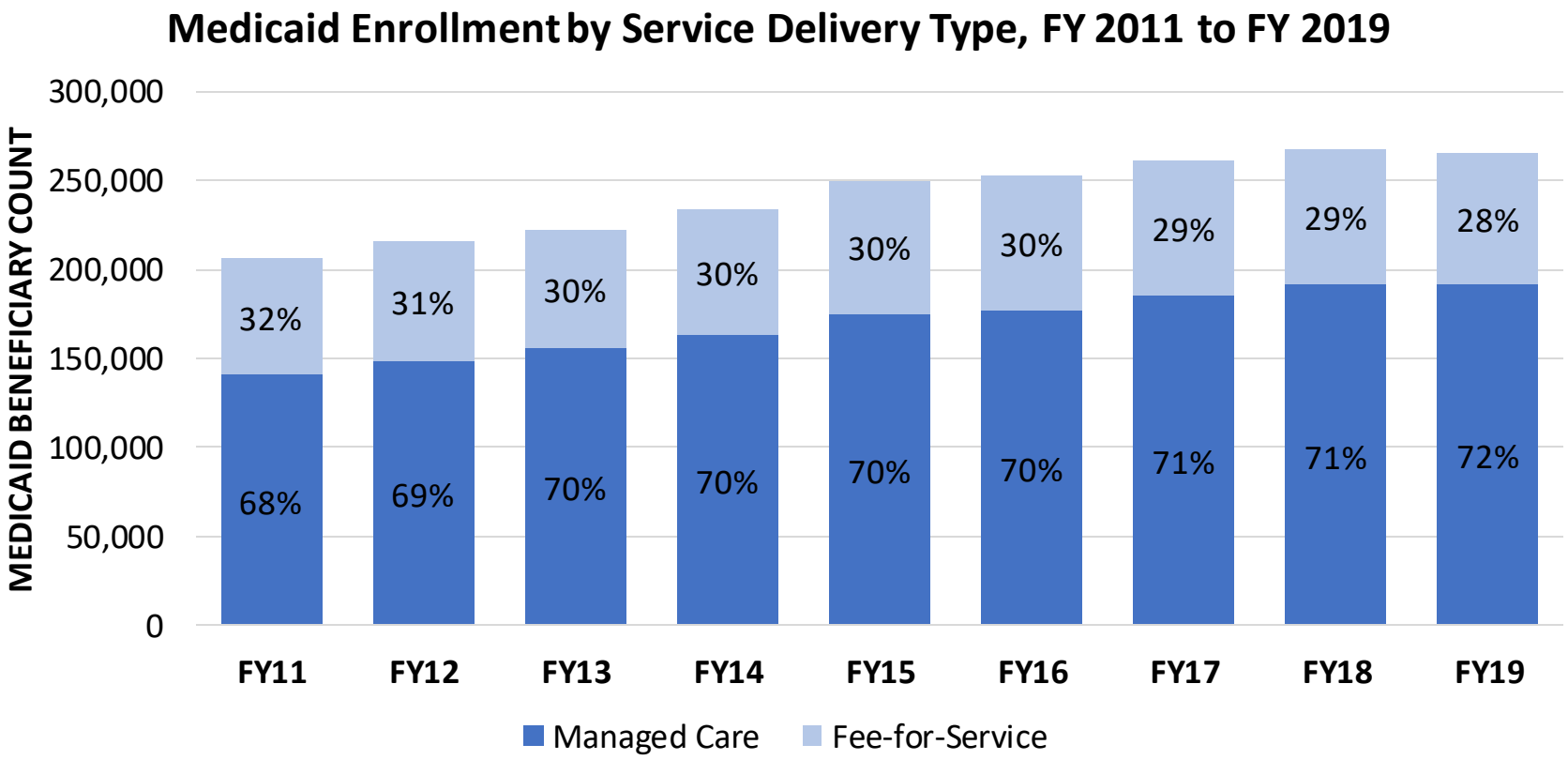
- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in March 2020 for eligibility in FY 2019 and claims with dates of service in FY 2019.
- **Note:** Reflects eligibility group at the time of payment. Disabled includes individuals eligible for long-term services and supports an institutional level of care. Excludes expenditures not attributable to individual beneficiaries (e.g., disproportionate share hospital payments).

Primary and Acute Care Costs Represent Greatest Share of Medicaid Spending



- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in March 2020 for claims with FY 2019 dates of service.
- **Note:** The "Other Care Spending" category includes health-related services such as optometrist, podiatrist, physical therapy, midwifery, and other services. Although managed care capitation is shown in the primary/acute care category, plans may spend some portion of those payments on services falling into other categories.

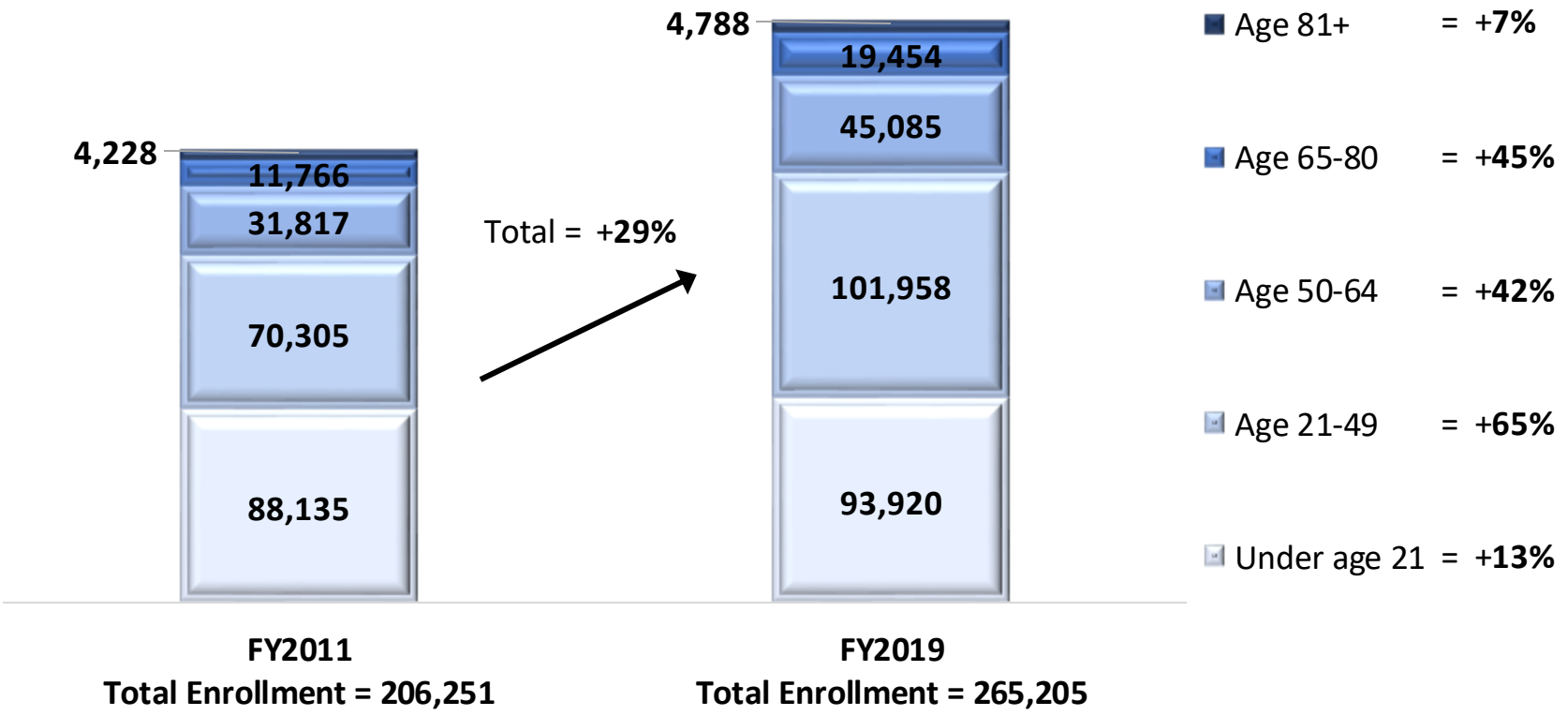
Nearly Three-Fourths of the District's Medicaid Enrollees Are in Managed Care



- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in March 2020.
- **Note:** Enrollment reflects average monthly.

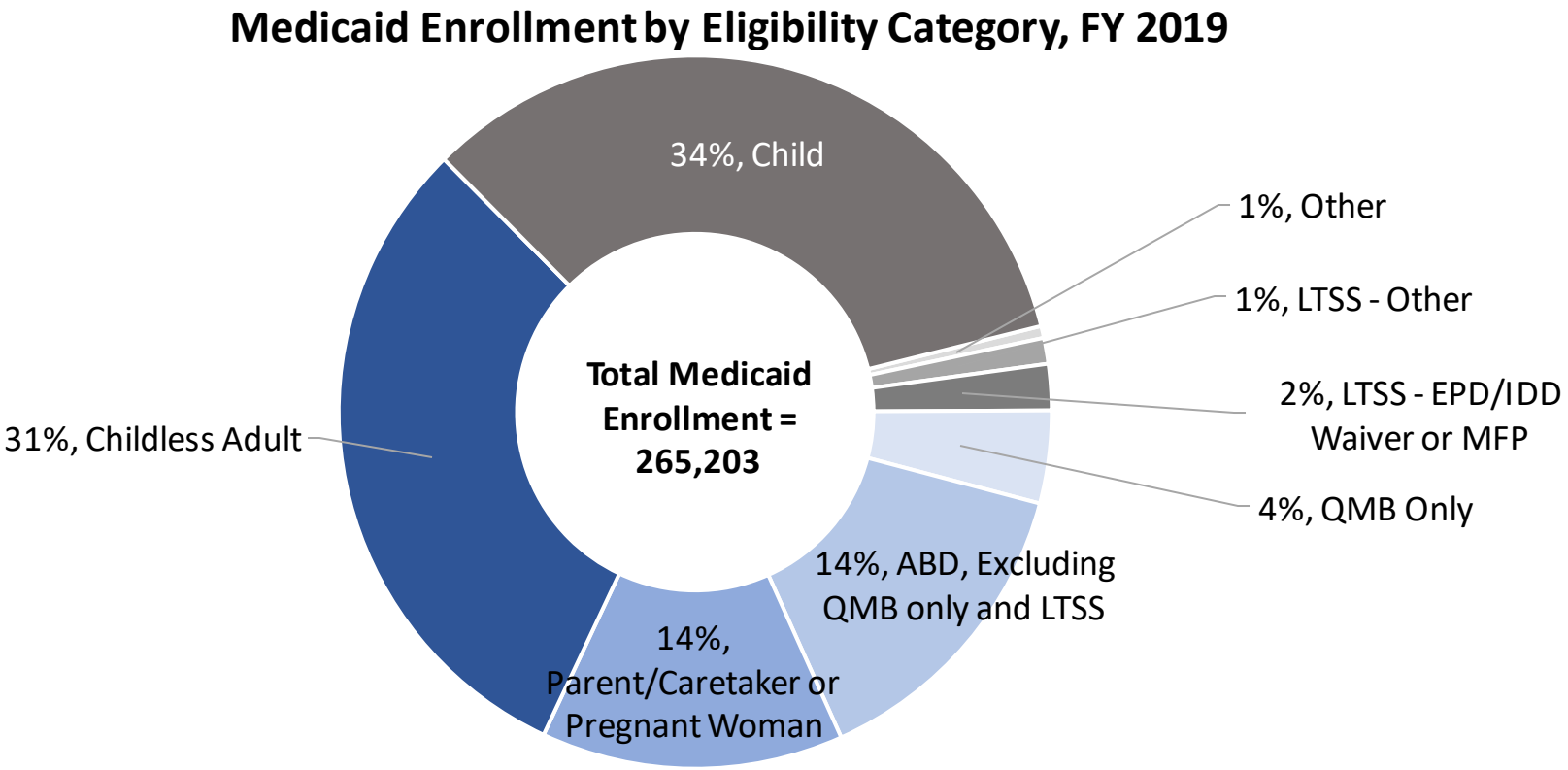
Adults Account for Most Medicaid Enrollment Growth From FY 2011 to FY 2019

Medicaid Enrollment Growth by Age, FY 2011-FY 2019



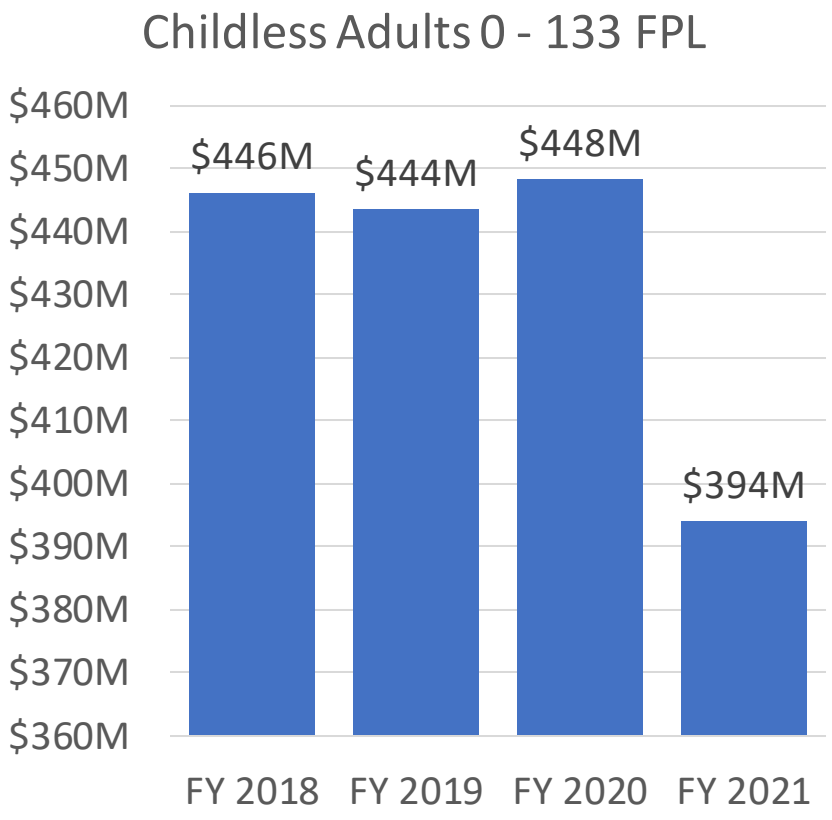
- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in March 2020.
- **Note:** Enrollment is average monthly.

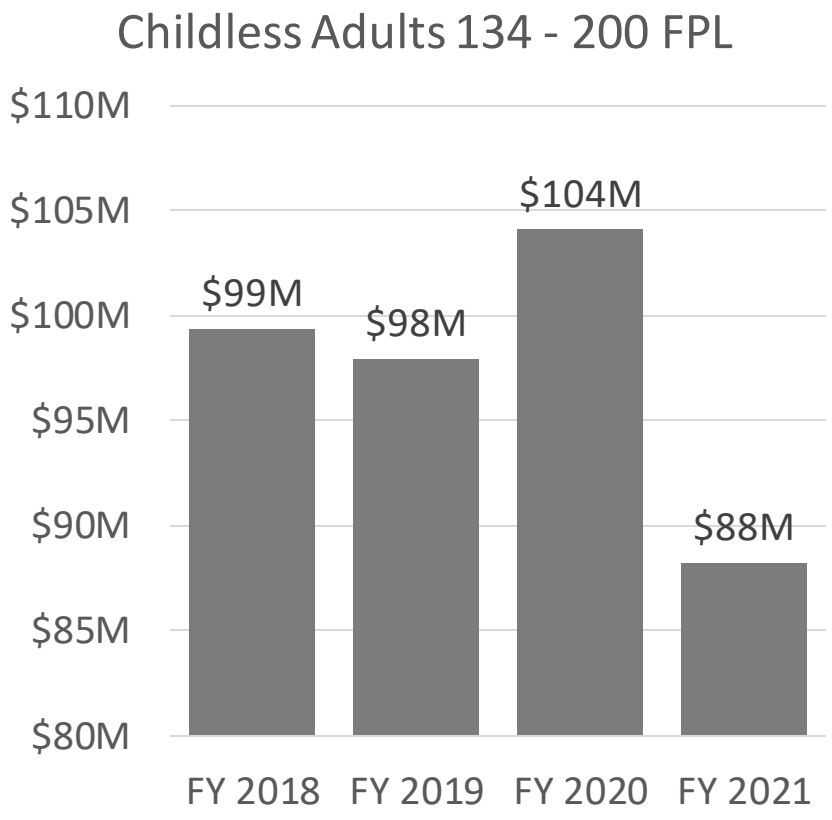
Childless Adults and Children Each Represent About One-Third of Medicaid Enrollees



- **Source:** DHCF Medicaid Management Information System (MMIS) data.
- **Note:** Enrollment reflects average monthly. ABD = aged, blind, or disabled; EPD = Elderly and Persons with Disability; ICF = intermediate care facility; IDD = Intellectual or Developmental Disability; LTSS = long-term services and supports; MFP = Money Follows the Person; NF = nursing facility; QMB = Qualified Medicare Beneficiary.

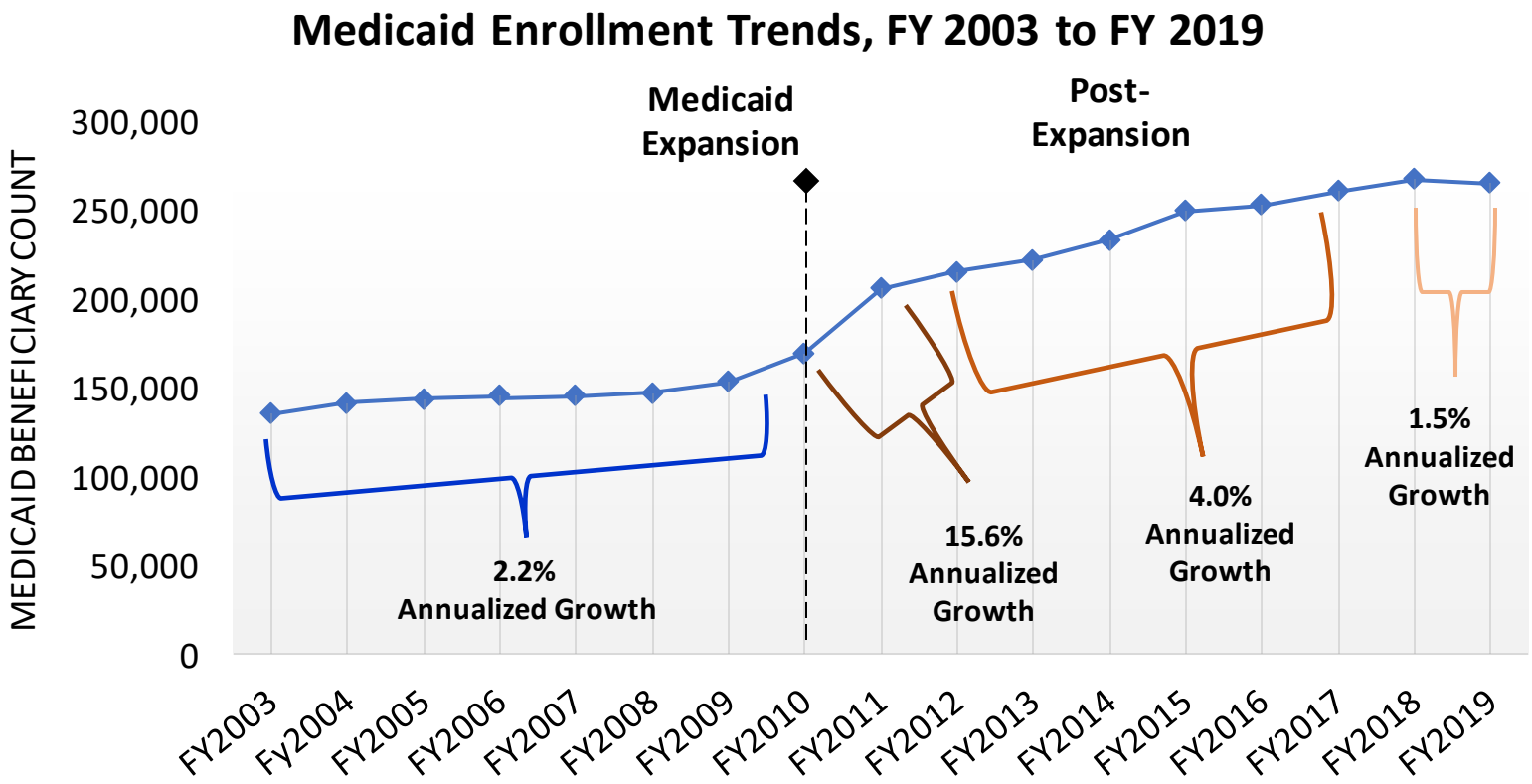
Shift to Managed Care Realized Cost Savings for Childless Adult Population in FY21





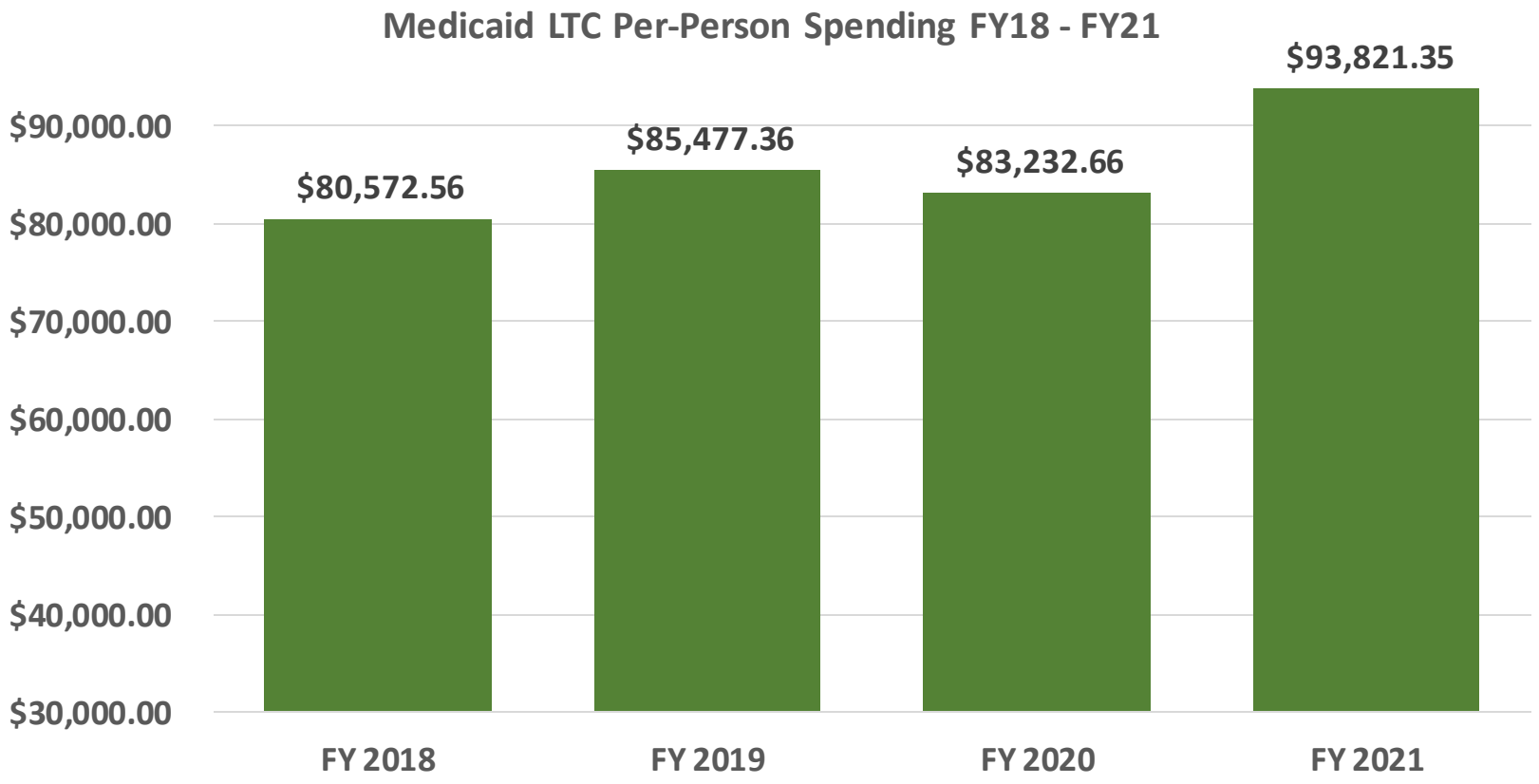
Sources: Spending data are from CFO solve reports for FY18 and FY19, the FY20 2nd quarter FRP 50 model for FY20, and the forecast model for FY21. FPL means the Federal Poverty Level.

Medicaid Enrollment Growth Post-ACA Implementation Has Slowed in the Last Two Years



- **Source:** Data for 2000-2009 data were extracted by Xerox from tape back-ups in January, 2010. Data for 2010-FY 2019 are from DHCF's Medicaid Management Information System (MMIS).

Long-Term Care Spending Per-Person is Projected to Increase in FY21 Due to Shifts in how PCA is Covered



Sources: DC spending trends are based on SOAR data; DC enrollment trends are based on data from DC MMIS projected for FY20 and FY21 using an exponential smoothing method which accounts for seasonality and gives recent data points more weight. Long-Term Care services include Nursing Home, ICF, EPD Waiver, IDD Waiver, MFP Waiver, and Participant Directed Waiver Services.

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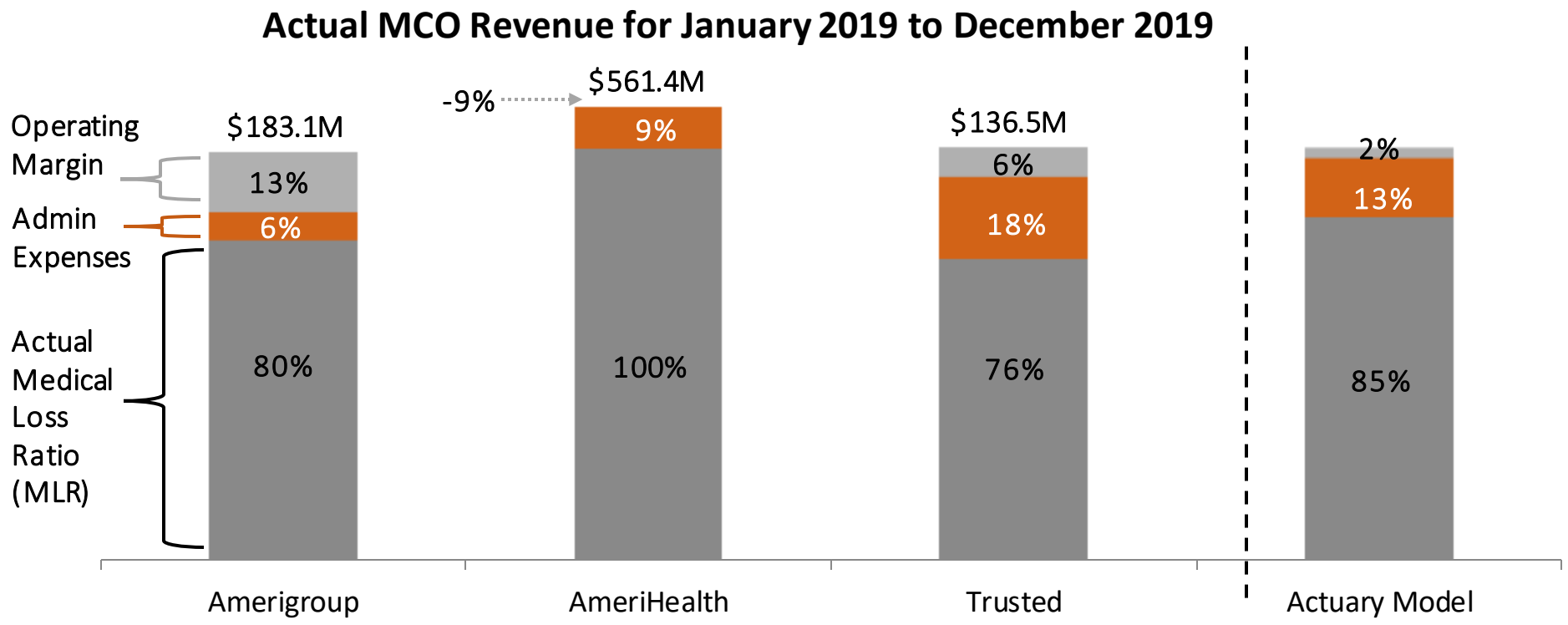
Only One Full-Risk MCO Spent at Least 85% of Revenue on Enrollee Medical Expenses



- **Source:** MCO Annual Statement filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Annual Statements for shared risk plan, HSCSN, as of December 2019.
- **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 IBNR) and cost containment expenses as of December 31, 2019, net of reinsurance recoveries. Claims incurred in 2019 include restatements of IBNR held for prior years. AmeriHealth's MLR reflects a large increase in IBNR held as of 12/31/2019, and Trusted's MLR reflects a substantial release of the IBNR held for 2018.

Several Metrics Quantitatively Assess the Efforts by MCOs to Achieve Value in Health Care

- **DHCF continues to monitor the Pay for Performance (P4P) indicators for each of the District's full-risk health plans, but suspended the financial withhold in FY 2020 due to a new procurement of health plans.**

  P4P indicators include:
  - Emergency room utilization for non-emergency conditions
  - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
  - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization

- **DHCF is developing new provider-level initiatives to achieve our goal of promoting high value in health care for Medicaid and Alliance beneficiaries.**

All Three Managed Care Plans Have Shown Improvement in the Pay-For-Performance Standards Compared to Baselines

Performance Metrics			
Health Plan	Preventing Use of Emergency Room For Non-Emergencies	Preventing Hospital Readmissions Within 30 Days of Previous Admissions	Preventing Avoidable Hospital Admissions
Health Plan Improvement From Baseline			
Amerigroup	4.5%	27.4%	25.9%
AmeriHealth	9.2%	36.6%	27.1%
Trusted	8.1%	34.7%	33.9%

- **Source:** Calculations performed by Mercer Consulting using MCO encounter data.
- **Note:** Results reflect most recent 12 months of experience, October 2018 to September 2019. Values shown in red if improvement has not fully met P4P Year 2 targets.

Medicaid MCO Results Mixed During FY 2019 with Some Regression

Performance Metrics			
Health Plan	Preventing Use of Emergency Room for Non-Emergencies	Preventing Hospital Readmissions Within 30 Days of Previous Admissions	Preventing Avoidable Hospital Admissions
Did the Health Plan Improve From Year Two Results?			
Amerigroup	Yes	Yes	No
AmeriHealth	No	Yes	Yes
Trusted	No	Yes	Yes

Health Plan Improvement From Year Two			
Amerigroup	3.6%	21.0%	-3.7%
AmeriHealth	-0.8%	9.8%	11.8%
Trusted	-3.2%	13.5%	15.4%

- **Source:** Calculations performed by Mercer Consulting using MCO encounter data.
- **Note:** Results reflect most recent 12 months of experience, October 2018 to September 2019. Results that have regressed from Year 2 results highlighted in red.

Top Ten Chronic Conditions for Fee-for-Service Beneficiaries Include Hypertension and Behavioral Disorders

Top Chronic Conditions For FFS Children And Adults, FY 2019

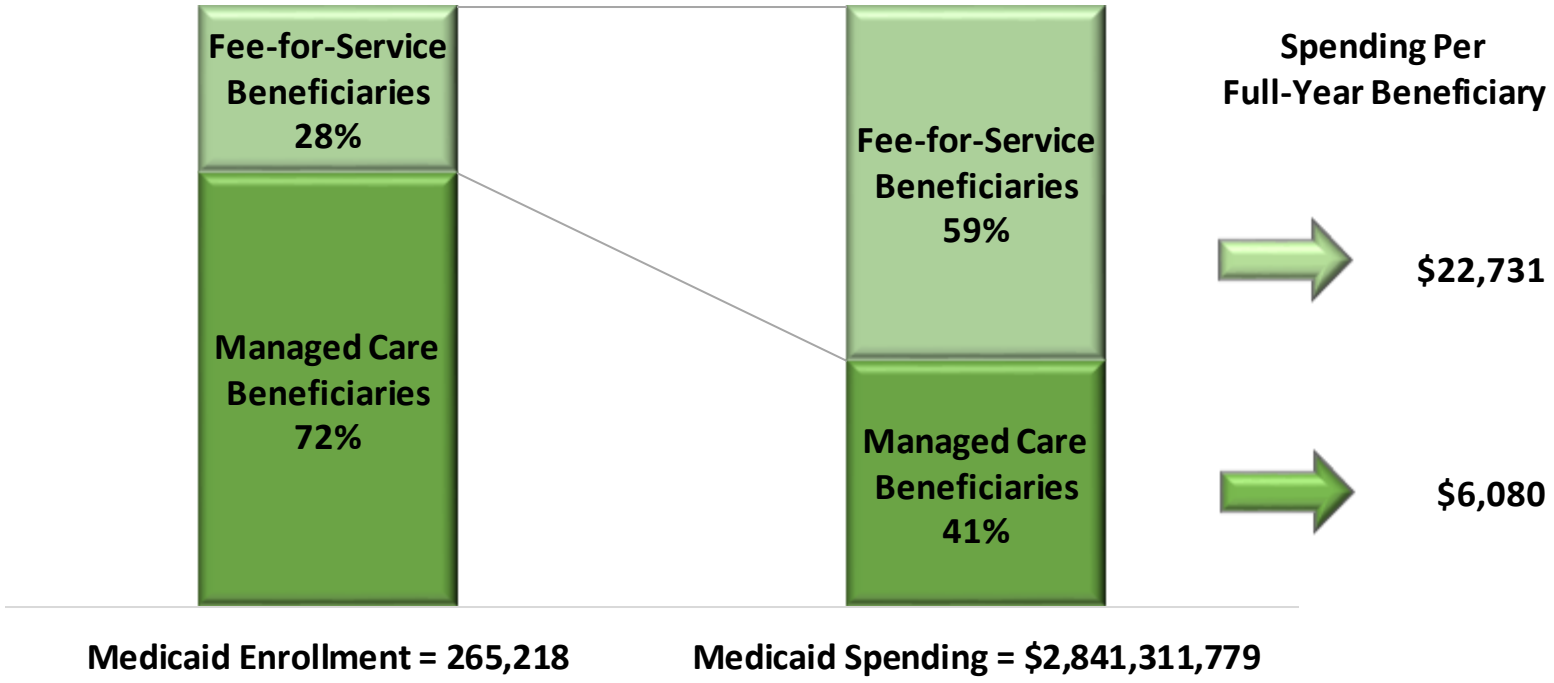
Adults		Children	
Condition	Percent of total	Condition	Percent of total
Hypertension	56%	Behavior Disorder	18%
Hyperlipidemia	30%	Asthma	13%
Diabetes	28%	Allergy	12%
Depression	28%	Depression	6%
Personality Disorder	26%	Obesity	5%
Osteoarthrosis	23%	Personality Disorder	5%
Asthma	22%	Anxiety	3%
Peripheral Atherosclerosis	19%	Congenital	3%
Obesity	18%	Dysrhythmia	1%
Other heart disease	15%	Sickle	1%

Source: DC Medicaid Management Information System (MMIS) data extracted in March 2020.

Note: FFS beneficiaries were identified as non-LTSS waiver individuals with full benefits, at least three MTM payments, and no MCO payments in FY 2019. Children are defined as under age 21. Adults are at or above age 21. Examples of behavior disorders include eating disorders, conduct disorders, and attention deficit disorders.

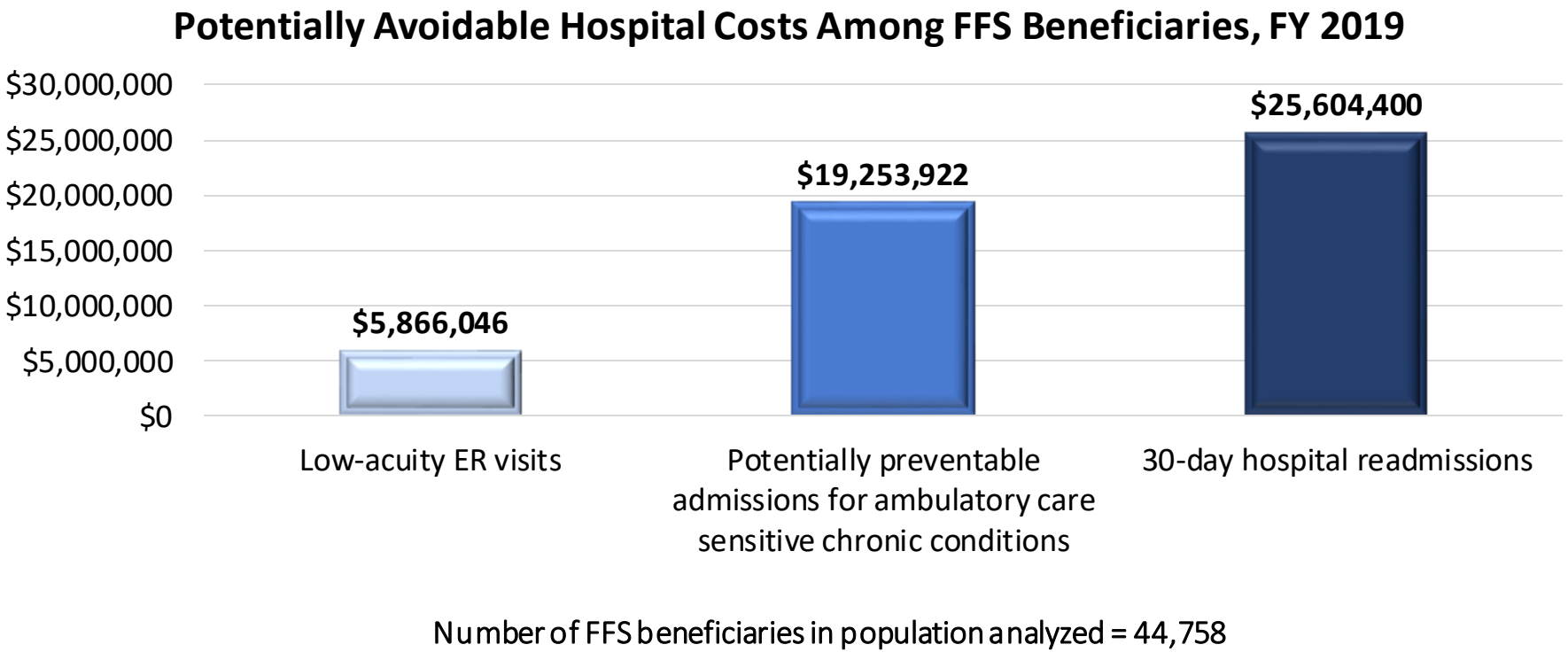
Top Ten Chronic Conditions for Fee-for-Service Beneficiaries Include Hypertension and Behavioral Disorders

Medicaid Enrollment and Spending by Service Delivery Type, FY 2019



- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in May 2020 for eligibility in FY 2019 and claims with dates of service in FY 2019.
- **Note:** Enrollment reflects average monthly and spending per full-year beneficiary is a per member per month value multiplied by 12. Spending reflects DHCF payments for both capitation and any fee-for-service utilization.

Over $50 Million Medicaid FFS Costs Potentially Avoidable in FY 2019

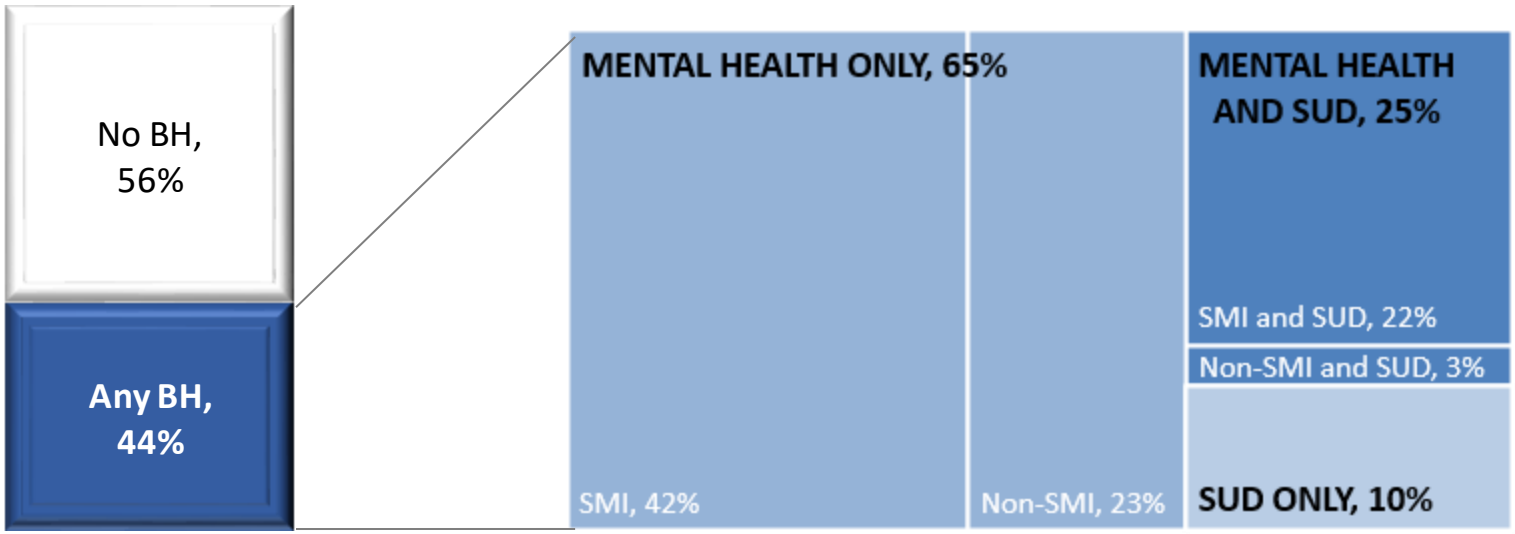


Number of FFS beneficiaries in population analyzed = 44,758

- **Source:** DC Medicaid Management Information System (MMIS) data extracted in March 2020 for claims with FY 2019 dates of service.
- **Note:** FFS beneficiaries were identified as non-LTSS waiver individuals with full benefits, at least three MTM payments, and no MCO payments in FY 2019. There may be an undercount of service use for enrollees who are dually eligible for Medicare due to incomplete crossover claims.

Almost Half of Fee-for-Service Beneficiaries Have a Behavioral Health Diagnosis

Distribution of Behavioral Health Diagnoses Among FFS Beneficiaries, FY 2019



Medicaid FFS beneficiaries = 72,959

Medicaid FFS beneficiaries with BH diagnosis = 31,844

- **Source:** DC Medicaid Management Information System (MMIS) data extracted in March 2020.
- **Note:** Reflects FY 2019 diagnoses for Medicaid beneficiaries enrolled during September 2019. Excludes individuals whose only BH diagnosis is tobacco use disorder. BH = behavioral health; SMI = serious mental illness; SUD = substance use disorder.

Waiver Offers First Step in Transforming District Medicaid Behavioral Health Services

- DHCF and the Department of Behavioral Health sought and were granted a waiver under Section 1115 of the Social Security Act in November 2019
  - Allows the District to offer services not otherwise coverable
  - Provides for a 5-year demonstration to pilot innovative policy changes
- Under this waiver, the District is:
  - Expanding the continuum of Medicaid behavioral health services
  - Advancing the Mayor's goals in fighting opioid use and other substance use disorders
  - Moving Medicaid towards whole person, integrated physical and behavioral health
- Waiver complements ongoing efforts, including the Mayor's Live.Long.DC. Opioid Response Plan

District Waiver Goals Promote Community-Based Treatment, Reduction of Inpatient/ED Utilization

- Reducing preventable or unnecessary hospital/ER stays, or admissions to acute/residential settings
- Increasing access to crisis stabilization and community-based services
- Improving care coordination, transitions to community following Institution for Mental Disease (IMD) stay
  - Medicaid historically limited coverage of adult inpatient and residential services under the "IMD Exclusion"
  - Children, adults over age 65 were only populations allowed to receive IMD services; limited coverage permitted for other MCO-enrolled beneficiaries
- Increasing rates of SUD identification, treatment, and retention
- Reducing overdose deaths, including for opioids

BH Transformation Waiver Services

Service	Target Age Group	Go-Live Date
IMD services for individuals aged 21-64	**21-64**	January 2020
Clubhouse (adult psychosocial day rehabilitation services)	**18+**	January 2020
Recovery Support Services (RSS)	**All**	January 2020
Independent Practice for Psychologists/Other Licensed Behavioral Health Practitioners	**All**	January 2020
Eliminate $1 Co-Pay for Medication-assisted Treatment (MAT)	**All**	January 2020
Supported Employment – SMI	**18+**	February 2020
Trauma-Targeted Care – Trauma Recovery And Empowerment Model (TREM) and Trauma Systems Therapy (TST)	**12+**	March 2020
Supported Employment – SUD	**18+**	April 2020
Crisis Stabilization (CPEP, Psych Crisis Stabilization Beds, Mobile Crisis and Outreach Services)	**Mobile Crisis – All Other – 18+**	June 2020
Transition Planning Services	**All**	September 2020

- **Note:** CPEP = Crisis Psychiatric Emergency Program; IMD = Institution for Mental Disease; SMI = serious mental illness; SUD = substance use disorder.

DC Among 15 States Selected for Demonstration Project to Further Transform Behavioral Health

- Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, section 1003 demonstration project to increase the treatment capacity of Medicaid providers to deliver substance use disorder treatment and recovery services.

- Collaborative Funding from
  - The Centers for Medicare & Medicaid Services (CMS), in consultation with
  - The Substance Abuse and Mental Health Services Administration and
  - The Agency for Healthcare Research and Quality, is conducting a 54-month

- Two phases of the project
  - Planning grants awarded to 15 states ($50 million aggregate) for 18 months; and
  - 36-month demonstrations with up to 5 states that received planning grants.

DHCF was awarded $4.6 million – the full amount requested. We see this work and the opportunity for a 36 month demonstration as a strong complement to DCOR and 1115.

SUPPORT ACT Grant's 4 Components Will Build Core Infrastructure and Competencies

1. Comprehensive needs assessment of Medicaid provider capacity to diagnose and treat SUD, building on Opioid Strategic Plan, Pew assessment. *Final Report Due in June/July.*
2. Education and technical assistance among Medicaid providers to build provider capacity to treat individuals with SUD in community settings (in procurement).
   - Prioritized providers include:
     - My DC Health Homes
     - My Health GPS
     - Buprenorphine waivered providers
   - Pilot e-consult and telemedicine tools to provide access to addiction specialists on-demand who can support Medicaid providers.
3. Build critical infrastructure to support appropriate, privacy-preserving information exchange, including:
   - Structured communication and referrals with District behavioral health providers (via MOU to DBH, underway).
4. Development of consent management tools to facilitate appropriate exchange of 42 CFR part 2 data via the DC HIE (in final stages of award).

Consistent With Recent Years, Home- and Community- Based Services Represent Greatest Share of LTSS Spending

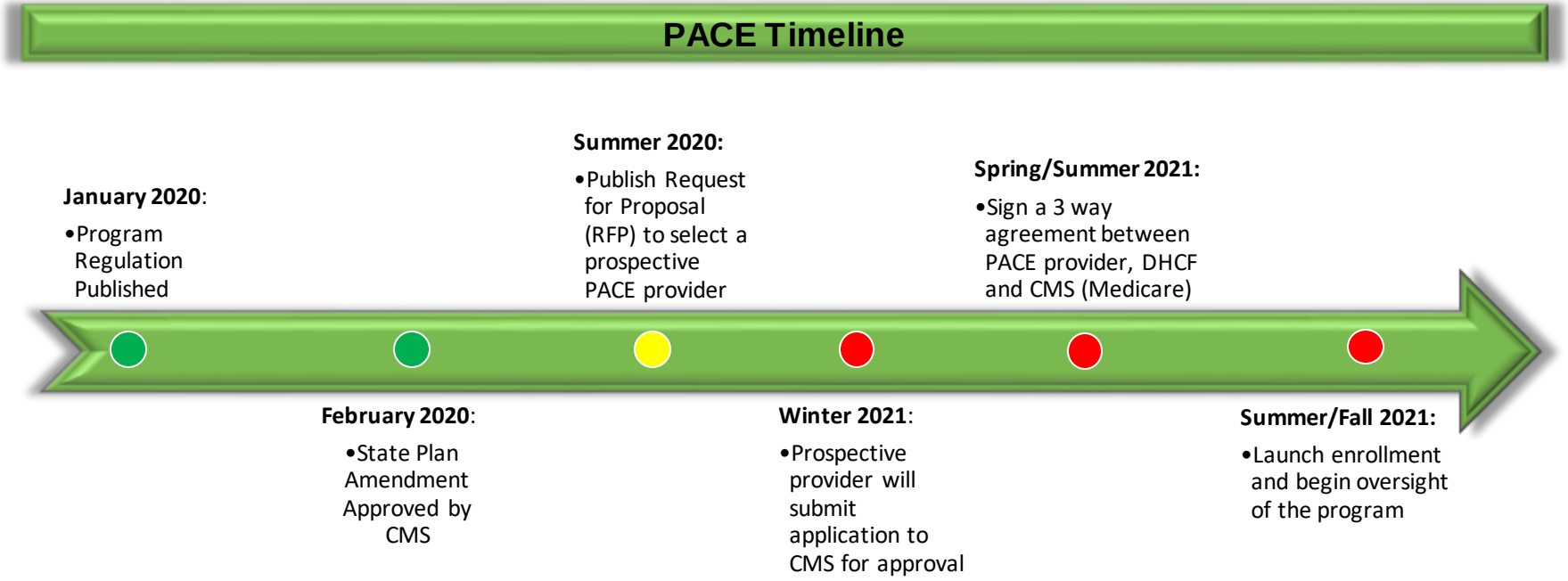
Medicaid LTSS Institutional and Waiver Spending, FY 2019

Service	Total Number of Recipients*	Total Service Cost	Average Cost Per Recipient
Institutional Total*	**4,385**	**$338,762,227**	**$77,255**
Nursing Facility	4,072	$246,746,081	$60,596
ICF/IDD	316	$92,016,145	$291,190
HCBS Total*	**8,679**	**$578,580,395**	**$66,664**
State Plan PCA	5,726	$210,991,666	$36,848
EPD Waiver	3,960	$109,255,421	$27,590
IDD Waiver	1,837	$258,333,309	$140,628
Institutional and HCBS Total*	**12,559**	**$917,342,622**	**$73,043**

- **Source:** DHCF Medicaid Management Information System (MMIS) data extracted in February 2020 for claims with FY 2019 dates of service.
- **Note:** Numbers reflect individuals ever receiving a given service during FY 2019.
- ICF = intermediate care facility; IDD = Intellectual and Developmental Disabilities; HCBS = home and community-based services; LTSS = long-term services and supports; PCA = personal care assistance; EPD = Elderly and Persons with Physical Disabilities.
- * The sum of recipients across services exceeds these unduplicated totals because some individuals receive more than one of the service types shown.

DHCF Continues Efforts to Establish the Program of All-Inclusive Care for the Elderly (PACE)

- PACE is a nationally recognized model of care integrating Medicare and Medicaid benefits for some of the District's highest-need beneficiaries: individuals 55+ meeting nursing facility level of care
- DHCF has made significant strides toward successful implementation of PACE in the District this year, including



The District Plans to Expand its D-SNP Program to Improve Alignment and Service Integration for Dual Eligibles

- Approximately 34,000 of DHCF's enrolled participants are dually eligible for both the Medicare program and Medicaid:
  - 23,000 individuals are "full duals" enrolled in both Medicare and full Medicaid
  - 11,000 individuals are "QMB only" enrolled in Medicare with some financial assistance paying Medicare cost-sharing from the Medicaid program

- While most District duals access Medicare benefits through fee-for-service Medicare, about a third of these individuals (more than 11,000) are enrolled in special Medicare Advantage plans designed to improve Medicare-Medicaid coordination

- The District must increase coordination efforts to comply with new federal Medicare-Medicaid alignment requirements, including by implementing a highly integrated dual eligible special needs plan (HIDE SNP) program in CY 2022. The HIDE SNP will:
  - Offer enhanced care management for many who now lack access to care management
  - Improve coordination of benefits and reduce duplication of services between payers
  - Simplify and streamline navigation of services for beneficiaries and their families and caregivers

Long-Term Care System Reforms Have Led to Increased Operational Efficiency

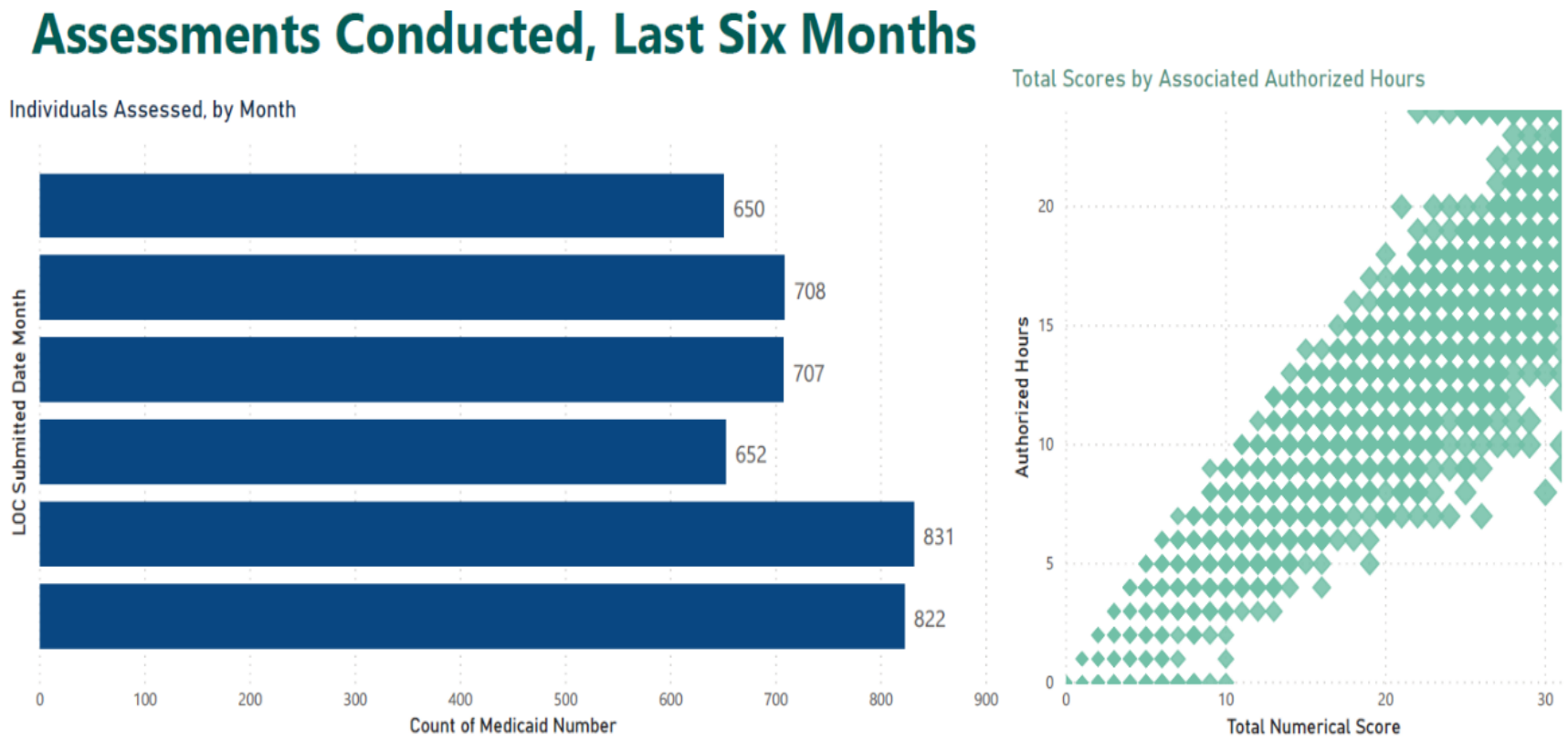
- The July 2018 implementation of a new assessment instrument, cloud-based clinical case management system, and new third-party assessment contract offer DHCF exponential dividends in visibility into program oversight and operations, population management, and program integrity

- In collaboration with the Medicaid Data Warehouse and other teams, DHCF's Long Term Care Administration (LTCA) can now report in real-time on:
  - ❑ Processing of Medicaid eligibility for long-term care populations
  - ❑ Requests for and completion of comprehensive assessments for long-term services and supports (LTSS) users and any applicants for services
  - ❑ Completion of person-centered service plans, identification of and authorization of appropriate service arrays, and updates to service plans as needs change
  - ❑ Reporting and management of serious incidents
  - ❑ Provider performance and implementation of system improvements

Systemic Improvements Supported By Expanded Analytic and Reporting Capacity

Assessment Completion

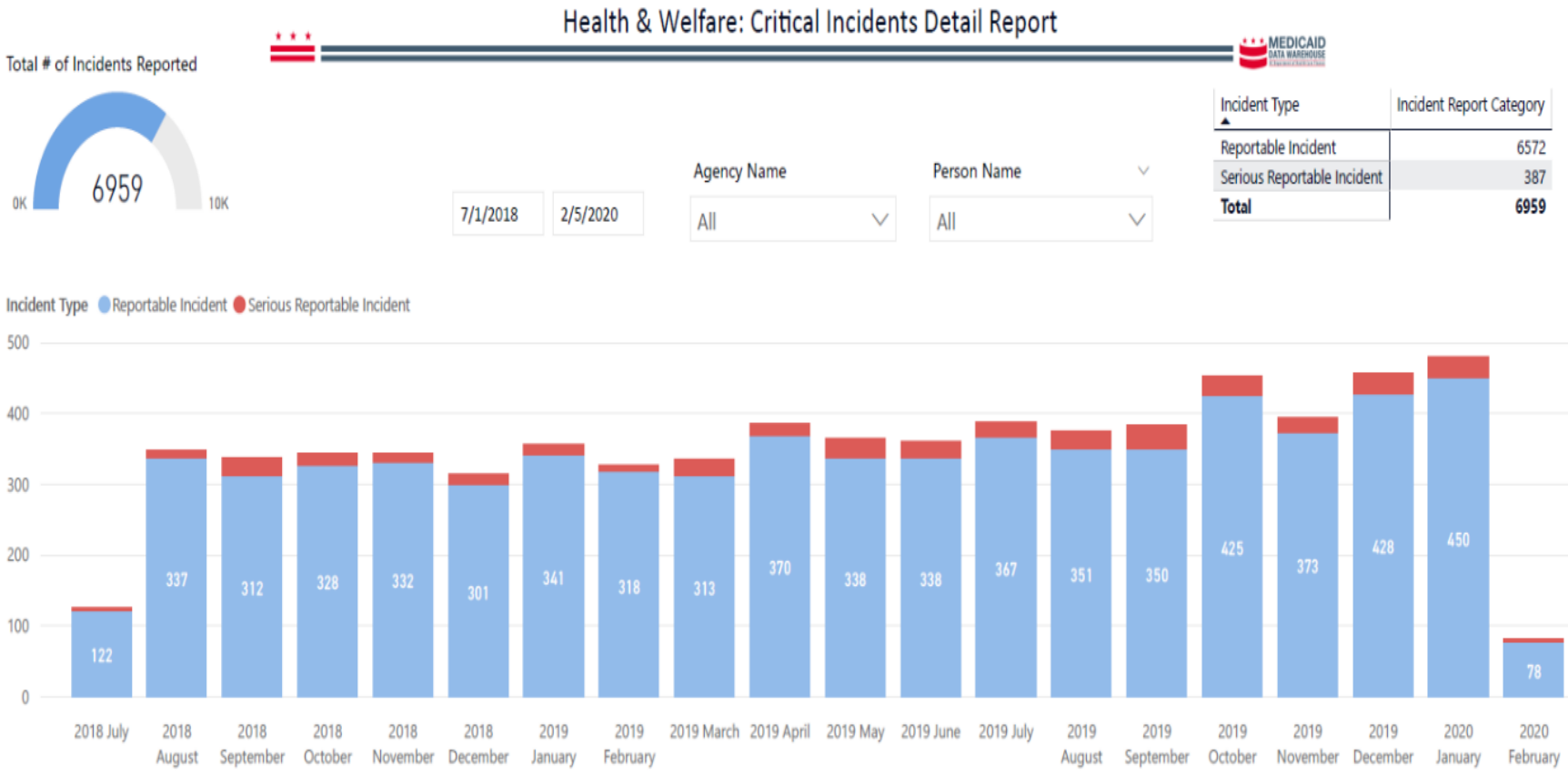
Requests for and completion of comprehensive assessments for LTSS users and new applicants for services



Systemic Improvements Supported By Expanded Analytic and Reporting Capacity

Incident Management

Reporting and management of reportable and serious reportable incidents among home and community-based LTSS users

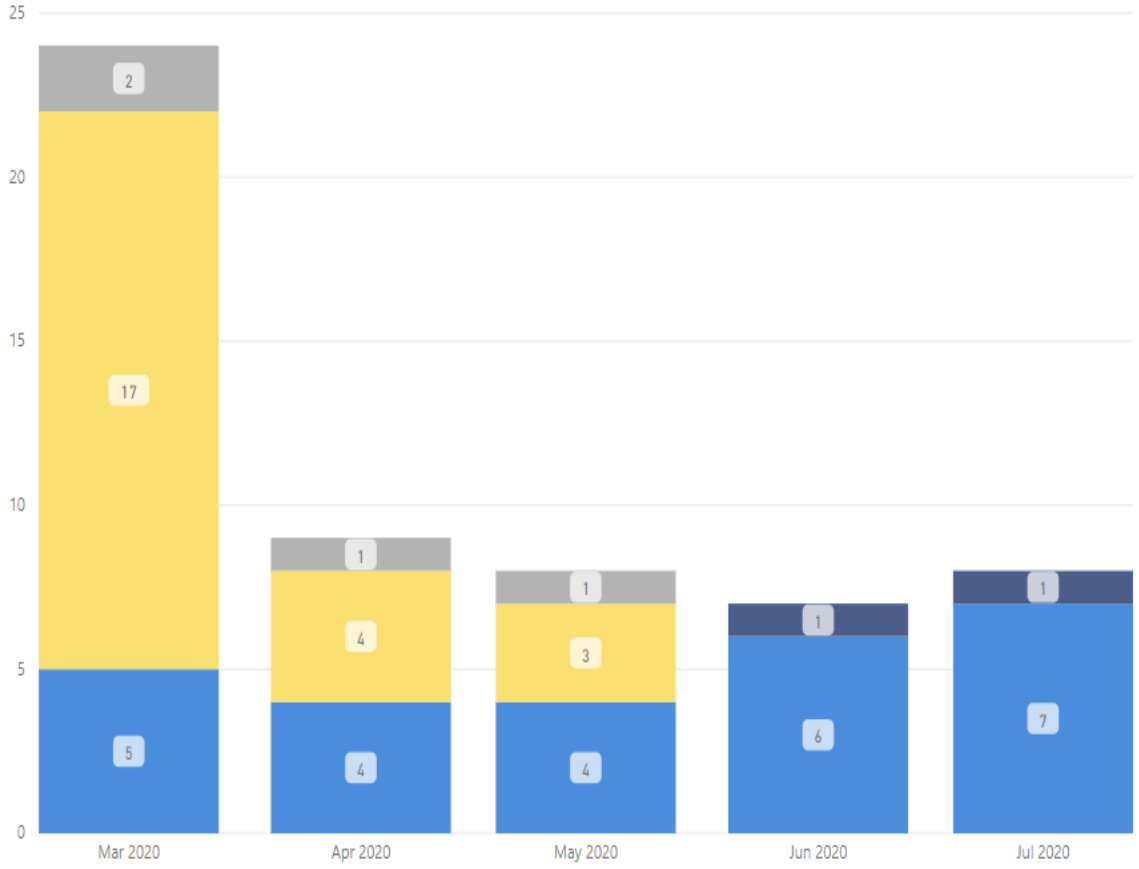


Enhanced Reporting Has Facilitated Service Delivery Management During the Public Health Emergency

Monitoring Application and Case Management

Monitoring preservation of eligibility and access to Medicaid services

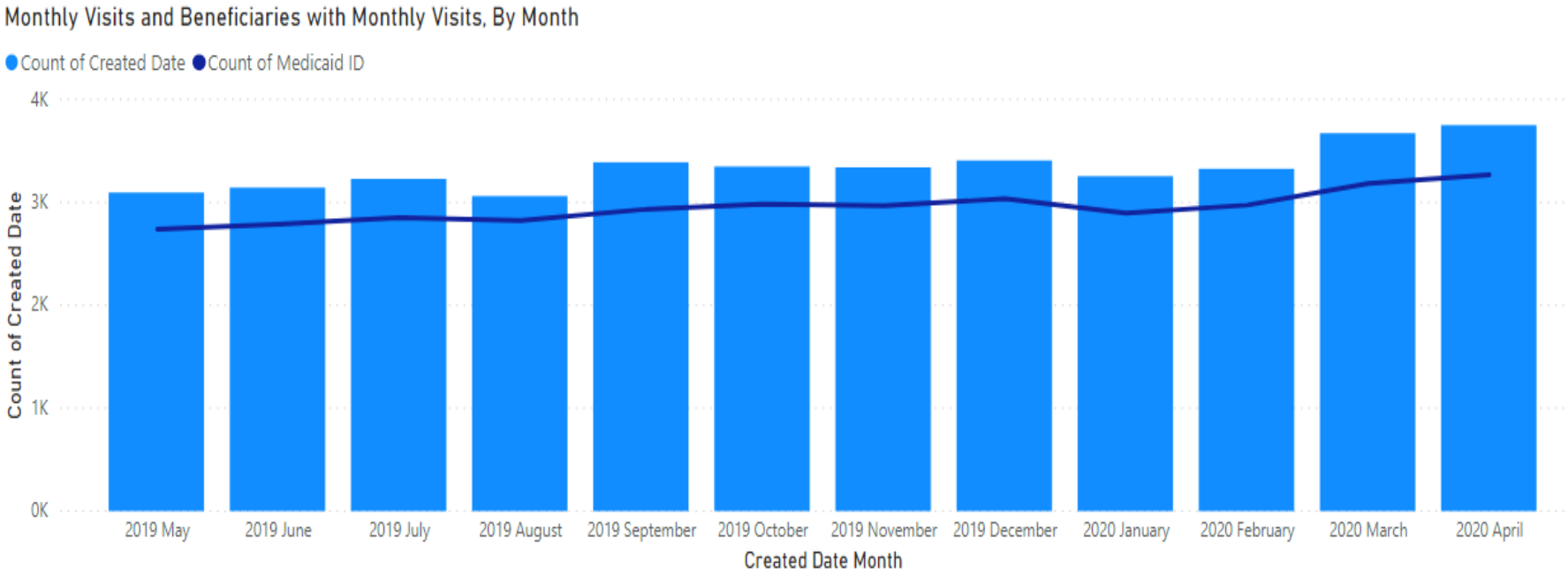
Assigned CM Agency	Count of Application
	10
ABSOLUTE HEALTHCARE RESOURCES LLC	2
ADVOQUATE HEALTH SERVICES, LLC	4
ALTASOURCE MANAGEMENT COMPANY LLC	2
ANNA HEALTHCARE, INC	2
AUTUMNLEAF GROUP, INC.	1
CARE CONCEPTS LLC.	2
CONTEMPORARY FAMILY SERVICES	1
EAST RIVER FAMILY STRENGTHENING CIL	1
FAMILY AND HEALTHCARE SOLUTIONS INC	11
JAMALL NURSING SERVICES UNLIMITED	2
K C COMMUNITY SERVICES INC	1
PREMIER SUPPORT SERVICES INC	1
PRESTIGE HEALTHCARE RESOURCES, INC.	4
PROGRESSIVE HEALTHCARE INC.	4
THE FAMILY WELLNESS CENTER,INC	5
ULTIMATE HOME HEALTH SERVICES LLC	4
VTM HEALTH SERVICES, LLC	4
Total	**61**



Tracking Application Status

Ability to Monitor Patient Care

Tracking increased care coordination visits by EPD waiver case managers (below); also monitoring use of enhanced rates and known contact between exposed aides and beneficiaries



Planned Changes to EPD Waiver Will Improve Operations and Program Integrity

- DHCF is proposing (subject to CMS approval) several changes to its 1915(c) waiver program for the Elderly and Physically Disabled; these include:
  - Deduplication of certain services already covered under the Medicaid State Plan
  - Modernization and expansion of assistive technology, including coverage of Personal Emergency Response System (PERS) benefits and medication management devices
  - Delinking waiver and State Plan personal care aide (PCA) benefits to establish a 16 hour limit on PCA services in the waiver

- These will enable the District to realize several key benefits:
  - More person-centered – and less "one size fits all" – care planning: currently 90% of waiver services spending is dedicated to one single overutilized service (personal care aide services)
  - More efficient operation of services like PCA and in-home skilled benefits: this will streamline authorizations, reporting, and oversight
  - Maintenance of cost-neutral status in the waiver, a Federal precondition of operating a waiver

New and Evolving Drug Treatments Affect Pharmacy Costs for DHCF Beneficiaries

- Recent examples of emerging drugs that have impacted pharmacy costs are treatments for hemophilia, enzyme deficiency, oncology, cystic fibrosis, Hepatitis C, and HIV

- **FFS pharmacy**
  - Increase due mostly to shift to new HIV drugs
  - Hepatitis C costs are decreasing

FFS	FY 2017	FY 2018	FY 2019
Pharmacy total	$226,755,195	$215,283,645	$216,218,684

- **MCO pharmacy**
  - Pharmacy per member per month (PMPM) trend is driven by unit cost and utilization increases
  - Growth is particularly high for Alliance adults

MCO population	Pharmacy PMPM trend in FY 2021 rate development
Medicaid children	+1.0%
Medicaid adults	+3.5%
Alliance adults	+8.5%

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  - *Pharmacy*
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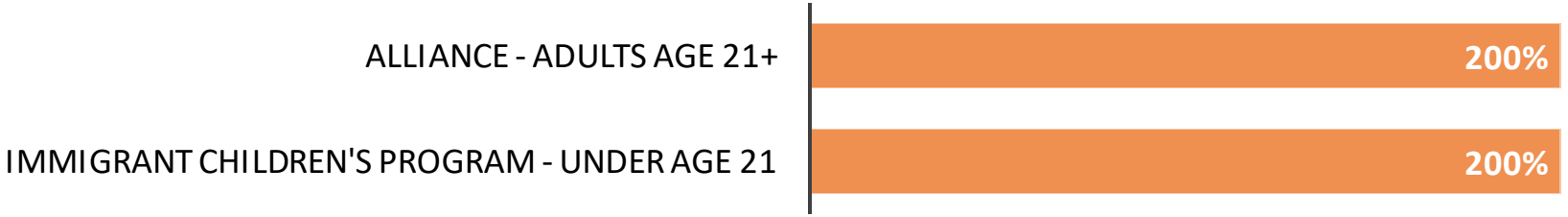
DC Healthcare Alliance and the Immigrant Children's Program Use Local Funds to Cover Low-Income Noncitizens Who Are Ineligible for Medicaid

DC Alliance and ICP Income Eligibility by Federal Poverty Level (FPL)

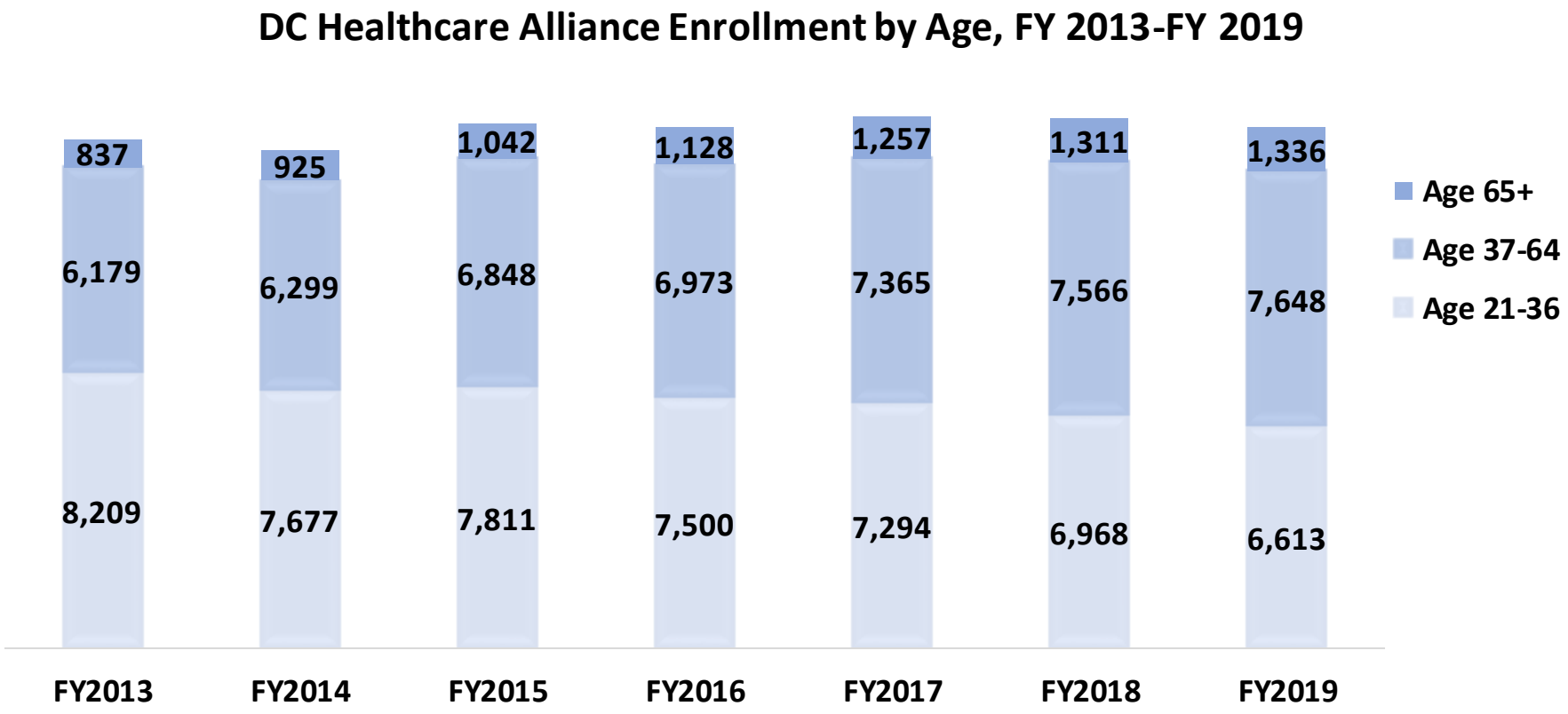


Key facts about Alliance/ICP:

- Alliance beneficiaries accounted for 5% of DHCF program enrollment in FY 2019; ICP beneficiaries accounted for about 1%
- Most Alliance and ICP beneficiaries live in Wards 1 and 4, compared to Wards 7 and 8 for Medicaid beneficiaries
- Noncitizens are more likely to be uninsured than citizens; however, the District's 2018 uninsured rate for noncitizens (10.1%) was less than a third of the national rate (33.1%)*

- **Note:** Low-income is 200% FPL, which is about $25,520 for an individual or $52,400 for a family of four.
- * **Source/Note:** Data extracted from U.S. Census Bureau, 2018 American Community Survey 1-year estimates. Rates reflect the civilian noninstitutionalized population.

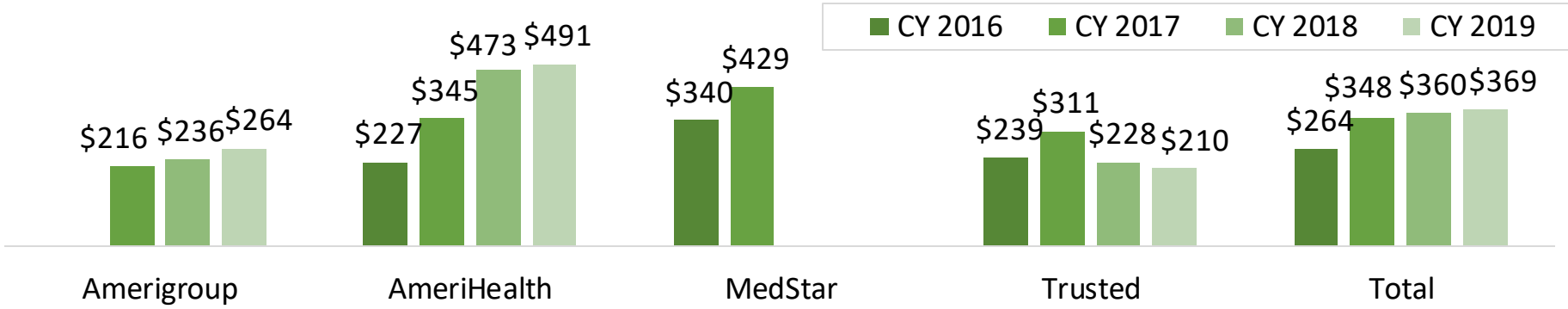
Alliance Population Age 37+ Has Grown While Younger Population Has Fallen



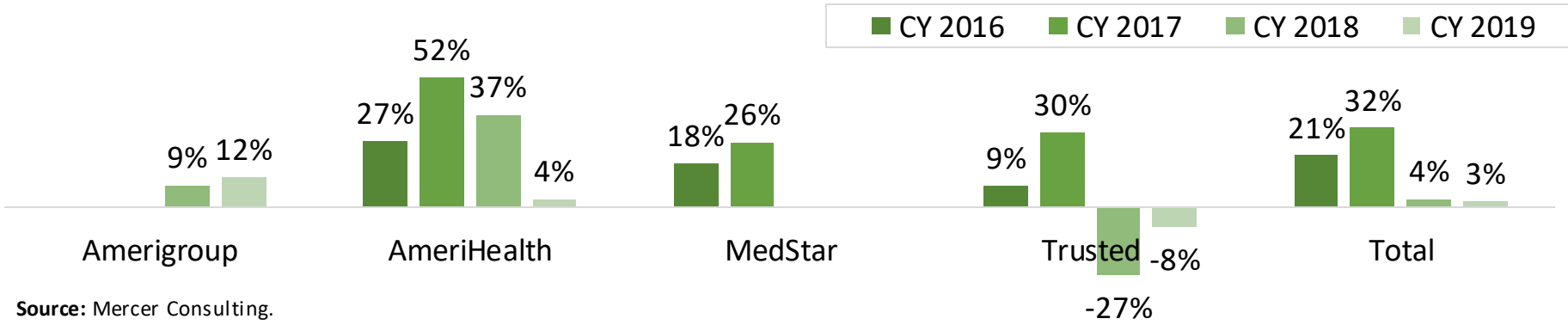
- **Source:** Medicaid data reported from DHCF's Medicaid Management Information System (MMIS) for FY 2019.
- **Note:** Data reflects average monthly enrollment. Age 37 corresponds with a cutoff used to determine managed care rates.

Alliance Cost Per Beneficiary Has Grown Substantially and Differs by Plan

Alliance Adult Medical Expenses Per Member Per Month (PMPM)



Alliance Adult Medical Expenses PMPM Percentage Growth Over Prior Year



- **Source:** Mercer Consulting.
- **Note:** CY 2015 incurred claims paid as of January 31, 2017. CY 2016 incurred claims paid as of January 31, 2018. Pharmacy benefits were carved in to the Alliance covered benefits in July 2016. CY 2017 incurred claims paid as of January 31, 2018 for MedStar and as of January 31, 2019 for Amerigroup, AmeriHealth, and Trusted. MedStar was in contract from January 2017-September 2017 and Amerigroup from October 2017-December 2017. CY 2018-2019 incurred claims paid as of January 31, 2020. All figures shown include IBNR, estimated based on historical payment lags.

Pharmacy Remains a Driver of Alliance Cost Per Beneficiary Trends

- Cost per beneficiary trends for Alliance populations have exceeded those of the District's Medicaid managed care populations
- Alliance per member per month (PMPM) trend drivers for FY 2021 differ by service category
  - PMPM for outpatient hospital and emergency room services driven by unit cost increases
  - PMPM for physician and pharmacy driven by both utilization and unit costs
- Alliance PMPM trends have varied over time
  - Higher PMPM trends continue to be observed for prescription drugs, including oncology and rheumatoid treatments
  - Unit cost and utilization growth for other services has leveled out in recent experience

Alliance Cost Per Beneficiary Trends in FY 2021 Rate Development

Selected service categories	PMPM trend
Pharmacy	+8.5%
Physician	+2.0%
Nursing facility	+2.0%
FQHC	+1.5%
Hospital and emergency room	+1.0%
Dental	0.0%
All services	+2.9%

- **Source:** Mercer, "Alliance Program FFY 2020 Capitation Rate Development," June 7, 2019; Mercer, "Final Rate Report for the DCHFP and Alliance Programs," January 31, 2020.

Nearly 4 in 10 Alliance Beneficiaries Losing Coverage Re-Enroll in Medicaid or Alliance Within a Year

Alliance Enrollment Analysis, FY 2017-FY 2019

Fiscal Year	Total Alliance Beneficiaries Ever Enrolled	Total Terminated	Total Terminated and Re-enrolled in Alliance Within 1 Year	Total Terminated and Re-enrolled in Medicaid Within 1 Year	Net Terminated and Re-Enrolled in Medicaid or Alliance Within 1 Year (% of Total Terminated)
2017	22,178	7,742	2,906	182	3,088 (40%)
2018	21,458	7,762	3,016	147	3,163(41%)
2019	21,143	7,345	2,487	80	2,567 (35%)

- **Source:** DC Medicaid Management Information System (MMIS) data extracted in March 2020.
- **Note:** Beneficiaries who disenrolled from the Alliance program but immediately enrolled in the Medicaid program are not included in the count of disenrolled beneficiaries. Re-enrollment figures for FY 2019 are lower in part because 12 months has not yet elapsed from the end of the fiscal year.

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- ❑ Conclusion

DHCF's Role During the Public Health Emergency

- Ensure **access to coronavirus testing and treatment** for Medicaid/Alliance and eligible beneficiaries

- Ensure **ongoing access to care** for beneficiaries in the event of an emergency

- Support Medicaid **providers** in providing **testing and treatment** for coronavirus, and in continuing **ongoing care delivery operations**

Changes Related to the PHE Since April MCAC Meeting

- **CMS**
  - HHS Secretary Azar extended the Federal PHE for an additional 90 days - new prospective end date is 7/25/20
  - DHCF Submitted CY18 & CY19 Medicaid claims data by provider to CMS to utilize in CARES funding distribution
- **Eligibility**
  - Beneficiaries whose coverage would have expired in July 2020 extended for an additional eligibility period
  - Created and disseminated eligibility brochure
  - Published guidance on treatment of stimulus and enhanced UI payments
- **Communication & Outreach**
  - NEW DHCF COVID Webpages for beneficiaries & providers
    - https://dhcf.dc.gov/page/medicaid-covid-19-updates
  - Transmittals Published
    - LTC Telephonic Signature Process; COVID Testing for Hospitals; Updated COVID Testing Codes for Labs; Teledenistry
  - COVID Outreach Provider Solicitation

Additional Changes Related to the PHE Still Under Consideration

- **Enhanced Financial Support To Medicaid Providers**
  - Rate changes for FQHCs
  - Rate change for behavioral health providers
- **1115 Waiver Considerations**

- **Requests Pending with CMS**
  - Disaster SPA
  - Authority to allow Medicaid pay for inmate care needed for more than 24 hours if delivered in the jail/outside of an inpatient setting

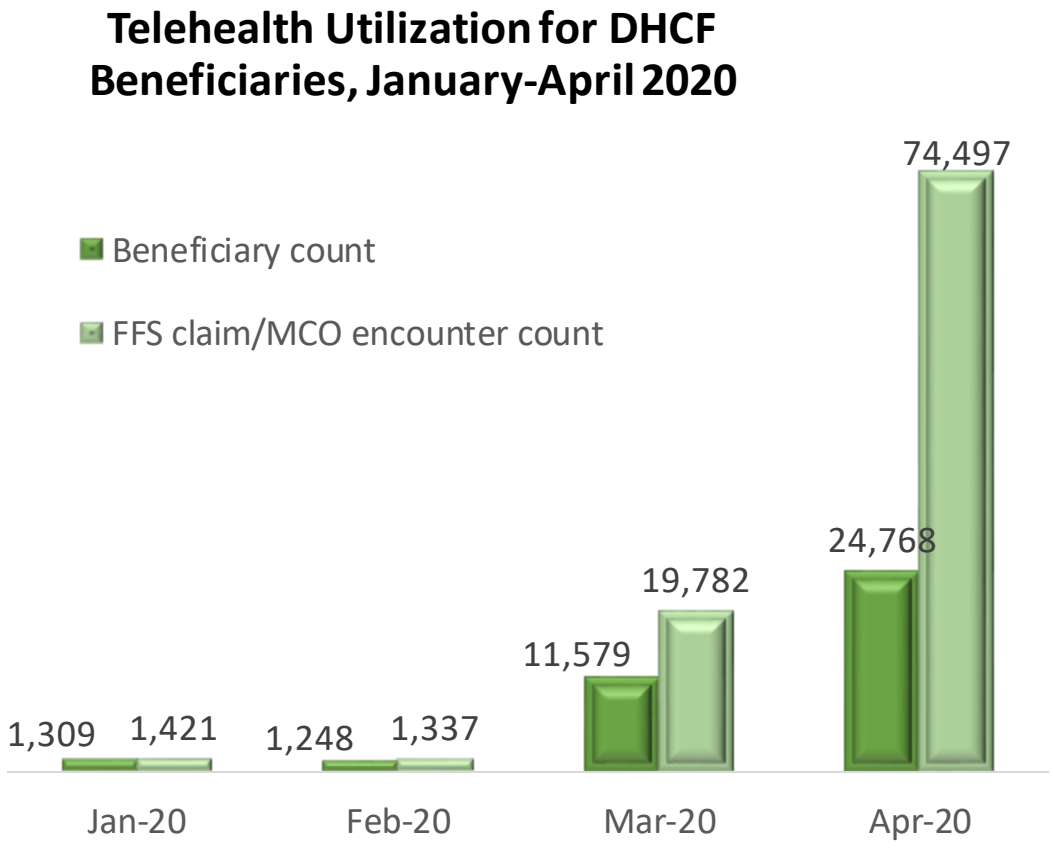
COVID-19 Policies and Spike in Unemployment May Substantially Increase Enrollment in Medicaid and Other DHCF Programs

- Increase in unemployment – nearly 62,000 new claims in DC between March 16 and April 12 – means that more people will be eligible for Medicaid and other DHCF programs

- CARES Act requires maintenance of effort on eligibility policies and on enrollment for duration of federal PHE, in exchange for 6.2% FMAP increase

- District has eased certain eligibility and enrollment policies (e.g., removal of face-to-face requirement for Alliance, allowing expanded self-attestation for all DHCF programs) and HBX has opened a special open enrollment period, which may encourage or make it easier for individuals to enroll in DHCF coverage

Sharp Rise in DHCF Telehealth Claims in Response to the COVID-19 Public Health Emergency



Source: DHCF Medicaid Management Information System (MMIS) data extracted May 14, 2020.

Note: Includes Medicaid, Alliance, and ICP. Reflects unique counts of beneficiaries and paid FFS claims/MCO encounters by date of service. Due to claims lag, counts for each month are likely to be higher when run at a future date.

During April 2020:

- Nearly 25,000 DHCF beneficiaries had a telehealth visit in April
- 95% of paid telehealth claims were for services delivered to the patient's home
- Behavioral health services accounted for 72% of paid telehealth claims

Significant Medicaid and Alliance Enrollment and Eligibility Changes Occurred to Make Care Accessible

Key Changes In Effect

	Medicaid	Alliance	ICP
Current Beneficiaries	• Eligibility automatically extended • Requirement to report changes is waived	• Eligibility automatically extended • Requirement to report changes is waived • No face-to-face interview	• Eligibility automatically extended • Requirement to report changes is waived

New Enrollees	• Allowing self-attestation of verification requirements except:
	  • U.S. citizenship and eligible immigration status for all;
	  • Level of care requirements for long term care and Katie Beckett/TEFFRA
		• Face-to-face interview is waived
		• Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status
			• Allowing self-attestation of verification requirements except U.S. citizenship and eligible immigration status

Administrative/Operational Changes:

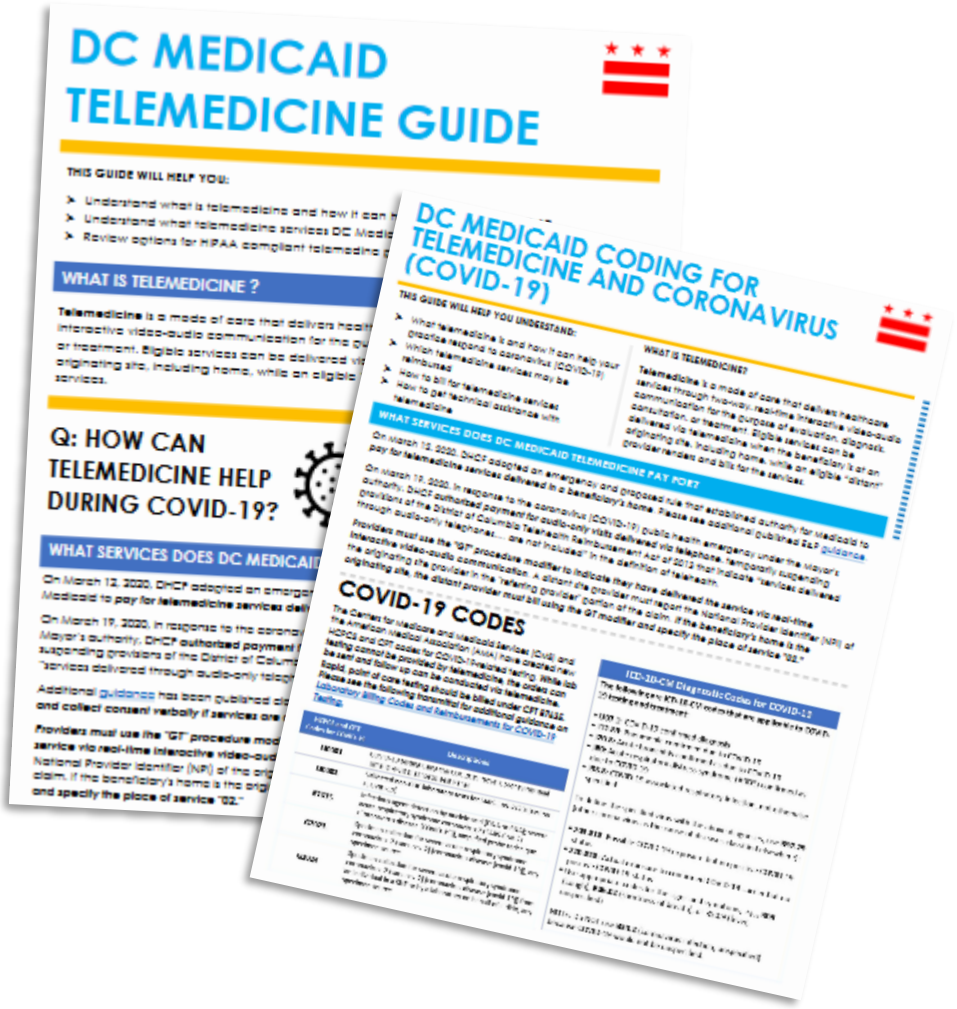
- DHCF may exercise extended time to make eligibility determinations
- DHCF is not required to act on any changes in circumstance that might affect eligibility

- **COVID-19 Testing**
  - Added seven testing codes to the fee schedule to allow laboratories to bill Medicaid for COVID-19 testing
  - Added two testing codes for coronavirus antibody tests

- **Telemedicine**
  - Beneficiary's home is now an allowable place of service (to be made permanent via rulemaking)
  - Increase in telemedicine visits since expansion

Telemedicine Policy Changes in Response to COVID-19

- Services may be rendered via telemedicine if
  - Already included in the DHCF fee schedule within broad categories specified in the DHCF telemedicine rule
  - Can be delivered at the standard of care
- Home as an originating site is allowable
- Providers have flexibility to work remotely
- Authorized during the public health emergency:
  - Audio-only services
  - Consent may be documented in clinical notes
  - Flexibilities on using services non-HIPAA compliant technology (per HHS)



https://dhcf.dc.gov/page/telemedicine

More Changes To Support Ease Of Access To Benefits And Provider Flexibility

- **Pharmacy**
  - Prescribers may write and pharmacies may dispense a 90-day supply of maintenance medications
  - Beneficiaries may request up to a 30-day advanced supply of non-maintenance medications
- **Prior Authorizations**
  - Temporarily suspending certain Medicaid fee-for-service prior authorization requirements
- **Provider Enrollment & Revalidation**
  - Temporarily waive application fee
  - Temporarily waive criminal background check
  - Temporarily waiver or allow provider site visits via telephone
  - Temporarily waive in-state licensure requirements
  - Temporarily cease provider revalidation process

Enhanced Flexibility For Medicaid Providers

- **Medicaid State Plan Services:**
  - **Adult Day Health Program (ADHP)**
    - Temporarily expand 1915(I) HCBS Adult Day Health Program (AHDP) services to include the following services
      - Wellness checks provided via telemedicine
      - Therapeutic activities conducted individually or in groups via telemedicine
      - Nursing services conducted individually via telemedicine
      - Meal or food delivery to the beneficiary's permanent or temporary residence
  - **Personal Care Aides & Skilled Nursing (RN/LPN)**
    - Temporarily allow vendor to conduct level of care (LOC) assessments via video/phone
    - Initial request for LOC assessment and request for re-assessment will not require physician or APRN authorization for the duration of the emergency period.
  - **My Health GPS**
    - Allow providers to complete the required initial/annual biopsychosocial assessment via telemedicine
    - Eliminate acuity tiers, face-to-face requirements, and update care team staffing requirements.

Enhanced Flexibility For Long-Term Care Providers

- **Medicaid Long Term Services and Supports:**
  - Temporarily allow the following services to be conducted electronically, in accordance with HIPAA requirements:
    - the ISP development and review
    - Service Coordinators to monitor services through a minimum of monthly contact
    - Case managers to conduct person-centered service plan (PCSP) initial and annual meetings
    - In-Home and Community Support, Companion, and Behavioral Support services
    - Level of Care (LOC) assessments
    - Training on a person's Individual Support Plan (ISP), Health Management Care Plan, Behavior Support Plan, Individual Program Plan (IPP), Personal Emergency Preparedness Plan (PEP), Nutrition, Specialized Dining Techniques, Transfer and Mobility Procedures, Seizure Disorders/Protocols, Medication/Sides Effects, etc.
    - Support broker visits
    - Adult Day Health Program (ADHP) services

Enhanced Flexibility For Long-Term Care Providers (continued)

- **Medicaid Long Term Services and Supports (EPD only):**
  - **Services My Way**
    - Temporarily allow payment for participant-directed services provided by family members of EPD waiver beneficiaries currently enrolled in the *Services My Way*
    - Temporarily modify provider qualifications to extend the CPR and First Aid training and certification deadline for *Service My Way* participant-directed workers (PDWs) with current CPR and First Aid
  - **Level of Care**
    - Temporarily allow vendor to conduct LOC assessments via video/phone
    - Initial request for LOC assessment and request for re-assessment will not require physician or APRN authorization for the duration of the emergency period.

Enhanced Financial Support To Medicaid Providers

- **Medicaid State Plan and Waiver Services**
  - **Personal Care Aides & Skilled Nursing (RN/LPN)**
    - Enhanced rate of time and ½ for staff working with a person medically quarantined
    - Overtime Pay
    - Reimbursement for cost incurred for hiring staff thru a staffing agency
  - **Adult Day Health Programs (ADHP)**
    - 75% of per diem rate when conducting Wellness checks provided via telemedicine
    - 100% of per diem rate to providers who 1) conduct a wellness check; and 2) provide one additional service in the same day
    - 25% of per diem rate retainer payment when closed to prevent the spread of COVID-19
  - **Nursing Homes**
    - Increase reimbursement by 20% to all facility rate components

Enhanced Financial Support To Medicaid Providers (continued)

- **Medicaid State Plan and Waiver Services**
  - **COVID-19 Testing**
    - Increase reimbursement of laboratory services related to the diagnostic testing of COVID-19 up to Medicare rate.
  - **ICF/IID**
    - Increase reimbursement rates by a 15% increase to the Direct Service cost center
      - Results in increases in other components of the per-diem rate including all other healthcare services, administration, active treatment, and Stevie Sellow's cost centers.
  - **My Health GPS**
    - A new PMPM rate - quarterly reimbursement rate increased to $304.98
    - Delay implementation of pay-for-performance and quality reporting requirements until fiscal year 2022

Enhanced Financial Support To Medicaid Providers (continued)

- **Medicaid State Plan and Waiver Services**
  - **IDD Day Programs**
    - Retainer payments for authorized day program services providers if a participant was unable to attend day program services as a result of the public health emergency
  - **IDD Services Providers**
    - Enhanced rate of time and ½ for staff working with a person medically quarantined
    - Overtime Pay
    - Reimbursement for cost incurred for hiring staff thru a staffing agency

Enhanced Flexibility For IDD - Long-Term Care Providers

- **Medicaid Long Term Services and Supports (IDD only):**
  - Services may exceed 20% limitation of telehealth up to 100%
  - Temporarily expand settings for companion & respite services
  - Modify provider qualifications
  - Modify process for level of care evaluations
  - Modify person-centered plan development
  - Modify incident reporting
  - Postpone agency certification reviews
  - Allow staffing ratios to be modified
  - Participants that require hospitalization due to a diagnosis of COVID19 may receive residential habilitation and/or in-home and companion services in a hospital setting up to 30 days

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Looking Ahead to June

- ❑ Continued Efforts in Response to PHE
- ❑ Data Dashboard
- ❑ FFS Transition to Managed Care:
  - Communication and Outreach

Keep up with DC Medicaid & Alliance Programs and get involved with DHCF!

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Visit https://dhcf.dc.gov/ for the latest on

- Response to covid-19
- DC Health Care Reform

Visit https://coronavirus.dc.gov for the latest on District-wide efforts related to covid-19

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

MURIEL BOWSER, MAYOR

FY 2021 PROPOSED BUDGET AND FINANCIAL PLAN

#DCHOPE