General Questions

1. **Please provide the current organizational chart for the agency, with the information to the cost center level. In addition, please identify the number of full-time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and cost center. If applicable, please provide a narrative explanation of any organizational changes made during FY 2023 and FY 2024, to date.**

Please see Attachment 1-A for the current organizational chart along with the number of full-time equivalents (FTEs) at each organizational level. Attachment 1-B reflects the employee responsible for the management of each program and cost center.

DHCF's Division of Clinician, Pharmaceutical, and Acute Provider Services (CPAPs) division is currently housed in the agency's Health Care Delivery Management Administration and is responsible for managing clinical and pharmaceutical policy for both the Managed Care and Fee-For-Service programs, and consults on utilization reviews, clinical criteria, and prior authorization. The DHCF Medical Director reports to the Medicaid Director and has the responsibility for the medical administration of the District's Medicaid program, which includes overseeing clinical program and benefit design as well as utilization management. The Medical Director and CPAPS currently work side-by-side and collaborate on a daily basis collaborate as their functions are closely aligned. In FY24, CPAPS will move to the office of the Medical Director, who will have supervisory oversight of its functions. This change in our organizational structure aligns the important work that our clinical services division performs with the clinical functions of the Medical Director. It will also provide organizational alignment of these two functions to increase the efficiency and quality of clinical services oversight in the District's Medicaid program.

The Department of Human Services' (DHS) Medicaid Branch moved to DHCF at the beginning of FY24. DHCF and DHS are coordinating to ensure the Economic Security Administration's Medicaid Branch processing functions for Long Term Care Services and Supports (i.e., initial applications, renewals and, change of circumstances) continue in a manner that is efficient and responsive to the needs of District residents and Medicaid providers.

2. **Please describe the agency's procedures for investigating allegations of sexual harassment or misconduct committed by or against its employees.**

DHCF follows the Mayor's Order 2023-131. Accordingly, the agency's procedures consist of the Sexual Harassment Officer (SHO) gathering information, conducting a thorough investigation, and reviewing the factual basis of the claim. In consultation with the Office of the General Counsel, the SHO prepares the investigative report with recommended determination and next steps. The SHO transmits the investigative report to the Agency Director or designee for shared awareness.

a. List and describe any allegations received by the agency in FY 2023 and FY 2024, to date, and whether or not those allegations were resolved, and if resolution resulted in a settlement.

DHCF did not receive any allegations in FY 2023 and FY 2024, to date.

b. Provide the amount for each instance in which the resolution resulted in a settlement.

Not applicable; please see the response above.

c. Has DHCF identified a primary and alternative sexual harassment officer ("SHO") as required by Mayor's Order 2023-131 ("Sexual Harassment Order"). If no, why not? If yes, please provide the names of the primary and alternative SHOs.

DHCF's primary SHO is Felicia Rothchild, Supervisory Human Resources Specialist. The alternative SHO is Portia Shorter, Human Resources Officer.

3. How many performance evaluations did the agency complete in FY 2023?

The responses below refer to performance period October 1, 2022 through September 30, 2023. DHCF completed 197 (81.74%) performance evaluations in FY 2023.

a. How many performance improvements plans were issued in FY 2023?

DHCF did not issue any performance improvement plans in FY 2023.

b. How many employees have submitted SMART Goals or other relevant workplans in FY 2024?

As practice, employee SMART Goals (Individual Performance Plans) are submitted by the immediate supervisor. DHCF submitted 227 (83.15%) Individual Performance Plans in FY 2024.

c. For each question, provide the total number and the percentage of total employees.

Please see the response above.

4. Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2023 and FY 2024, to date. In addition, please describe any variance between the amount budgeted and actually spent.

a. At the agency level, please provide information broken out by source of funds and by Account Group and Account;

b. At the program level, please provide the information broken out by source of funds and by Account Group and Account; and,
c. At the Cost Center level, please provide the information broken out by source of funds and by Account Group.

Please see Attachment 4.

5. Please provide a complete accounting of all interagency projects that the agency was a buyer or seller for during FY 2023 and FY 2024, to date. For each, please provide a narrative description as to the purpose of the project and which programs, activities, and services within the agency the project affected.

Please see Attachment 5.

6. Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2023 and FY 2024, to date.
a. Provide a complete accounting of all reprogrammings within the agency in FY 2023 and FY 2024 to date.
b. For each reprogramming, please provide a narrative description as to the purpose of the transfer and which programs, cost centers, account groups and accounts within the agency the reprogramming affected.

Please see Attachment 6.

7. **Specifically regarding REPROG25-0077, $9.9 million was reprogrammed from DHCF at the end of FY 2023, of which $4.7 million was reprogrammed from FFS-Medicaid. The explanation given was that DHCF's "surplus is due to a one-time savings in general non-personnel categories and hiring delays." Please provide a detailed narrative explanation of these one-time savings, contributing factors to the hiring delays, enrollment projections compared to actual enrollment data, and any other details regarding the availability of funds in this reprogramming. Include a break down by program, cost-center, account, award, and task where applicable.**

This reprogramming was based on DHCF's FY 2023 3rd quarter Financial Review Process (FRP), which is the quarterly tracking of budgeted spending versus a combination of actual experience and forecast for the remainder of the fiscal year. Please see "Attachment 1 to Q7" for a copy of the FRP. In the column labeled "(Over)/Under Variance" on page 2 of the PDF, one can see the projected local surplus of $9,932,479. At a high level, the sources of the reprogrammed funds are as follows – in millions.

Disproportionate Share Hospital Payments	$4.7
Personal Services	$2.3
Contracts	$1.9
Equipment & Other Services	$1.0

TOTAL **$9.9**

Disproportionate Share Hospital Payments

The largest component of the $9.9 million surplus is $4,714,164 from Disproportionate Share Hospital (DSH) Payments. These are payments to qualifying hospitals to reimburse them for uncompensated care costs associated with unreimbursed Medicaid cost and the cost of caring for the uninsured. When we formulated the FY 2023 budget, we estimated DSH payments would be $64.4 million. In addition, because the FY 2023 final budget assumed the Public Health Emergency would end in July 2022, we used a Medicaid match rate of 30% local funds and 70% Medicaid grant. However, DSH disbursements are ultimately based on the DSH survey tools the qualifying DSH hospitals submit to DHCF each year. Those showed that uncompensated care costs were $56.1 million, and we had the benefit of enhanced Medicaid reimbursement at +6.2% for the first two quarters, +5% for the third quarter, and +2.5% for the fourth quarter. The combination of the reduced need and greater federal reimbursement made $4.7 million of local funding available to reprogram.

Personal Services

The Personal Services surplus of $2,338,141 was due to vacancy savings, which stems from internal hires and delays in backfilling certain positions. Internal hires allow staff to have professional growth but have the downside of creating another new vacancy that must be filled. The $2.3 million of vacancy savings fell in the following areas:

Cost Center	Cost Center Description	Amount
10001	BUDGET DIVISION	$56,410
10002	ACCOUNTING DIVISION	$55,000
70152	DCAS - PROGRAM MANAGEMENT DIVISION	$250,218
70153	PROJECT MANAGEMENT DIVISION	$176,046
70154	ORGANIZATIONAL CHANGE DIVISION	$105,263
70158	PROGRAM INTEGRITY SUPPORT DIVISION	$42,198
70159	HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	$140,000
70160	DIVISION OF MANAGED CARE	$105,078
70162	DIVISON OF QUALITY AND HEALTH OUTCOMES	$100,000
70260	HEALTH CARE OPERATIONS SUPPORT OFFICE	$75,002
70262	DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	$60,332
70264	DIVISION OF REGULATIONS & POLICY MANAGEMENT	$76,442
70266	DIVISION OF ELIGIBILITY POLICY	$468,013
70268	HIT/HIE PROJECT MANAGEMENT DIVISION	$29,421
70271	LONG TERM CARE OVERSIGHT DIVISION	$21,273

70275	OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE	$87,916
70278	SUPPORT SERVICES DIVISION - HT0	$155,628
70279	HUMAN RESOURCES DIVISION - HT0	$88,902
70488	ANALYTICS AND RESEARCH	$245,000
Grand Total		**$2,338,141**

Contracts

The contracts surplus of $1,906,971.05 was primarily due to delays in contract procurements caused by appeals to the Contracts Appeals Board. The $1.9 million in contracts funding in the reprogramming came from the following cost centers.

Cost Center	**Cost Center Description**	**Amount**
70155	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	$216,650
70160	DIVISION OF MANAGED CARE	$263,452
70261	DIVISION OF CLAIMS MANAGEMENT	$195,766
70266	DIVISION OF ELIGIBILITY POLICY	$161,774
70269	HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION	$163,223
70270	LONG TERM CARE SUPPORT SERVICES DIVISION	$547,819
70280	INFORMATION TECHNOLOGY DIVISION - HT0	$358,287
Grand Total		**$1,906,971**

The final component of the reprogramming was $973,202.95 from a combination of Other Services and Equipment. The third quarter FRP takes account of updated needs and the realities of how much can be spent when only three months of the fiscal year remain. These savings came from the following cost centers.

Cost Center	**Cost Center Description**	**Amount**
70153	PROJECT MANAGEMENT DIVISION	$6,944
70155	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	$477,030
70159	HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	$8,989
70260	HEALTH CARE OPERATIONS SUPPORT OFFICE	$10,319
70263	HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION	$4,993
70268	HIT/HIE PROJECT MANAGEMENT DIVISION	$325
70270	LONG TERM CARE SUPPORT SERVICES DIVISION	$11,648

70278	SUPPORT SERVICES DIVISION - HT0	$58,386
70279	HUMAN RESOURCES DIVISION - HT0	$100,109
70280	INFORMATION TECHNOLOGY DIVISION - HT0	$276,102
70281	CONTRACTS DIVISION	$11,711
70489	CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	$6,647
Grand Total		**$973,203**

8. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2023 and FY 2024, to date, broken down by program and cost center:

a. Grant Number/Title;
b. Approved Budget Authority;
c. Funding source.
d. Expenditures (including encumbrances and pre-encumbrances);
e. Purpose of the grant;
f. Organization or agency that provided or received the grant;
g. Grant amount;
h. Grant deliverables;
i. Grant outcomes, including grantee/subgrantee performance;
j. Any corrective actions taken or technical assistance provided;
k. Agency program and cost center supported by the grant;
l. Agency employee responsible for grant deliverables; and
m. Any grants where the funds have been reduced in FY 2024, and the amount of the reduction.

Please see Attachment 8. The current fiscal year expenditures are through the first quarter of FY24, December 31, 2023.

9. Please provide the following information for all contracts, including modifications, active during FY 2023 and FY 2024, to date, broken down by program and cost center:

a. Contract number;
b. Approved Budget Authority;
c. Funding source;
d. Expenditures (including encumbrances and pre-encumbrances); FY24
e. Purpose of the contract;
f. Name of the vendor;
g. Original contract value;
h. Modified contract value (if applicable);
i. Whether it was competitively bid or sole sourced;
j. Final deliverables for completed contracts;
k. Any corrective actions taken or technical assistance provided;

l. Agency employee(s) serving as Contract Administrator; and
m. Any grants where the funds have been reduced in FY 2024, and the amount of the reduction.

Please see Attachment 9.

10. Please provide a list of all Department of General Services work orders submitted in FY 2023 and FY 2024, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed).

Please see Attachment 10.

11. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2023 and FY 2024, to date. Please include the following:
a. Revenue source name and code;
b. Description of the program that generates the funds;
c. Cost center that the revenue in each special purpose revenue fund supports;
d. Total amount of funds generated by each source or program in FY 2023 and FY 2024, to date; and
e. FY 2023 and FY 2024, to date, expenditure of funds including reprogrammings, and the purpose of expenditure;
f. Fund balance at the end of FY 2023 and FY 2024 to date.

Please see Attachment 11.

12. For each grant lapse that occurred in FY 2023, please provide:
n. A detailed statement on why the lapse occurred;
o. Any corrective action taken by DHCF; and
p. Whether the funds were carried over into FY 2024, and how much funding was carried over.

No grant lapses occurred in FY2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY23-24 PERFORMANCE OVERSIGHT QUESTIONS

13. Please provide DHCF's capital budgets for FY 2023 and FY 2024, to date, and include the following information:
a. The amount budgeted and actually spent;
b. Impact on operating budget; and
c. Programs funded by the capital budget.

Please see Attachment 13.

14. Provide DHCF's fixed costs budget and actual dollars spent for FY 2023 and FY 2024, to date, and include the following information:

a. Source of funding;

b. Narrative explanation for changes; and

c. Steps the agency has taken to identify inefficiencies and reduce costs.

Please see Attachment 14.

15. Please provide the following information for all contract modifications made during FY 2023 and FY 2024, to date:

a. Name of the vendor;

b. Purpose of the contract;

c. DHCF employee responsible for the contract;

d. Modification term;

e. Modification cost, including budgeted amount and actual spent;

f. Narrative explanation of the reason for the modification;

g. Funding source; and

h. Whether or not the contract was competitively bid.

Please see Attachment 15.

16. Did DHCF meet the key performance indicators set forth in the performance plan for FY 2023? For any performance indicators that were not met, please provide a narrative description of why they were not met, and the corrective actions taken.

In FY 2023, DHCF had 40 performance measures, 21 key performance indicators (KPIs) and 19 workload measures.

Only one metric, "Number of referrals to the Medicaid Fraud Control Unit or other agencies for criminal or civil resolution," was unmet. The relevant DHCF section, Division of Program Integrity (DPI), prioritizes identifying fraud and referring those cases to law enforcement to ensure prosecution. The target was 14 cases, but the agency had seven referrals.

The seven investigations that were conducted and subsequent referrals involved highly complicated cases that required significant coordination between multiple agencies and extensive coordination with law enforcement post-referral. DHCF is currently reviewing the target to determine whether alterations would be appropriate.

17. What are DHCF's key performance indicators for FY 2024?

Please see Attachment 17.

18. How many grievances were filed against DHCF providers and DHCF during FY 2023? Please briefly describe the grievances filed and DHCF's response. How many of these grievances did DHCF find in favor of the beneficiary?

In FY2023, the Office of the Health Care Ombudsman and Bill of Rights (OHCOBR) received 172 complaints, which were categorized as Quality-of-Service issues. The majority of these issues included home health services, long-term care (nursing home), and non-emergency transportation.

While OHCOBR reviews and seeks to resolve all complaints, there is no formal finding in favor of beneficiaries or otherwise.

19. Provide an update on ARPA fund budgets and expenditures for FY 2023 and FY 2024, to date, including:

- **a. Amounts originally budgeted and for which program, cost center, account, and account group;**
- **b. Amounts expended by program, cost center, account, and account group;**
- **c. Amounts obligated, encumbered, or pre-encumbered by program, cost center, account, and account group;**
- **d. A narrative explanation for reprogramming ARPA funds by program, cost center, account, and account group;**
- **e. A narrative explanation on the progress of spending or obligating ARPA funds, including any contributing factors that may have delayed expenditures.**

Please see Attachment 19-A for (a) – (c) and Attachment 19-B for (d) and (e).

20. For FY 2023 and FY 2024, to date, please indicate how many contracts and procurements were for an amount under $250,000, how many were for an amount between $250,000-$999,9999, and how many were for an amount over $1 million.

Please see Attachment 9 for relevant information.

21. Please provide the typical timeframe from the beginning of the OCP solicitation process to contract execution for:

Please note the below timeframes are OCP estimates, which are dependent upon what is being procured and its availability in the market.

a. Contracts and procurements under $250,000.

Approximately one to two weeks.

b. Contracts and procurements between $250,000-$999,999.

Approximately one to nine months.

c. Contracts and procurements over $1 million.

Approximately nine months to 1.5 years.

22. In cases where you have been dissatisfied with the procurement process, what have been the major issues?

The DHCF COO meets regularly with leadership from the Office of Contracting and Procurement (OCP) on DHCF's existing and planned procurements. The Contract Appeals Board's (CAB) lengthy appeals and subsequent review process has consistently challenged DHCF's ability to procure services timely. For specifics, please refer to OCP's submission for their FY23 performance oversight hearing.

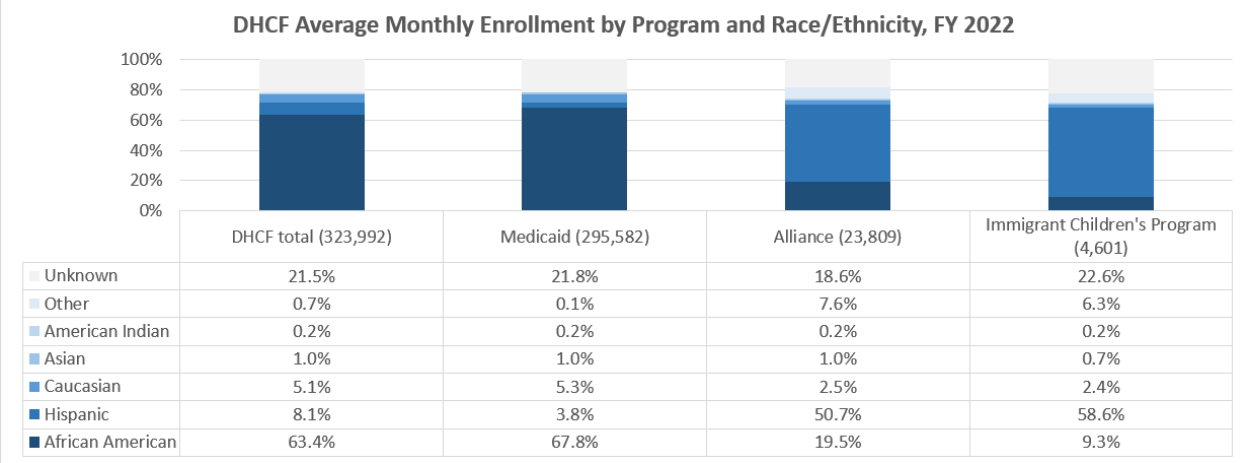
23. What changes to contracting and procurement policies, practices, or systems would help your agency deliver more reliable, cost-effective, and timely services?

The DHCF COO meets regularly with leadership from OCP on DHCF's existing and planned procurements. Shortening the CAB's appeals review process would benefit the agency and its ability to procure timely.

24. Consider one area where your agency collects race information. How does your department use this data to inform decision making?

DHCF does not collect race information on personnel. With respect to the Medicaid and Alliance programs, DHCF does not collect information on race, but individuals may self-report the data on their application for coverage.

Please see below for the most recent self-reported race data.



	DHCF total (323,992)	Medicaid (295,582)	Alliance (23,809)	Immigrant Children's Program (4,601)
Unknown	21.5%	21.8%	18.6%	22.6%
Other	0.7%	0.1%	7.6%	6.3%
American Indian	0.2%	0.2%	0.2%	0.2%
Asian	1.0%	1.0%	1.0%	0.7%
Caucasian	5.1%	5.3%	2.5%	2.4%
Hispanic	8.1%	3.8%	50.7%	58.6%
African American	63.4%	67.8%	19.5%	9.3%

Source: DHCF Medicaid Management Information System (MMIS) data extracted November 30, 2022.

Note: Among all DHCF beneficiaries with available data, 94% reflect a race/ethnicity other than white (73.4 percentage points out of 78.5 percentage points with data).

25. What legal barriers does your agency face when trying to 1) make progress toward racial equity or 2) better understand racial inequity within the agency's context and operations (if any)?

Limits on the collection of reliable racial and other socioeconomic data from program applicants and participants impact DHCF's ability to analyze performance measures stratified by race/ethnicity. DHCF is exploring ways to augment its information on race/ethnicity by using other data sources to develop reports.

26. How does your agency's spending address existing racial inequities (grant disbursement, procurement/contracting, etc.)?

DHCF focuses on 4 key pillars of the health equity framework to provide insight into various disparities and help inform strategies to address them. These include:

1) Improving Performance Measurement and Data Collection;

2) Including Equity in Value-based Payment;

3) Ensuring Equity is Present in Care Design and

4) Ensuring Community Engagement in order to identify and address racial/ethnic health disparities among DHCF beneficiaries.

One current example of DHCF's ongoing work in care design includes our collaboration with DBH to identify and address barriers to accessing behavioral health services by modifying our reimbursement and service-delivery model for behavioral health. This includes carving behavioral health services into our MCO contracts, as well as expanding the reach of supporting and ancillary services in our upcoming 1115 waiver renewal.

In addition, as DHCF incorporates value-based care models into its programs, the agency promotes equity through the models' emphasis on person-centered, culturally-competent care. DHCF's recent Practice Transformation Collaborative helped support providers in this area with technical support for developing sustainable business models that deliver high patient satisfaction and quality person-centered care across the care continuum.

27. What does racial diversity look like within your agency's staff? Please provide data on the racial diversity among leadership and at all staff grade levels. How does retention differ by race across levels? How does pay differ by race within levels?

DHCF does not collect information on race within the agency's staff.

Medicaid

28. Please provide an Account Group level breakout of budget and expenditures for DIFS Cost Center Codes: H3201 (Medicaid Provider Payments), H3202 (Public Provider Payments), and H3203 (Alliance Provider Payments) for FY 2023 and FY 2024, to date.

Please see Attachment 28.

29. For the Medicaid fee for service (FFS) and managed care programs, please provide spending/costs and utilization data, both actual and projected, for FY 2023 and FY 2024, to date.

Please see Attachment 29. For actual and projected figures please see response to Oversight Response 30.

30. For FY 2023, FY2024 and FY 2025, please provide the following data:

a. Projected monthly Medicaid enrollment for each FFS and MCO;
b. Projected monthly Medicaid enrollment by eligibility category;
c. Average monthly capitation rate per MCO enrollee;
d. Average estimated monthly cost per FFS beneficiary; and
e. All other information related to assumptions that inform the proposed Medicaid Provider Payment budget.

DHC formulates the budget based on three main factors:

- Enrollment Trends: DHCF reviews historical trends, impacts of policy changes (both local and federal) as well as economic indicators.
- Utilization: DHCF reviews historical trends in utilization to determine if there are any factors that may cause a shift in forecasting that should be accounted for, including service shifts and number of units used. These factors are then trended forward and adjusted to include any policy changes.
- Rates and Inflation: The cost of care is also impacted by scheduled rate increases (ranging from annually to every 5 years) that are outlined in our state plan. Also, several rates are dependent on living and minimum wage increases which are estimated and factored into the updated rates. We also include inflation factors per our state plan as well to ensure that provider cost is supported if there is not a cost report audit or schedule provider rate update.

The above components are used to estimate how much the agency anticipates spending in the formulation year. Each year the budget is built using Zero based budgeting and is not built off of the previous year's budget target.

The below table provides the trend in enrollment prior to the pandemic, during the pandemic and what we anticipate through the end of FY2024. Enrollment reports are analyzed monthly to

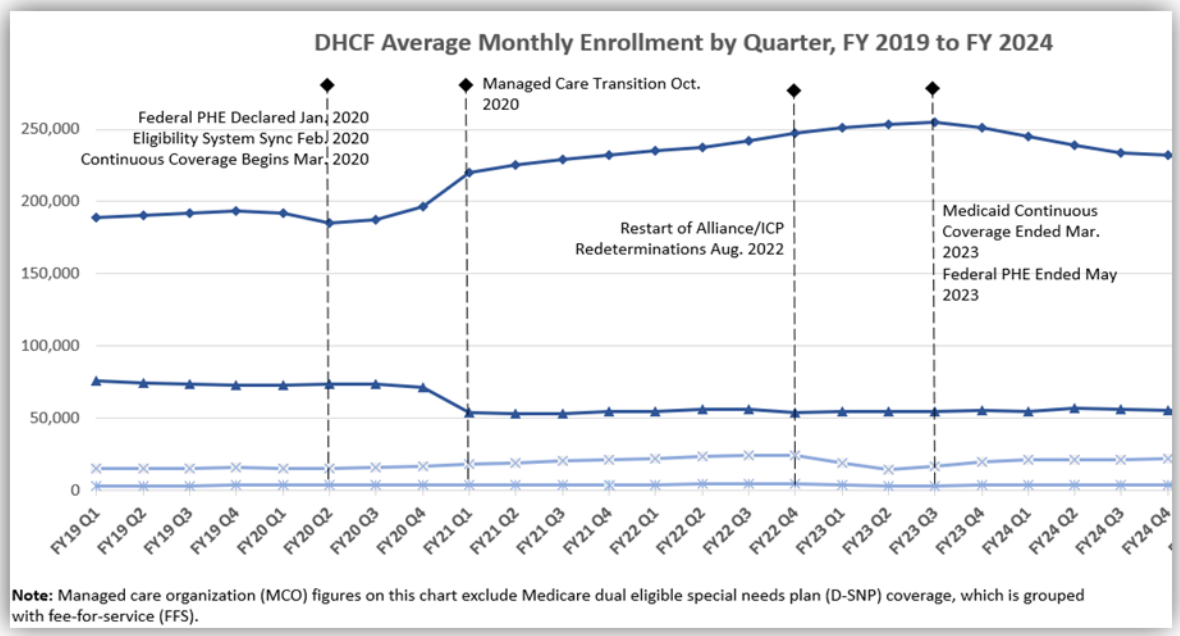
detect any shifts that were not anticipated and determine the reason and impact of the change on the forecast. It is also important to remember that enrollment does not always have a direct relationship to cost (unless analyzing MCO cost). It is possible to have a steady enrollment and experience increased cost. The enrollment reports are also made available to the public monthly via DHCF's website.

In December 2022, DHCF submitted the FY2023 budget to the Mayor using the assumptions that the pandemic would end before FY23 and that the enhanced FMAP would also end in FY23. This required that the FY2023 budget would require additional local funding support in replacement of the 6.2% additional federal match. The budget also assumed that redetermination would actually end 12 months after the proposed end of the PHE (01/15/21) and that DHCF would have an MOE requirement as a part of having access to the HCBS ARPA funding. Eighteen months later, the only assumption that remained intact was that DHCF was required to meet the requirements set forth under the MOE for receiving HCBS ARPA funding.

The pandemic ended in FY23; however, the enhanced FMAP continued through the first quarter of FY2024 but was reduced each quarter incrementally and as seen above, Medicaid redeterminations started in the spring of 2023 (Alliance began in the summer of 2022). Attached, please find the FY2023 Budget versus Expenditure report for FY2023 for provider payments.

The Medicaid program is an entitlement program. Each year DHCF estimates the amount of federal funding that will be needed to support the program; however, we can only spend up to the amount spent on either administrative cost or provider payments. The payments are based on the bills that providers submit within 365 days of the date of service. People utilize their health care based on the experience they are having at that time and therefore, while historical spending is used as a base, it can change year to year based on how people use health care. For this reason, DHCF tends to have multiple reprogramming's within a year to better align the budget with actual experience within the operating fiscal year. As we review spending trends against budget during the fiscal year, we determine if we need to curtail spending in other categories to ensure sufficient funding is available to support provider payments. In the case of FY2023, you will see that provider payments ended the year with the appearance of a deficit; however, the expenditures are balanced bottom line to ensure provider payments expenses will be supported.

See below chart for visual detailing of enrollment.



31. Identify each District of Columbia agency that submitted Medicaid claims in FY 2023 and FY 2024, to date, and include the following information:

a. The number and total dollar amount of claims filed per agency each month;

Please see Attachment 31 for the total dollar amount of claims filed per agency each month.

b. The number and total dollar amount of claims denied per agency each month, including any pattern or common reason for the denial;

Please see Attachment 31 for the total dollar amount of claims denied per agency each month.

Based on FY 23-24 YTD denied claims history, the most common reasons for denials were:

- Ineligible program code
- Beneficiary name mismatch
- Beneficiary not eligible/not found
- Service covered by MCO
- Exact duplicate claim

c. Whether the agency uses a third-party billing agent; and

Please see response to 31(d) below.

d. Whether each agency has been integrated into the ASO and, if not, whether there are plans for the agencies to process claims through the ASO.

The billing agents used by each of the agencies that conducted claiming to DC Medicaid as exhibited in Attachment 31 are as follows:

Agency	Billing Agent
DC Public Chartered Schools (DCPCS)	ASO
Office of the State Superintendent (OSSE)	ASO
DC Public Schools (DCPS)	ASO
Child & Family Services (CFSA)	ASO
St. Elizabeth's Hospital & Dental Clinic	Within agency
DC Behavioral Health (DBH) (formerly Dept of Mental Health)	Within agency
DC Fire Department & Ambulance Services (FEMS)	Digitech/ADPI

The Department of Youth Rehabilitation Services (DYRS) does not submit claims to Medicaid. The agency submits invoices from servicing facilities for ancillary services paid by the facility for fee-for-service eligible youth. DHCF reimburses the facility based on these invoices.

Currently, there are no new opportunities for integration of other District agencies into the ASO, due to the following reasons: (1) procurement of their own billing vendor; (2) discontinuance of enrollment with DC Medicaid; or (3) no longer providing Medicaid reimbursable services.

32. Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY 2023 and FY 2024, to date, including but not limited to reports of the DC Auditor, the Office of the Inspector General, Department of Health and Human Services OIG, and the Centers for Medicare and Medicaid Services.

a. Include any warning letters, regarding any program or systems managed by DHCF, and responses issued by DHCF and partner agencies.

b. In addition, please provide a narrative explanation of actions taken to address any issues raised by the investigation, review, program/fiscal audit, and warning letter.

CMS Payment Error Rate Measurement (PERM) Program*:* The PERM program measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produces error rates for each program. The Centers for Medicare & Medicaid Services (CMS) is required to estimate the amount of improper payments in Medicaid and CHIP annually.

During FY2023 and FY2024 YTD, CMS initiated the PERM RY24 process. DHCF is working with a PERM Statistical Contractor, Review Contractor, and Eligibility Review Contractor to conduct PERM activities. DHCF has provided multiple data productions and is working with the various contractors to ensure a smooth and efficient PERM Cycle. The PERM auditors are completing their reviews of DHCF's data processing and eligibility systems, as well as reviewing medical records received directly from Medicaid providers. DHCF has worked diligently to produce all requested documentation, resolve any disputes as they arise, and contact selected Medicaid providers to ensure that they produce requested records to the PERM auditors in a timely manner.

CMS MCO Focused Review: CMS conducted a focused review of DHCF's Division of Program Integrity (PI), with a specific focus Medicaid Managed Care Organizations (MCO) program integrity activities in June 2022. The review was a comprehensive overview of all PI activities, both within DHCF and within each of the District's 3 MCOs that took place over 3 days.

In August 2023, CMS issued its final report. *See* Attachment 32(a). The report identified seven observations related to DHCF's Program Integrity operations, as well as two recommendations: 1) that DHCF-DPI establish a procedure to ensure all MCO Compliance Plans meet regulatory elements; and 2) that DHCF amend MCO contract language to include a specific requirement of compliance with 42 CFR § 438.608(d)(2). DHCF-DPI implemented the two recommendations and CMS issued a Closure Letter on November 2, 2023 indicating that the review had been favorably closed. *See* Attachment: Q32-B. DHCF-DPI also reviewed the observations listed in Attachment 32(a) and has implemented a variety of changes and improvements to managed care oversight activities to ensure that DHCF continues to successfully defend the Medicaid program against fraud, waste, and abuse.

Unified Program Integrity Contract (UPIC): DPI has paired with the Northeastern UPIC to conduct audits and recover overpayments. The NEUPIC allows for the coordination and integration of existing CMS oversight functions into a single contractor and allows for PI functions to span Medicare claims data in addition to Medicaid. The NEUPIC works with a variety of states in the Northeast, and DPI meets bi-monthly with the UPIC to discuss leads and developing areas of PI concern. In addition, the NEUPIC selected the District to work on a project developing best practices for oversight of the MCO program. The project is currently midway through its process, with Stage 1 involving reviews of deliverables that the MCOs produce to DHCF having been recently completed. Stage 2 will begin in Q2 of FY24 and will involve the UPIC reaching out directly to the MCOs to follow-up on information gleaned from Stage 1.

Please see Attachment 32 for additional detailing.

33. Please identify each incident of Medicaid abuse or fraud investigated in FY23 and to date in FY24 and any associated sanction/penalty. What problem areas or patterns have been discovered regarding fraud in the District's Medicaid program? Please identify providers and amounts recouped for each, including any supporting documentation.

DHCF's Division of Program Integrity (DPI) includes an Investigations Branch, a Surveillance Utilization Review Section (SURS), and a Data Analytics Branch. Although the Investigations Branch primarily focuses on the investigation of fraud based on information or data mining obtained from various sources and SURS focuses on audits of providers to ensure proper billing utilization, the branches work in conjunction with each other. These joint efforts can include combined data-mining efforts, joint efforts on specific cases (such as an audit based on statistical sampling to identify trends and a follow-up or concurrent investigation to determine if there is a related credible allegation of fraud), and referrals from one branch to the other when an audit identifies potential fraud, or an investigation determines the case involves abuse. In addition, DPI oversees program integrity activities conducted by the District's Managed Care Organizations (including audits and investigations), conducts information sharing and coordination with the Department of Behavioral Health (DBH) and Department on Disability Services (DDS) concerning program integrity issues, and completes collaboration with law enforcement agencies.

DHCF investigated or continues to investigate **131** cases of alleged Medicaid fraud in FY23. In FY23, **07** cases were referred to law enforcement. As of January 12, 2024, DHCF referred an additional **01** case to law enforcement and investigated or continues to investigate **08** additional cases of alleged Medicaid fraud in FY24 (for a total of **139** cases investigated or continuing to be investigated across FY23 and FY24 to date). Please refer to **Table 1** below for more details on these investigative cases.

Based on preliminary investigations that are ongoing or have resulted in a credible allegation of fraud and a referral to law enforcement, problem areas include:

- Falsification of records/documents;
- Billing issues, including claims for services not rendered, excessive units of services, and other irregularities;
- Kickback payments or other illegal remunerations;
- Providing services without maintaining the necessary supporting documentation to justify the billing; and
- Organized groups' involvement in fraud schemes, including the recruitment of beneficiaries and others into schemes.

Additionally, the collective program integrity efforts resulted in the discovery of the following problem areas or patterns:

- Behavioral health services claims with excessive units of service and services not provided;
- Community Service Workers related claims involving services not provided;
- Personal Care Services, including Personal Care Aides and Participant Directed Workers related claims with excessive units of services billed, services not provided, and kickback payments;
- Dental claims for services not provided and excessive units of service billed;
- Durable Medical Equipment and Prosthetics, Orthotics and Medical Supplies billings for excessive units, lack of documentation, and falsified documentation;
- Physician services fraud;

- Pharmacy claims involving prescription fraud, specifically billing for services not provided;
- Disability services claims with excessive units of service and services not provided;
- Providers billing for services reportedly provided to beneficiaries after the date of death;
- Providers submitting false information during the Medicaid program enrollment process;
- Providers submitting claims for services during periods professional license was suspended; and
- Beneficiary involvement in fraud schemes, including falsification of medical conditions, falsification of records, and providing/accepting kickback payments or other illegal remuneration.

Normally, DHCF does not recoup funds from providers suspected of committing fraud. After the completion of a preliminary investigation, the agency makes referrals to law enforcement, when appropriate. 42 CFR 455.23 requires that the State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

TABLE 1

Provider Type	Date Referred	Referred To	Status w/ Date & Detail
CSA	11/14/2022	MFCU & L.E.	Pending Criminal Investigation
MHRS	1/23/2023	MFCU & L.E.	Pending Criminal Investigation
PDW	5/2/2023	MFCU & L.E.	Pending Criminal Investigation
CSW	5/2/2023	MFCU & L.E.	Pending Criminal Investigation
CSA	7/17/2023	MFCU & L.E.	Pending Criminal Investigation
CSA	7/17/2023	MFCU & L.E.	Pending Criminal Investigation
PDW	4/7/2023	MFCU & L.E.	Pending Criminal Investigation
DENTAL	--	--	On-going
DBH	--	--	On-going
PCA/SMW?/Other	--	--	On-going
DDS	--	--	On-going
Nurse-PCA	--	--	On-going
PCA Recruiter/PCA	--	--	On-going
PCA Beneficiary	--	--	On-going

SMW PDW	--	--	On-going
HHA/PCA	--	--	On-going
Unlicensed Dentist	--	--	On-going
SMW-Mult.	--	--	On-going
SMW PDW	--	--	On-going
SMW PDW	--	--	On-going
Pharmacy	--	--	On-going
Transportation	--	--	On-going
SMW PDW	--	--	On-going
DENTAL	--	--	On-going
DBH Core Svc Psychiatry	--	--	On-going
Physician	--	--	On-going
PDWs	--	--	On-going
SMW PDW	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
PCA	--	--	On-going
DENTAL	--	--	On-going
Beneficiary PCA	--	--	On-going
SMW PDW	--	--	On-going
PCA	--	--	On-going
DENTAL	--	--	On-going
MD - Allergist	--	--	On-going
Mental Health	--	--	On-going
HSCSN/Medical Dr.	--	--	On-going
CSW	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going

PCA	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
Pharmacy	--	--	On-going
DBH	--	--	On-going
DME	--	--	On-going
PCA	--	--	On-going
DBH	--	--	On-going
PCA	--	--	On-going
DBH	--	--	On-going
Beneficiary	--	--	On-going
PCA	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
HHA/PCA	--	--	On-going
PDW/CDDC Employee	--	--	On-Going
PDW	--	--	On-Going
PDW	--	--	On-Going
PDW	--	--	On-Going
PDW	--	--	On-Going
CSW	--	--	On-going
DENTIST	--	--	On-Going
PDW	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
DME	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
DENTAL	--	--	On-going
Ophthalmology	--	--	On-going
PDW/Estate	--	--	On-going
PDW	--	--	On-going
CSA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going

PDW	--	--	On-going
Psychologist	--	--	On-going
PCA	--	--	On-going
DENTAL	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
PDW	--	--	On-going
HHA	--	--	On-going
PCA	--	--	On-going
PCA	--	--	On-going
LCSW	--	--	On-going
PDW	--	--	On-going
DME	--	--	On-going
DME	--	--	On-going
DME	--	--	On-going
Pharmacy	--	--	On-going
DDS	--	--	On-going
DDS	--	--	On-going
LAB - MCO/MedStar	--	--	On-going
Physician	--	--	On-going
Dental	--	--	On-going
CFDC	--	--	On-going
Lab	--	--	On-going
DBH CSW	--	--	On-going
DDS/IDD	--	--	On-going
DENTAL	--	--	On-going
DBH	--	--	On-going
HHA	--	--	On-going
PCA	--	--	On-going
Dentist	--	--	On-going
DBH	--	--	On-going
MCO	--	--	On-going
DBH	--	--	On-going
PDW	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
Physician	--	--	On-going
PCA	--	--	On-going
CSA	--	--	On-going
Pharmacy	--	--	On-going

MHRS	--	--	On-going
CASE MGMT	--	--	On-going
Pharmacy	--	--	On-going
LAB	--	--	On-going
PDW	--	--	On-going
PCA	--	--	On-going
PDW/PCA	--	--	On-going
HHA	--	--	On-going
HHA	--	--	On-going
MHRS	--	--	On-going
HHA	--	--	On-going
HHA	--	--	On-going

TOTAL - 139

34. Federal regulations require an annual program independent review of the Medicaid Managed Care program. Provide a copy of the review for FY 2023, or the most recent review conducted. Also include the following information:

a. The agency's interpretation of the key findings and conclusions;

b. Action plans for addressing the review's key findings and conclusions; and

c. Narrative text about how the reviews will proceed under the new MCO contracts.

Federal regulations require an annual independent program review of the Medicaid Managed Care program be performed by an External Quality Review Organization (EQRO). The EQRO conducts an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services an MCO, or its Contractors, furnish to Medicaid beneficiaries. The results of this independent external quality review (EQR) are compiled into the District of Columbia Medicaid Managed Care Annual Technical Report (ATR). The ATR is the public facing end-product of the annual EQR and must be made available on DHCF's website and upon request either in print or electronically. The ATR must include:

1. The results of the EQR-related activities.
2. The EQRO's assessment of each MCO's strengths and weaknesses related to quality, timeliness and access.
3. Recommendations for: improving the quality of health care services furnished by each MCO; and how the DHCF can target goals and objectives in the District's quality strategy.
4. Comparative information about all MCOs.
5. An assessment how each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The most recent review can be found here:

https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/2022%20DC%20ATR%20Report_FINAL.pdf

The ATR for FY 2023 will be available April 26, 2024.

a) The agency's interpretation of the key findings and conclusions

The key findings and conclusions are summarized below. Each reflect that the District's MCO average fell short of meeting national benchmarks on measures relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care.

Findings

Performance Improvement Projects (PIPs) are a federal requirement intended to achieve significant improvement in measurement of quality performance with objective indicators, as well as to generally sustain this improvement over time (42 CFR §438.330). PIPs conducted this year include the following:

PIP Topic	Description	Medicaid Program	Findings
Behavioral Health PIP	Measures percentage of children and adults six years of age and older who had a follow-up visit within in 7 and 30 days after either an emergency department (ED) visit or hospital admission for mental illness.	DC Healthy Families Program (DCHFP), DC Health Care Alliance (Alliance), Immigrant Children's Program (ICP), Children and Adolescent Supplemental Security Income Program (CASSIP), Dual Choice Program (D-SNP)	Results limited because PIP was submitted as a proposal in 2023. Measurement year (MY) 2023 (calendar year 2024) will be the baseline period. PIP validation scores ranged from 74% - 100%
Maternal Health PIP	Measures birthing and postpartum persons who receive timely prenatal and postpartum care	DCHFP, Alliance, ICP	In the third remeasurement year, on average, both prenatal and postpartum care rates declined from baseline. PIP validation scores ranged from 71% - 82%.
Childhood Obesity Management	Measures percentage of children and	CASSIP	In the first remeasurement year, results were mixed. The

and Prevention PIP	adolescents who had a well-care visit where the provider documented weight assessment and counseling for nutrition and physical activity. PIP is ongoing, baseline was MY 2021.		rate for counseling for nutrition was worse than baseline while the rate for BMI percentile and counseling for physical activity remained steady, and the rate for well-care visits increased from baseline. PIP validation score was 92% indicating that one can have high confidence in MCO results.
Fall Risk Management PIP	Measures percentage of enrollees who are at risk for a fall and whose risk is reduced through plans of care and prevention strategies	D-SNP	In the baseline year, 25.53% of eligible enrollees discussed fall risk with a provider, 55.58% of eligible enrollees report receiving a fall risk intervention from a provider. PIP validation score was 100% indicating that one can have high confidence in MCO results

Performance Measure Validation (PMV) evaluates the accuracy and reliability of measures produced and reported by the MCO and determines the extent to which the MCO followed specifications for calculating and reporting the measures. The first audit focused on validating the accuracy of reported PIP measures and the second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures.

Information Systems Capabilities Assessments determined MCOs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. The MCOs received overall PMV ratings of 100% for the PIP measures and for the EPSDT measures[1]. All measures were assessed as "reportable."

[1] PMV ratings for EPSDT measures are reported from FY 2022. Fiscal year 2023 findings are not yet available.

The EQRO conducts an **Operational Systems Review (OSR)** to assess MCO compliance with federal and DHCF managed care program requirements, which may impact the quality, timeliness, or accessibility of health care services provided to Medicaid enrollees. This comprehensive review determines compliance on the OSR Standards (i.e., core requirements that have to be met in order to deliver services to Medicaid enrollees): Information Requirements (42 CFR §438.10); Disenrollment Requirements and Limitations (42 CFR §438.56); Enrollee Rights and Protections (42 CFR §438.100-114); MCO Standards (42 CFR §438.206-242); Quality Assessment and Performance Improvement Program (42 CFR §438.330); and Grievance and Appeal System (42 CFR §438.402-424).

MCO scores ranged from 93% to 100%[2]. All MCOs were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, most of which related to the Grievance and Appeal System standard. MCO overall weighted scores demonstrated a slight decline in compliance with federal and DHCF program requirements during the current audit compared to the previous year's OSR review. This may be due to the fact that the period in which the audit was conducted coincided with the first measurement year for one of the MCOs.

Network Adequacy Validation (NAV) assessed that the MCOs have robust provider networks demonstrating 100% compliance with geographic and provider-to-enrollee requirements. During 2022, MCO-access to timely provider appointments was generally higher, with improvement in the MCO average for adult and pediatric routine appointments.

Accuracy of the MCOs' Provider Directory remains an area of improvement. All MCOs are to continue efforts to improve the reliability of Provider Directory content ensuring enrollees have access to accurate provider information. As part of the Centers for Medicare & Medicaid Services (CMS) mandate to implement a Provider Directory application programming interface (API), each MCO is working with CRISP as the District's Health Information Exchange (HIE) to assist them and their provider network in maintaining the accuracy of the Directory.

Encounter Data Validation (EDV) is a medical record review to determine the accuracy of encounter data (i.e., MCO claims submitted to the DHCF). As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical. The audit concluded an overall moderate level of encounter data accuracy, meaning medical record documentation supported the encounters' associated diagnosis and procedure codes. MCO performance ranged from 76% to 100%, with an average of 91%, exceeding the procurement target of 90%, established by DHCF for the first year of review. However, only two of the four MCOs met the 90% target. Lack of provider response to medical record request most frequently contributed to noncompliance.

[2] Scores reported here are preliminary, pending final 2023 OSR report.

DHCF also reviews performance on:

- Healthcare Effectiveness Data and Information Set (HEDIS®), which was developed and is maintained by the National Committee for Quality Assurance (NCQA). Each MCO is required to be accredited by NCQA as part of their contract with the District and is mandated to report HEDIS measures to maintain accreditation. HEDIS data are collected through a combination of surveys, provider medical record audits and insurance claims data.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a consumer survey that measures the satisfaction of enrollees with the MCO, provider accessibility, patient/provider relationship and communication.

HEDIS and CAHPS performance measure results, on average, did not meet the national average benchmarks.

Conclusion

The EQRO evaluated MCO compliance in providing Medicaid managed care enrollees with quality and timely access to care and concluded, on average, MCOs are meeting requirements and demonstrating their commitment to quality improvement. In most instances, stakeholders can have high confidence in their compliance with federal regulations and DHCF contract requirements.

While MY 2021 performance continued to be influenced by the COVID-19 PHE and recovery efforts, there were signs of improvement in select PIP performance measure results, as well as timely access to routine provider appointments. HEDIS and CAHPS performance measure results, on average, did not meet the national average benchmarks.

b) Action plans for addressing the review's key findings and conclusions:

Opportunity exists to improve results in the areas of behavioral health and maternal health. These areas support goals and objectives identified in DHCF's Medicaid Managed Care Quality Strategy. In FY 2023, DHCF continued the maternal health PIP and initiated a new PIP targeting enrollee access to behavioral health services, to achieve the DHCF goal of improved access to quality, whole-person care.

DHCF continues to closely monitor MCO performance and compliance utilizing the enhanced quality improvement approach, and as needed, holding MCOs accountable through progressive discipline of corrective action plans, enhanced monitoring which requires monthly reporting on activities to resolve noncompliance, and intermediate sanctions.

DHCF recently updated and published its Medicaid Managed Care Quality Strategy which includes specific objectives and strategies to address health equity and behavioral health. This will further enhance DHCF's efforts to ensure access to quality, whole-person care;

improve management of chronic conditions; improve population health; and ensure high-value, appropriate care for all Medicaid managed care enrollees.

c) ***Narrative text about how the reviews will proceed under the new MCO contracts*.**

The reviews will continue as they have in past years as the external quality review process must follow the 42 CFR §438.350. DHCF contracted with an external quality review organization (EQRO) in August 2022 for a five (5) year term to conduct annual, independent reviews of the MCOs. To meet these requirements, the EQRO, evaluates each MCO's compliance with federal and DC-specific requirements (i.e., the MCO contract and any applicable DC regulations) in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols (Updated in 2022: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305)

The EQRO will conduct the following EQR activities for the new MCO contracts:

1. Performance Improvement Project (PIP) Validation
2. Performance Measure Validation (PMV)
3. Compliance Review also known as Operational Systems Review (OSR)
4. Network Adequacy Validation (NAV)
5. Encounter Data Validation (EDV)

In accordance with 42 CFR §438.364(a). the EQRO will produce a detailed technical report describing the method that data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care

furnished by the MCO. The EQRO will identify MCOs' strengths and weaknesses relating to quality, access, and timeliness of care provided to managed care enrollees and include recommendations for improvement.

Consistent with our policies and procedures, DHCF will take appropriate action should the MCO not remediate non-compliance with the federal or District regulatory requirements. This includes issuance of corrective action plans (CAPs); implementation of enhanced monitoring within the program area where the finding occurred; and in extreme cases, initiation of intermediate sanctions per 42 CFR §438.700.

35. For the Medicaid fee for service (FFS) and managed care programs, and the Alliance program, please provide a description of and reason for any changes or planned changes in FY23 and FY24, to date, regarding:

a. Services provided and eligibility requirements in FY23 or FY24; and

In FY22, the Office of Contracting and Procurement (OCP) issued a solicitation to contract with three managed care organizations (MCOs) to provide healthcare and pharmacy services for DHCF's Medicaid managed care program, also known as the DC Healthy Families Program (DCHFP), Immigrant Children's Program (ICP) and the DC Healthcare Alliance (Alliance). Through this solicitation, DHCF introduced an expanded service category for coverage and administration of behavioral health (BH) services to eligible populations. The new contracts were implemented on April 1, 2023.

The new contract is intended to expand up to a 10-year period consisting of nearly a five-year base period and a five-year option period. Implementation of behavioral (BH) services will begin on April 1, 2024, during the second year of the base period. Staff from the Department of Behavioral Health (DBH) and DHCF have partnered to conduct training and discussions necessary to ensure readiness by BH providers, contracted MCOs, and other entities critical to the integration of BH services into managed care.

As noted above, effective April 1, 2024, BH services previously reimbursed as FFS will integrate into the managed care program for their assigned enrollees. As part of our integration planning efforts, DHCF engaged in a comprehensive rate study, that included development of new services, changes to payment methodologies, and new rates. These services and supports were added to the current contract in advance of the planned integration, and many of the service and rate changes resulting from the rate study have already been implemented.

New services include Attachment and Biobehavioral Catchup, Collaborative Care, Dialectical Behavioral Therapy, Intensive Care Coordination, Motivational Enhancement Therapy-Cognitive Behavioral Therapy, and Psychiatric Consult to a Primary Care Physician, and represent expansion of coverage across the life span for both MH and SUD.

DHCF has also consolidated equivalent procedures across Provider Types to improve analysis of access, utilization, and demand, and to simplify claims submission and prior authorization requests for Providers and MCOs. Procedures, such as Diagnostic Assessment or Medication Management, were classified distinctly and reimbursed differently depending on setting, provider type, and condition. Through our comprehensive rate study, we conducted a full assessment of similar procedures, and simplified and aligned coding with nationwide industry standards.

Alliance beneficiaries now have equitable coverage to Medicaid beneficiaries for BH services and supports.

b. Reimbursement rates/methodologies in FY23 or FY24.

In FY24, DHCF implemented a maximum fee schedule for Inpatient and Outpatient hospital services for DCHFP, Alliance and ICP MCOs per the FY24 Budget Support Act (BSA). Maximum fee schedules allowed DHCF to manage the hospital expenses considered in the MCO capitation

rates. Risk Corridors have been maintained in the DCHFP, Alliance, and CASSIP managed care programs for FY23 and FY24 as a mechanism to minimize unanticipated gains/losses by MCOs.

36. For each waiver program, please provide a description of and reason for any changes or planned changes in FY 2023 and FY 2024, to date, and:

a. FY 2023 and FY 2024, to date, enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by gender; and

b. Enrollment cap, number of vacancies, number of people on the waiting list, if applicable.

Please refer to the response to Question 28 for aggregated budget and spending information for FY23 and the first quarter of FY24 for the waiver programs. These data are aggregated and reflect total utilization, although expenditures and utilization per enrollee are not included.

The EPD Waiver was amended effective January 1, 2023, to include authority for supplemental payments for direct care workers, and amended effective January 1, 2024 to increase, or continue a pandemic-era increase, in payment rates for certain EPD providers (case management agencies and assisted living facilities). The IDD Waiver was renewed for another five-year period effective October 1, 2022. This renewal incorporated changes to expand eligibility criteria, add new services, and include authority for supplemental payments for direct care workers. The Individual and Family Supports (IFS) Waiver was amended effective October 1, 2022, and this amendment added expanded eligibility criteria, participant-directed services and authority for supplemental payments for direct care workers.

a. Please see "Attachment 36-A" for FY23 and FY24, to date, for enrollment by gender for the EPD Waiver, "Attachment 36-B" for FY23 and FY24, to date, for enrollment by gender for the IDD Waiver, and "Attachment 36-C" for FY23 and FY24, to date, for enrollment by gender for the IFS Waiver.

Please note that FY24 enrollment data should be considered preliminary. As with reports based on claims data, DHCF employs a three-month reporting lag for enrollment data to ensure accuracy and completeness of the data.

b. ***IDD Waiver***: The IDD Waiver has a capacity of 1,963 for Waiver Year 2 (October 1, 2023 through September 30, 2024). As of January 11, 2024, 1,758 individuals were enrolled in the IDD Waiver. There is no waiting list.

IFS Waiver: The capacity for the IFS waiver is 120 for Waiver Year 4 (October 1, 2023 through September 30, 2024). This waiver has 50 enrollees as of January 11, 2024. There is no waiting list.

EPD Waiver: The enrollment cap for the number of unduplicated participants in Waiver Year 8 (January 1, 2024 through December 31, 2024) is 6,260. The enrollment is 5,269 as of January 11, 2024. There is no waiting list.

37. Please provide a list of all State Plan Amendments (SPAs) or demonstration projects submitted to CMS for approval in FY 2023 or planned for submission in FY 2024 and FY 2025. For each, please provide a narrative description, an update on its status, reason for the SPA, and details of any service changes that will occur because of the SPA.

f. Please provide a description of the stakeholder engagement performed in preparation for any SPAs or demonstration waiver applications developed for FY 2023 or FY 2024.

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-23-0001	None	COVID-19 Disaster SPA. Updates housing supportive services provider qualification criteria, provides reimbursement for retroactive provider rate changes, increases the personal needs allowance, and waives pharmacy signature requirements.	Effective: 3.1.20 through the end of the COVID-19 Public Health Emergency Approved: 5.5.23 Submitted: 3.3.23	N/A	FY22: $0 FY23: $0
DC-22-0011	None	COVID-19 Disaster SPA. Provides compliance with the requirements for mandatory coverage of COVID-19 vaccines, testing, and treatment without cost-sharing under section 9811 of the American Rescue Plan.	Effective: 3.11.21 through 3.31.24 Approved: 1.27.23 Submitted: 10.31.23	Provides mandatory COVID-19 vaccines, testing, and treatment coverage.	FY22: $0 FY23: $3,614,571
DC-23-0003	None	COVID-19 Disaster SPA. Modifies the re-evaluation process for participants in the Housing Supportive Services program and allows for supplemental payments to direct care workers under section 9817 of the American Rescue Plan Act.	Effective: 5.1.22 through 5.11.23 Approved: 5.11.23 Submitted: 4.4.23	N/A	FY23: $18,713,000 FY24: $18,713,000

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-22-0008	None	Allows pharmacies to receive reimbursement for the administration fee associated with providing VFC program vaccine and immunizations	Effective: 9.1.22 Approved: 10.19.22 Submitted: 8.23.22	N/A	FY22: $0 FY23: $0
DC-22-0006	DHCF established and convened eight (8) meetings with the Maternal Health Advisory Group to discuss services under the benefit, reimbursement methods, and rates.	Permits the coverage of doula services under the Medicaid State Plan.	Effective: 10.1.22 Approved: 9.28.22 Submitted: 7.22.22	Adds new doula services.	FY23: $578,585.63 FY24: $548,918.38
DC-22-0007	None	Removes the fifteen (15) day limit that an individual identified for inclusion in the Pharmacy Lock-in Program has to submit a request for a hearing on the lock-in decision from the state plan pages.	Effective: 10.1.22 Approved: 10.21.22 Submitted: 8.22.22	N/A	FY22: $0 FY23: $0
DC-22-0009	None	Aligns the District's Alternative Benefit Plan (ABP) with the District's State Plan for Medical Assistance as required under Section 1937 of the Social Security Act.	Effective: 10.1.22 Approved: 12.8.22 Submitted: 11.2.22		FY23: $0 FY24: $0

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-22-0010	None	Delays the rebasing of per diem specialty hospital rates until the expiration of the COVID-19 public health emergency.	Effective: 10.1.22 Approved: 11.30.22 Submitted: 9.27.22	N/A	FY22: $0 FY23: $0
DC-22-0014	None	Make technical changes to move covered eligibility groups from preprint State Plan pages into the MACPRO system, CMS's new system for capturing eligibility coverage groups. Also waives income eligibility restriction to disregard all income between statutory limit of 150% FPL and State Plan eligibility levels for all Medicaid 1915(i) services.	Effective: 10.1.22 Submitted: 12.31.22 Approved: 3.29.23	N/A	FY22: $0 FY23: $0

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-1766.R00.04	Stakeholder meeting held and 30-day public comment period provided prior to submission of waiver, as required by federal law.	(1) Modifies the Developmental Disabilities (DD) criteria for waiver enrollment eligibility; (2) Adds new services (remote support services and individual-directed goods and services); (3) Sets payment rates for new services; (4) Adds the option for participant-directed services (PDS); (5) Modifies reimbursement methodology to include District-funded payment enhancements; and (6) Modifies the waiver enrollment process.	Effective: 10.1.22 Approved: 9.27.22 Submitted: 7.15.22	See description	FY23: $2,145,615 FY24: $4,078,892
DC-1766.R00.05	N/A	Makes a technical correction to align the Level of Care Criteria set forth in Appendix B-6-d: Evaluation/Reevaluation of Level of Care with the District's already approved institutional criteria.	Effective: 10.1.22 Approved: 12.21.22 Submitted: 12.13.22	N/A	FY23: $0 FY24: $0
DC.0307.R05.00	Stakeholder meeting held and 30-day public comment period provided prior to submission of waiver, as required by federal law.	Expands IDD waiver eligibility to people with developmental disabilities (DD) without a diagnosis of an intellectual disability (ID).	Effective: 10.1.22 Approved: 9.27.22 Submitted: 7.15.22	See description	FY23: $257,885,176 FY24: $331,524,272

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC.0307. R05.01	N/A	IDD Waiver: Makes a technical correction to align the Level of Care Criteria set forth in Appendix B-6-d: Evaluation/Reevaluation of Level of Care with the District's already approved institutional criteria.	Effective: 10.1.22 Approved: 12.21.22 Submitted: 12.13.22	N/A	FY23: $0 FY24: $0
1915(c) Appendix K Amendment #9	None	Allows for the staffing ratio for day programs to be temporarily adjusted to support community-based day services for Day Habilitation, Small Group Day Habilitation and Employment Readiness.	Effective: 10.1.22 through 11.11.23 Approved: 4.25.23 Submitted: 4.4.23 .	N/A	N/A
DC-22-0013	None	Allows nurse practitioners and physician assistants to complete the face-to-face encounter before DMEPOS are supplied to the beneficiary, without requiring supervision of a physician.	Effective: 11.1.22 Approved: 12.5.22 Submitted: 11.17.22	N/A	FY22: $0 FY23: $0

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC.0334. R05.00	30-day public comment period provided prior to waiver amendment submission.	EPD Waiver: Modifies the criteria for involuntary termination of participant-directed service option to extend the period in which episodes of non-compliance may result in involuntary termination from twelve (12) months to thirty-six (36) months and allows supplemental provider payments and participant budget allocations.	Submitted: 9.30.22 Approved: 12.13.22 Effective: 1.1.23	N/A	FY23: $0 FY24: $0
DC-23-0002	None	Complies with changes to the eligibility rules for the Former Foster Care Children eligibility group, as enacted by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. L. No. 115-217, section 1002.	Effective: 1.1.23 Approved: 5.19.23 Submitted: 3.28.23	N/A	FY23: $23,218 FY24: $29,062
DC-23-0004	None	Allows the District to extend 1915(i) Housing Support Services, direct support worker supplemental payments, and 1915(i) Adult Day Health Program COVID-19 flexibilities while returning to normal operations.	Effective: 5.12.23 through 5.11.24 Approved: 5.11.23 Submitted: 4.27.23	N/A	FY22: $0 FY23: $0

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-23-0005	None	Authorizes temporary extensions of increases to the personal needs allowance for certain beneficiaries, delays rebasing rates for federally qualified health centers and specialty hospitals, increases reimbursement rates for certain facilities and services, and modifications to the District's health home program while returning to post-COVID-19 operations.	Effective: 5.12.23 through 5.11.24 Approved: 6.14.23 Submitted: 5.26.23	N/A	FY22: $0 FY23: $0
1915(c) Appendix K Amendment #10	None	Allows the District to phase out flexibilities regarding companion services through six (6) months after the end of the PHE.	Effective: 5.12.23 through 11.11.23 Approved: 6.15.23 Submitted: 6.1.23 .	N/A	N/A
DC-23-0006	None	Authorizes an exemption from the Medicaid Recovery Audit Contractor (RAC) requirements for two years.	Effective: 6.1.23 through 5.31.25 Approved: 8.4.23 Submitted: 6.1.23	N/A	FY23: $0 FY24: $0

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-23-0007	None	Updates reimbursement methodology for Assertive Community Treatment, adds coverage for Intensive Care Coordination (ICC) services for children and youth with significant behavioral concerns, ands confirm coverage specifications and service standards as required to qualify for enhanced the Federal Medical Assistance Percentage (FMAP) on community-based mobile crisis services under §1947 of the Social Security Act.	Effective: 8.1.23 Approved: 9.8.23 Submitted: 7.10.23	Adds coverage of ICC.	FY23: $5,913,628 FY24: $23,717, 150
DC-23-0008	None	Authorizes supplemental payments in Fiscal Year 2024 to Medicaid-enrolled physician groups, with at least five hundred (500) physicians and that contract with a public general hospital located in an economically under-served area of the District to deliver inpatient, emergency department, and intensive care physician services to Medicaid beneficiaries.	Effective: 10.1.23 Approved: 8.17.23 Submitted: 5.22.23	N/A	FY23: $0 FY24: $4,500,000
DC-23-0009	Various stakeholder meetings over the course of several years.	Adds provider types and services for children and adolescents under age 21 who need autism spectrum disorder (ASD) treatment.	Effective: 10.1.23 Approved: 8.25.23 Submitted: 6.28.23	Adds explicit coverage of ASD under the Medicaid State Plan.	FY24: $3,368,317 FY25: $3,425,578

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY23 or FY24 by Effective Date (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/ (Savings)
DC-23-0010	None	Expands the scope of covered transplant procedures to include small bowel and pancreas transplant procedures.	Effective: 10.1.23 Approved: 12.8.23 Submitted: 11.20.23	Adds coverage for small bowel and pancreas transplants.	FY24: $219,100 FY25: $227,426
DC.0334.R05.00	30-day public comment period	EPD Waiver: Increases the Assisted Living Facility (ALF) provider reimbursement rates and increases the reimbursement for Case Management service providers to ensure sufficient funding for case manager wages and administrative costs.	Effective: 1.1.24 Approved: 12.8.23 Submitted: 10.4.23	N/A	N/A
DC-22-0012	None	Authorizes the District to continue its authority beyond the public health emergency to permanently reimburse COVID-19 vaccines and COVID-19 vaccine administration at one hundred percent (100%) of the Medicare rates.	Effective: 4.1.24 Approved: 2.6.23 Submitted: 11.20.23	N/A	FY24: $3,311,044 FY25: $6,431,739

Table 2: SPAs/Waivers Submitted to CMS in FY24, Currently under Review (as of January 16, 2024)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/(Savings)
DC-23-0015	None	Removes language describing various therapy modalities, that are assumed covered	Proposed Effective Date: 11.1.23	N/A	FY24: $6,358,100 FY25:

		under the Counseling/Therapy service; updates supervision requirements for behavioral health providers in Federally Qualified Health Centers (consistent with District Law); clarifies education and experience requirements for credentialed staff able to provide State Plan rehabilitative services; and updates rates for select behavioral health services according to the fee schedule.	Submitted: 11.14.23		$7,780,943
DC-23-0011	None	Authorizes the District to continue to delay rebasing of specialty hospitals and updates cost adjustment factor to the inflation methodology, which will allow the Medicaid program to reimburse specialty hospitals at a rate that is fair and reasonable.	Proposed Effective Date: 10.1.23 Submitted: 12.15.23	N/A	FY24: $0 FY25: $0
DC-23-0016	None	Allows the coverage and reimbursement for up to three cycles of fertility enhancing drugs during a beneficiary's lifetime.	Proposed Effective Date: 1.1.24 Submitted: 12.22.23	Adds coverage of fertility enhancing drugs	FY24: $818,210 FY25: $282,374
DC-23-0014	None	Provides technical correction to clarify that emergency transportation services are not included in manage care plan contracts.	Proposed Effective Date: 10.1.23 Submitted: 12.29.23	N/A	FY24: $0 FY25: $0
DC-24-0003		Provides assurances with third-party payer requirements on prior authorization as required by the Consolidated	Proposed Effective Date: 2.1.24	N/A	FY24: $0 FY25: $0

		Appropriations Act of 2022.	Submitted: 1.3.24		

Table 3: FY24 and FY25 Anticipated SPA/Waiver Submission

SPA/Waiver	Description
Continuous Eligibility for Children	As of 1.1.24, provides 12-months of continuous eligibility for children up to age nineteen (19), as required by the Consolidate Appropriations Act of 2023.
Beneficiary Sanctions	Proposes changes to expand DHCF's authority to sanction beneficiaries for participating in potentially fraudulent, abusive, or wasteful activities.
Certified Professional Midwives	Establishes Medicaid enrollment and reimbursement of licensed certified professional midwives.
Physician Supplemental Payments	Provides a supplemental payment in FY 24 to eligible an eligible group practice with at least five hundred (500) physicians that are members of the group.
Behavioral Health Carve-In	Provide coverage of behavioral services as part of Medicaid managed care plans.
American Rescue Plan Act Section 9817 Supplemental Payments (Permanent SPA)	Allows the use of ARPA funds to make supplemental provider payments for State Plan rehabilitative services, home health services, and personal care aide services to strengthen the Medicaid home and community-based workforce.
Personal Needs Allowance (Permanent SPA)	Increases the personal needs allowance for long term care beneficiaries to $100.
Justice Involved Juveniles	Effective 1.1.25, provides physical and behavioral health screenings to juveniles within thirty (30) days of release from an institutional setting and targeted case management services for thirty (30) days pre- and post-release from incarceration, as required by the Consolidated Appropriations Act of 2023.
Home Health Reimbursement Rate Increase	Increases the reimbursement rate for services provided under the Medicaid home service benefit.
Weight Management Drugs	Provides coverage for certain weight management drugs.
Sunsets of Health Homes	Sunsets the health home benefit administered by the Department of Behavioral health as the service is not utilized and comparable services are available under the Medicaid State Plan.

38. The Committee's FY 2024 Budget Report made a policy recommendation for DHCF to apply for any waivers necessary and to offer State Plan Amendments as appropriate to cover violence interruption services through Medicaid. At the budget oversight hearing, DHCF stated they are in discussions with the Office of Neighborhood Safety and Engagement about what violence interruption services currently funded by the District could be covered under Medicaid.

a. What programs did DHCF and ONSE identify that could be covered under Medicaid?

DHCF, along with the Office of Gun Violence Prevention (OGVP), convened a workgroup in the spring of 2023 with representatives of each of the programs in the District with potential for Medicaid coverage of Community Violence Prevention (CVP). These programs include:

- Cure the Streets community violence intervention (CVI) program
  - Operated by the Office of the Attorney General (OAG)
- Violence Interruption CVI program
  - Operated by the Office of Neighborhood Safety and Engagement (ONSE)
- Project Change hospital-based violence intervention program (HVIP)
  - Operated by the Office of Victim Services and Justice Grants (OVSJG)

These programs contain service components that overlap with the allowable services federal Medicaid rules. These services - approved in other states' State Plan Amendments (SPA) and recommended by national organizations such as the Health Alliance for Violence Intervention (the HAVI) include:

- assessment of needs;
- care coordination (to facilitate the beneficiary or participant's access to appropriate services, including medical, behavioral health, social, and other necessary services designed to prevent further impacts of community violence prolong life, and promote the beneficiary's physical and mental health);
- conflict mediation; counseling, (including counseling to address and mitigate the impact of trauma);
- crisis intervention;
- development of an individualized service plan;
- discharge planning;
- mentorship;
- patient education;
- peer support;
- referrals to certified and licensed health care professionals or social service providers;
- screening services to victims or potential victims of violence.

b. Is DHCF developing a waiver application or SPA to cover violence prevention programs in FY 2024?

DHCF is on track to implement a Community Violence Prevention (CVP) benefit in Medicaid, effective October 1, 2024, which we anticipate will include the allowable services outlined above. This timing is in part to ensure sustainability for the heavily ARPA funded CVP programs beyond FY24 and to allow for significant community, CVI program, and HVIP stakeholder engagement.

A Medicaid CVP benefit would provide financial sustainability and allow for the enhancement and expansion of services. Based on experiences in other states that have implemented CVP SPAs and DHCF's experience onboarding non-traditional Medicaid providers, we expect relatively low utilization of the benefit at the beginning of FY25.

39. The Committee's FY 2024 Budget Report made a policy recommendation for DHCF to expand coverage for medically-tailored meals under Medicaid. Is DHCF developing a waiver application or SPA to cover medically-tailored meals in FY 2024?

a. If so, would this waiver also cover produce prescriptions?

DHCF is exploring ways to expand DC Medicaid's coverage of food and nutrition services in FY 2024 and beyond. Currently, DHCF provides coverage of vitamins/supplements under the State Plan prescription drug benefit and covers food preparation as a component of Assisted Living, Personal Care Aide, and Homemaker services.

DHCF is currently conducting a pilot (Produce Rx) that explores systemwide approaches to provide produce prescriptions to Medicaid individuals with diet-related chronic conditions. DHCF is reviewing options to expand coverage of produce prescriptions to the broader DC Medicaid program by leveraging recent expansion of 1115 demonstration authority by the Centers for Medicare and Medicaid Services to address health related social needs like hunger and nutrition.

40. Please provide details regarding all Psychiatric Residential Treatment Facility (PRTF) placements paid for with Medicaid funds. To the fullest extent possible, please break down this data by what MCOs the youth were assigned to, the youth's length of stay, where the PRTF was located and what other District agencies were involved with each youth's case.

Table 1 below reflects the delivery system in which the PRTF beneficiary is served at the time of placement. Each Medicaid MCO is specified in the Table below. There was a total of 23 Medicaid beneficiaries placed at a PRTF in FY23**.**

Table 1. PRTF Beneficiaries Served:

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	4	17.4%
AmeriHealth Caritas DC	7	30.4%
Medstar Family Choice	4	17.4%
CareFirst Community Health Plan/DC	1	4.4%
HSCSN	7	30.4%
Total	**23**	**100%**

Length of Time from Determination to Placement

The letter of medical necessity issued by the Department of Behavioral Health (DBH) is valid for 60 days from the date of determination; therefore, the youth must be placed within that 60-day timeframe. Although the majority of youth that meet the medical necessity threshold are placed within that timeframe, there are instances in which they might be placed outside of the 60 days. Reasons for a delay in placement include:

- Youth has absconded;
- Delayed approval of the Interstate Compact on the Placement of Children (ICPC); and
- PRTF placement difficult due to symptomatology.

Table 2 outlines the states where the PRTFs are located, and the number of beneficiaries served there.

Table 2: Beneficiaries Served by State:

State	Beneficiaries Served FY23
Arkansas	2
Florida	4
Georgia	1
Pennsylvania	1
Virginia	9
Maryland	5
Tennessee	1
Total	**23**

Beneficiaries' Length of Stay

Each beneficiary's length of stay is highly dependent on the individual's diagnosis, condition, progress, and prognosis. Therefore, the beneficiaries' length of stay varies greatly from beneficiary to beneficiary. However, generally the average length of stay in a PRTF in FY23 was 9.3 months (approximately 283 days).

Sister Agency Involvement

As noted earlier, DBH is responsible for certifying medical necessity for the PRTF level of care for placements to be funded by Fee-for-Service Medicaid. In June of FY21, a prior authorization requirement was put in place for PRTF care paid for by Fee-for-Service (FFS) Medicaid. The prior authorizations are approved by DHCF only if medical necessity has been confirmed by the DBH PRTF Placement Review Committee. This committee also reviews and makes determinations about the need for continued stays in PRTFs.

If the youth was recommended for placement by a sister agency (see Table 3 below) and approved by the Review Committee, the recommending agency works with the PRTF to ensure the placement, appropriate reviews, and authorizations are obtained, and works collaboratively with DBH for monitoring the care of the youth in the PRTF. DBH has primary responsibility for the oversight of the care being provided by all youths in PRTFs.

DBH actively works with sister agencies to establish a centralized reporting and monitoring system for all current and future PRTF placements. In every case, DHCF will work with all contracted MCOs – Amerigroup, AmeriHealth Caritas DC, MedStar Family Choice, and Health Services for Children with Special Needs (HSCSN) - along with DBH, to facilitate the smooth transfer of monitoring responsibilities for youth moving from Managed Care to FFS Medicaid in their placements. Note that the District's special needs health plan, HSCSN, places and monitors their enrollees in PRTFs. In addition, HSCSN collaborates with DBH as well as other agencies involved with their enrollees, in an effort to maximize the available resources to support monitoring HSCSN enrollees.

Table 3 is based on information from DBH regarding which sister agency has placed the youth. If the youth is not affiliated with the Children and Family Services Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), or Court Social Services (CSS), DBH has primary responsibility for monitoring.

Table 3. Beneficiaries Placed at a PRTF by Sister Agencies:

Agency	Total Number of Beneficiaries FY 23	Other Agency Involvement
Child and Family Services (CFSA)	2	DBH, HSCSN, DCPS
District of Columbia Public School (DCPS)	1	DBH, HSCSN
Department of Youth Rehabilitation Services (DYRS)	10	DBH, HSCSN, DCPS
DC Superior Court (Court Social Services)	2	DBH, DYRS, DCPS
HSCSN	3	DBH, CFSA, DCPS, DYRS
MedStar Family Choice	2	DBH, DYRS, DCPS
Office of the State Superintendent of Education (OSSE)	3	DBH, HSCSN

41. Please provide a status report on compliance with the terms and conditions set forth in the Salazar Consent Decree, specifically, outreach required to improve utilization of primary and dental care.

Salazar[3] is a long-running consent decree case, originally filed in 1993, governing several aspects of the District's administration of Medicaid, including: (1) service delivery of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services benefit; (2) notice of the availability of the EPSDT benefit; (3) timely processing of initial applications for Medicaid eligibility[4]; (4) adequate advance notice of termination from Medicaid benefits during annual renewal[5]; and (5) reimbursement of eligible out-of-pocket expenditures. The single remaining claim involves service delivery of the EPSDT benefit to children enrolled in Medicaid. The case was aggressively litigated, resulting in numerous additional court orders which broadened the scope of required compliance by the Department of Health Care Finance.

On November 5, 2019, the District renewed its motion to terminate Court oversight, alleging that it has satisfied the conditions of the Settlement Order or, alternatively, that Court oversight is no longer appropriate given there is no ongoing legal violation. On March 31, 2022, the Court denied without prejudice the District's renewed motion to terminate but noted that the District has a compelling argument that prospective application of the Settlement Order is inequitable. Since then, at the Court's direction, the Parties have been engaged in settlement discussions to explore the possibility of an exit strategy.

In 2023, the District submitted all required reports to the Court. As for the measures, while the District consistently has met or was above the national average for utilization measures for well-child visits and dental services, the District's utilization performance continues to remain below the target required by the 1999 Settlement Order and the 2003 Dental Order.

Most DC Medicaid beneficiaries are enrolled in Medicaid Managed Care Organizations (MCOs), including approximately 90% of the children insured by the Medicaid program. MCOs are responsible for ensuring there is an adequate provider network to serve the beneficiaries enrolled in their health plan; notifying beneficiaries of the services available, when they are due, and how to access needed services; and monitoring the quality of care provided to the beneficiary population. MCOs provide on-going outreach to the beneficiaries enrolled in the health plan, informing and encouraging them to seek needed services. In order to do this appropriately, regular reports are run by the MCOs to identify children who are due or overdue for particular preventive services or to identify beneficiaries who may need interventions based on multiple trips to the emergency room or some other unusual care pattern. As part of their contract with the District,

[3] *Salazar v. District of Columbia*, Civil Action No. 93-452 (TSC).
[4] Provisions relating to the third category were dismissed by consent in 2009 after the parties agreed that the District had satisfied the exit criteria.
[5] Provisions relating to the fourth category were dismissed by Court order in 2013 because those requirements conflicted with the Affordable Care Act (ACA).

MCOs are also responsible for various reporting requirements so that the District can monitor the outreach services being provided by the MCOs to the beneficiaries. This includes quarterly reports on utilization of and notice and outreach for EPSDT services.

DHCF, through its own efforts and in working with MCOs, providers, and sister agencies, strives to increase utilization of preventive care and encourages families to take their children to the doctor for well-child visits. The national average for children ages 0-20 years old receiving well-child visits in FY 2021 was 54%, while the District reported a utilization rate of 53% in FY 2022. In FY 2020 and FY 2021, the District was above the latest available national average for well-child visits. In addition, prior to the COVID-19 pandemic, the District was above or close to the national average for all age categories specified in the Centers for Medicare and Medicaid Services (CMS) Form 416 (Annual EPSDT Participation Report).

The District has historically ranked in the top tier of Medicaid programs nationwide in utilization measures, and the improvements in the District's dental benefit have been highlighted and commended by CMS. However, the expectations for utilization of dental services as outlined in the Dental Order remain problematic. The District continues to meet the substantive requirements of the Dental Order, but not performance measures, such as the requirement that 80% of Medicaid-enrolled children aged 3-20years old receive any dental visit. The latest data shows that 48% of DC Medicaid children aged 3-20 years old received any dental service in FY22, while the national average in FY21 for the same measure was 45%.

As DHCF continues to work with the MCOs on outreach for preventive services in order to improve utilization of primary and dental care, the agency remains proud of the progress the District has made to ensure access to medical care for Medicaid-enrolled children.

42: For Medicaid enrollees required to renew manually in FY 2023 and FY 2024, to date, please provide, broken out by month:

a. The number and percentage of households that returned renewal forms prior to the end of their certification period;

b. The number and percentage of households that were terminated for failure to manually renew prior to end of their certification period; and

c. The number and percentage of households that lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period.

The table below reflects Medicaid enrollees required to renew manually (i.e., non-passively) beginning with May 2023, which is the first month with renewals due after the end of the federal COVID-19 public health emergency.

a. See column 3 below. Most individuals who returned a renewal form prior to their certification date would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their certification date.

This includes non-MAGI beneficiaries who responded during their one-month extension and MAGI children who were reinstated or had a termination paused while DHCF ensured compliance with federal ex-parte (passive) renewal requirements.

b. See column 4 below. This group reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after a one-month extension.

c. See column 6 below. This group is a subset of column 4 and reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**Total receiving non-passive renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-05-31	4,982	2,071	1,933	978	568
2023-06-30	9,967	4,869	3,434	1,664	1,043
2023-07-31	20,348	9,342	6,473	4,533	2,004
2023-08-31	19,474	9,125	6,297	4,052	1,772
2023-09-30	7,753	3,913	2,771	1,069	662
2023-10-31	15,556	7,167	5,132	3,257	1,048
2023-11-30	17,789	7,587	6,557	3,645	697
Percent of total receiving non-passive renewal form					
2023-05-31	100%	42%	39%	20%	11%
2023-06-30	100%	49%	34%	17%	10%
2023-07-31	100%	46%	32%	22%	10%
2023-08-31	100%	47%	32%	21%	9%
2023-09-30	100%	50%	36%	14%	9%
2023-10-31	100%	46%	33%	21%	7%
2023-11-30	100%	43%	37%	20%	4%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known. Column-specific notes are provided below.

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 includes MAGI children who were terminated and later reinstated, MAGI children whose termination were paused, and non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

43: For enrollees who were terminated for procedural reasons since renewals restarted, please provide:

a. The number of applications submitted during the grace period, including the average number of days into the grace period the application was submitted;

b. The number of enrollees who were without coverage for a period of time and subsequently filed a new application within the same year, including the number of days the individual was without coverage; and

c. The number and percentage of households who lost coverage at the end of their certification period and were not able to regain coverage within the 90-day grace period following the end of their certification period.

See column 2 of table below for the number of beneficiaries terminated for procedural reasons (i.e., failure to manually renew prior to the end of their certification period). This group reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after a one-month extension. The table reflects Medicaid enrollees required to renew beginning with May 2023, which is the first month with renewals due after the end of the federal COVID-19 public health emergency.

a. See column 3 of the table below for the number of individuals who returned a renewal form during their 90-day grace period, which is a subset of column 2 (MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension for failure to manually renew). Colum 5 provides the average number of days into the grace period the renewal form was submitted.

b. See column 3 for the number of individuals who were without coverage for a period of time and subsequently filed a renewal within the 90-day grace period.

DHCF does not currently track Medicaid renewals by individuals who were without coverage for a period of time and later file a new application beyond their 90-day grace period. DHCF is looking at ways to examine the extent to which individuals who have not completed a renewal later return as a new applicant.

c. See column 4 of the table below for the number of individuals who did not return a renewal form during their 90-day grace period, which is a subset of column 2 (MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension for failure to manually renew).

Medicaid Beneficiaries Terminated for Failure to Manually Review and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5
Recertification Date	Terminated for failure to manually renew prior to the end of their certification period	Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period	Lost coverage at the end of their certification period and were not able to regain coverage during the 90-day grace period following the end of their certification period	Average number of days into the grace period the renewal was submitted
Number of beneficiaries				
2023-05-31	1,933	568	1,365	32
2023-06-30	3,434	1,043	2,391	31
2023-07-31	6,473	2,004	4,469	29
2023-08-31	6,297	1,772	4,525	31
2023-09-30	2,771	662	2,109	31
2023-10-31	5,132	1,048	4,084	22
2023-11-30	6,557	697	5,860	12
Percent of total terminated for failure to manually renew prior to certification end				
2023-05-31	100%	29%	71%	NA
2023-06-30	100%	30%	70%	NA
2023-07-31	100%	31%	69%	NA
2023-08-31	100%	28%	72%	NA
2023-09-30	100%	24%	76%	NA
2023-10-31	100%	20%	80%	NA
2023-11-30	100%	11%	89%	NA

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known. NA is not applicable. Column-specific notes are provided below.

- Column 2 reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension.
- Column 3 is a subset of column 2 and reflects individuals who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and we expect the number of beneficiaries to regain coverage from these groups to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.
- Column 4 is a subset of column 2 and reflects individuals who did not return a renewal form during their 90-day grace period.
- Column 5 reflects the date that the beneficiary filed the renewal with the District.

44: Regarding renewal notices:

a. Of Medicaid enrollees who have been required to renew manually in FY 2023 and FY 2024, to date, how many received pre-populated renewal forms no later than 60 days prior to the end of their certification period?

See table below. It reflects Medicaid enrollees required to renew manually (i.e., non-passively) beginning with May 2023, which is the first month with renewals due after the end of the federal COVID-19 public health emergency.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form by Pre-Populated Status, FY 2023 and FY 2024 to Date

Recertification Date	Total receiving non-passive renewal form	Number of beneficiaries who received pre-populated renewal forms no later than 60 or 90 days prior to the end of their certification	MAGI beneficiaries who received pre-populated renewal forms	Non-MAGI beneficiaries who received pre-populated renewal forms
2023-05-31	4,982	4,982	4,982	0
2023-06-30	9,967	8,053	7,817	236
2023-07-31	20,348	18,496	18,357	139
2023-08-31	19,474	15,726	15,566	160
2023-09-30	7,753	4,086	3,878	208
2023-10-31	15,556	12,188	11,986	202
2023-11-30	17,789	11,951	11,707	244

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: MAGI beneficiaries required to renew manually receive a pre-populated form 60 days in advance of their certification date. Non-MAGI beneficiaries who received an eligibility determination in DCAS after a November 2021 (and are therefore not required to submit a conversion renewal form) also received a pre-populated renewal form. The data in the table reflect mostly MAGI beneficiaries since most non-MAGI beneficiaries require a conversion renewal form. December and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.

b. Please describe any problems the Department is encountering in sending notices to Medicaid recipients.

Throughout the Medicaid unwinding process, DHCF has received feedback from beneficiaries, advocates, and other stakeholder partners regarding Medicaid renewal notices.

Two common issues raised were 1) beneficiaries reporting they did not receive a renewal notice or termination notice in the mail; and 2) beneficiaries reporting that they received multiple or conflicting notices on the status of their Medicaid benefits.

DHCF has taken the following actions to address these issues:

First, DHCF went on a broad outreach campaign to remind those with upcoming renewal dates to update their Medicaid mailing address and contact information to ensure Medicaid renewal packets and other notices were mailed to the correct address. DHCF is legally required to conduct outreach by mail but expanded options to include texts and phone calls as well.

DHCF and DHS also established an enhanced process for returned mail that generates a new notice when a piece of returned mail provides an in-District forwarding address.

Second, DHCF is reviewing its quality assurance processes around notice printing and mailing to ensure that unnecessary or largely duplicative notices are not being generated and mailed to beneficiaries. DHCF mails notices based on certain system triggers in its integrated eligibility system. Legal requirements for sending notice sometimes can result in what appears to be excessive or duplicative communications. For example, DHCF mails a notice of pending termination if the agency has not received a completed renewal package or there are outstanding verifications 30 days prior to the certification end date. Therefore, even a beneficiary submits their renewal close to or after this deadline, they are likely to receive a notice of pending termination despite having recently taken action to renew their benefits.

Finally, DHCF continually reviews and updates system notices to ensure they use language that conveys information clearly and efficiently. Program participants can expect ongoing changes to notices with the goal of providing .

45. What is the average length of time for each MCO and FFS to complete:

a. Non-urgent prior authorizations?

b. Urgent prior authorizations?

c. Long-term care prior authorizations?

The managed care contract requires non-urgent and long-term care prior authorizations be reviewed within a 14-day timeframe with the option for an additional 14 days, if approved by DHCF. For urgent prior authorizations, the timeframe is no more than 72 hours. The MCOs only provide prior authorizations for skilled nursing and personal care aid services. The following chart illustrates the average length of time for each MCP.

Prior Authorization Average Determination Timeframes			
MCO	**Non-Urgent**	**Urgent**	**Long-Term Care**
AmeriHealth Caritas, DC	7 Days	72 Hours	1 Day
Amerigroup DC	6 Days	24 Hours	3 Days
MedStar Family Choice	3 Days	24 Hours	3 Days
HSCSN	8 Days	48 Hours	11 Days
Fee-For-Service	3 Days	24 hours	N/A

46. Which of the MCOs and FFS currently provide a patient portal? Please describe the features of each, and any differences between them.

The information below illustrates the different enrollee portals currently offered by the managed care organizations. Two MCOs provide mobile apps in addition to the enrollee portals located on their perspective website. HCSCN and FFS do not have enrollee portals currently. Enrollees can contact HSCSNs' Enrollee Services Department for assistance.

Managed Care Plan	Website Enrollee Portal	App Enrollee Portal
AmeriHealth Caritas DC	• Access ID card • View current medications (but cannot order replacement refills) • Track past claims and claim payment status (with amounts), and • Choose and/or change PCP • View care gaps and screenings that are recommended, their due date and whether they are due or overdue	• Access ID card • Access medicine cabinet to find out more information about current medications and order replacement refills • View paid claims amounts not visible in the app) • Choose and/or change PCP • View care gaps and screenings that are recommended, their due date and whether they are due or overdue
Amerigroup DC	• Change primary care provider • View or print Enrollee ID card • Manage your CarelonRx Pharmacy prescriptions, if applicable • Update your contact info • Chat with a live person or send us a secure message • Request a call back from Member Services • View Claims	• Find a doctor, hospital, pharmacy, or specialist • View Claims • Manage Prescriptions • Complete Health Risk Assessment (HRA) • Chat with a live person • Restrictions: Enrollees cannot access medical records

	• My Family health records, simply shows gaps in care, not actual health records.	
MedStar Family Choice DC	• Request to change their primary care provider • Request a new or replacement ID card, and • View claims and authorizations • Restrictions-Enrollees cannot receive medical records through the portal	No App available

47. Please detail all software upgrades made to the DC Access System (DCAS) in FY 2023 and FY 2024, to date, including the date of the upgrade, the problem being addressed, and the status of the upgrade (completed, pending, paused, etc.)

Please see Attachment 47 and Zip File 47. Contents from the zip file correspond with the attachments to explain at a high- level what was provided for the release/project, as there are often multiple initiatives being addressed with any given release/project.

All upgrades are complete.

48. Please provide spending/costs, both actual and projected, for FY 2023 and FY 2024, to date, for Information Technology Management, broken down by IT equipment and IT contracts.

Please see chart below:

			FY2023 Actuals			FY2024 Quarter 1 Actuals				
	Account	Account Description	Budget	Expendtures	Variance	Budget	Commitment	Obligation	Expendtures	Variance
	7132002	IT CONSULTANT CONTRACTS	96,177,175	29,418,995	66,758,180	109,147,109	7,666,320	24,064,838	4,529,018	145,407,285
CONTRACTUAL SERVICES - OTHER Total			**345,742,376**	**140,073,940**	**205,668,436**	**109,147,109**	**7,666,320**	**24,064,838**	**4,529,018**	**145,407,285**
	7131035	IT HARDWARE MAINTENANCE	10,356	-	10,356	1,850,099	-	-	607,659	2,457,758
	7131036	IT SOFTWARE MAINTENANCE	-	-	-	1,540,628	-	513,671	37,309	2,091,608
	7131044	OCTO IT ASSESSMENT	219,127	217,538	1,589					-
OTHER SERVICES & CHARGES Total			**1,946,932**	**774,370**	**1,172,561**	**3,390,727**	**0**	**513,671**	**644,968**	**4,549,366**
	7171003	PURCHASES EQUIPMENT & MACHINERY	89,247	84,466	4,781					-
	7171008	IT HARDWARE ACQUISITIONS	6,180,375	338,625	5,841,750	6,347,632	-	0	-	6,347,632
	7171009	IT SOFTWARE ACQUISITIONS	9,628,186	5,789,533	3,838,653	11,332,557	526,194	1,584,321	1,128,366	14,571,438
PURCHASES EQUIPMENT & MACHINERY Total			**16,527,569**	**6,224,418**	**10,303,151**	**17,680,189**	**526,194**	**1,584,321**	**1,128,366**	**20,919,070**
	7111020	IT SUPPLIES	127,136	12,727	114,409	197,625	-	9,019	-	206,644
SUPPLIES & MATERIALS Total			**376,945**	**92,401**	**284,544**	**197,625**	**0**	**9,019**	**0**	**206,644**
Grand Total			**364,593,821**	**147,165,129**	**217,428,692**	**260,831,300**	**16,385,028**	**52,343,698**	**12,604,704**	**342,164,730**

49. Please provide the steps DHCF has taken in FY 2023 and FY 2024, to date, to address the following common complaints about the DCAS application system:

a. No confirmation of completed application;

Applicants who submit an application or renewal through District direct receive a confirmation of submission screen. However, applicants do not receive confirmation of submission when items are dropped off at services centers, or via mail.

All applicants are sent automatic notice triggered by various dispositions of their applications or renewals.

b. Benefits cut off when a completed application is pending; and

A resident who has submitted a completed application but continues to await processing will continue to receive benefits until a decision has been reached regarding their eligibility, regardless of whether their modality of submission.

c. Length of time newborn applications are pending.

A deployment is scheduled for Spring 2024 to provide a streamlined process for newborns to be added as a result of reporting information at renewal.

50: How many people, as a raw number and percentage of all Medicaid renewals, were required to complete the Conversion Renewal Form, D2 Renewal Form, and non-MAGI MAGI Renewal Form?

See columns 4 through 6 in the table below for beneficiaries required to submit each renewal form type. The table reflects Medicaid enrollees required to renew manually (i.e., non-passively) beginning with May 2023, which is the first month with renewals due after the end of the federal COVID-19 public health emergency.

Medicaid Beneficiaries Due for Renewal by Non-Passive Renewal Form Type, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	Beneficiaries due for renewal	Total receiving non-passive renewal form	Beneficiaries required to complete the conversion renewal form	Beneficiaries required to complete the non-MAGI renewal form	Beneficiaries required to complete the D2 (MAGI) renewal form
Number of beneficiaries					
2023-05-31	14,504	4,982	0	0	4,982
2023-06-30	21,621	9,967	1,914	236	7,817
2023-07-31	31,414	20,348	1,852	139	18,357
2023-08-31	28,508	19,474	3,753	160	15,566
2023-09-30	17,621	7,753	3,667	208	3,878
2023-10-31	42,814	15,556	3,399	202	11,986
2023-11-30	29,783	17,789	5,840	244	11,707
Percent of total due for renewal					
2023-05-31	100%	34%	0%	0%	34%
2023-06-30	100%	46%	9%	1%	36%
2023-07-31	100%	65%	6%	0%	58%
2023-08-31	100%	68%	13%	1%	55%
2023-09-30	100%	44%	21%	1%	22%
2023-10-31	100%	36%	8%	0%	28%
2023-11-30	100%	60%	20%	1%	39%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

For each form, please include the following info for FY 2023 and FY 2024, to date:

a. How many people (as a raw number and percentage) returned the form before the date of termination of their Medical Assistance?

See column 3 in tables below for each renewal form type. Most individuals who returned a renewal form prior to their certification date would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their

certification date. This includes non-MAGI beneficiaries who responded during their one-month extension and MAGI children who were reinstated or had a termination paused while DHCF ensured compliance with federal ex-parte (passive) renewal requirements.

b. Of the people who submitted the form before the date of termination of their Medical Assistance, how many people still had their Medical Assistance coverage terminated?

Individuals who submit a renewal form prior to their certification date retain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible, but a small number are determined ineligible and disenrolled.

c. Of the people who were sent the form and did not return it before the termination date of their Medical Assistance, how many people returned the form during the month following their termination from coverage?

See column 4 in tables below for each renewal form type. This group reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after a one-month extension.

d. Of the people who returned each form within the month following their termination, how many people (both as a raw number and percentage) were reenrolled in their Medical Assistance coverage?

See column 6 in tables below for each renewal form type. This group is a subset of column 4 and reflects MAGI adults terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**Total receiving conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-05-31	0	0	0	0	0
2023-06-30	1,914	1,096	699	119	90

1	2	3	4	5	6
Recertification Date	**Total receiving conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-07-31	1,852	988	716	148	80
2023-08-31	3,753	2,017	1,442	294	218
2023-09-30	3,667	1,870	1,508	289	255
2023-10-31	3,399	1,678	1,454	267	160
2023-11-30	5,840	2,681	2,758	401	8
Percent of total receiving conversion renewal form					
2023-05-31	0%	0%	0%	0%	0%
2023-06-30	100%	57%	37%	6%	5%
2023-07-31	100%	53%	39%	8%	4%
2023-08-31	100%	54%	38%	8%	6%
2023-09-30	100%	51%	41%	8%	7%
2023-10-31	100%	49%	43%	8%	5%
2023-11-30	100%	46%	47%	7%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**Total receiving non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-05-31	0	0	0	0	0
2023-06-30	236	149	78	9	11
2023-07-31	139	84	41	14	3
2023-08-31	160	89	62	9	17

1	2	3	4	5	6
Recertification Date	**Total receiving non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-09-30	208	125	72	11	14
2023-10-31	202	118	70	14	11
2023-11-30	244	128	101	15	1
Percent of total receiving non-MAGI renewal form					
2023-05-31	0%	0%	0%	0%	0%
2023-06-30	100%	63%	33%	4%	5%
2023-07-31	100%	60%	29%	10%	2%
2023-08-31	100%	56%	39%	6%	11%
2023-09-30	100%	60%	35%	5%	7%
2023-10-31	100%	58%	35%	7%	5%
2023-11-30	100%	52%	41%	6%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving D2 (MAGI) Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**Total receiving non-passive D2 (MAGI) renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-05-31	4,982	2,071	1,933	978	568
2023-06-30	7,817	3,624	2,657	1,536	942
2023-07-31	18,357	8,270	5,716	4,371	1,921
2023-08-31	15,566	7,021	4,796	3,749	1,537
2023-09-30	3,878	1,918	1,191	769	393
2023-10-31	11,986	5,375	3,635	2,976	878

1	2	3	4	5	6
Recertification Date	**Total receiving non-passive D2 (MAGI) renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-11-30	11,707	4,778	3,700	3,229	688
Percent of total receiving D2 (MAGI) renewal form					
2023-05-31	100%	42%	39%	20%	11%
2023-06-30	100%	46%	34%	20%	12%
2023-07-31	100%	45%	31%	24%	10%
2023-08-31	100%	45%	31%	24%	10%
2023-09-30	100%	49%	31%	20%	10%
2023-10-31	100%	45%	30%	25%	7%
2023-11-30	100%	41%	32%	28%	6%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: The sum of components can exceed the total because individuals can appear in more than one category. December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.
Notes applicable to tables that appear under responses to items a through d:

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects MAGI adults terminated at their certification date and/or non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 includes MAGI children who were terminated and later reinstated and/or MAGI children whose termination were paused and/or non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects MAGI adults terminated at their certification date and/or non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible, but a small number are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

51: For the Aged, Blind, and Disabled ("ABD") Medicaid population, how many enrollees on a monthly basis were passively renewed, and how many were sent a renewal form in FY 2023 and in FY 2024, to date?

a. For the ABD population that was sent a renewal form, how many were sent the Conversion Renewal Form, and how many as a raw number and percentage of the overall were sent the Non-MAGI Renewal Form in FY23 and in FY24 to date?

b. For the ABD population that was sent the Conversion Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90 day grace period in FY 2023 and in FY 2024, to date?

c. For the ABD population that was send the non-MAGI Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90 day grace period in FY 2023 and in FY 2024, to date?

For Aged, Blind, and Disabled (ABD) beneficiaries passively renewed and those required to submit a non-passive renewal form, see columns 3 and 4 of the table under item a below. The table reflects Medicaid enrollees required to renew beginning with June 2023, which is the first month with non-MAGI renewals due after the end of the federal COVID-19 public health emergency.

a. See columns 5 and 6 below.

Medicaid ABD Beneficiaries Due for Renewal by Passively Renewed and Non-Passive Renewal Form Type, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries due for renewal**	**ABD beneficiaries passively renewed**	**ABD beneficiaries receiving non-passive renewal form**	**ABD beneficiaries required to complete the conversion form**	**ABD beneficiaries required to complete the non-MAGI form**
Number of beneficiaries					
2023-06-30	528	41	487	419	68
2023-07-31	471	29	442	431	11
2023-08-31	1,863	133	1,730	1,697	34
2023-09-30	1,945	136	1,809	1,744	65
2023-10-31	17,623	16,535	1,088	1,038	52
2023-11-30	4,170	1,533	2,637	2,589	50
Percent of total due for renewal					
2023-06-30	100%	8%	92%	79%	13%
2023-07-31	100%	6%	94%	92%	2%
2023-08-31	100%	7%	93%	91%	2%
2023-09-30	100%	7%	93%	90%	3%
2023-10-31	100%	94%	6%	6%	0%

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries due for renewal**	**ABD beneficiaries passively renewed**	**ABD beneficiaries receiving non-passive renewal form**	**ABD beneficiaries required to complete the conversion form**	**ABD beneficiaries required to complete the non-MAGI form**
2023-11-30	100%	37%	63%	62%	1%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

b. See column 3 below for the number of Medicaid ABD beneficiaries who returned a conversion renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension.

   See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid ABD Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries required to complete the conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-06-30	419	180	220	19	27
2023-07-31	431	173	234	24	25
2023-08-31	1,697	787	768	142	146
2023-09-30	1,744	741	862	141	164
2023-10-31	1,038	459	490	89	44
2023-11-30	2,589	979	1,419	191	1
Percent of total receiving conversion renewal form					
2023-06-30	100%	43%	53%	5%	6%

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries required to complete the conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-07-31	100%	40%	54%	6%	6%
2023-08-31	100%	46%	45%	8%	9%
2023-09-30	100%	42%	49%	8%	9%
2023-10-31	100%	44%	47%	9%	4%
2023-11-30	100%	38%	55%	7%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

c. See column 3 below for the number of Medicaid ABD beneficiaries who returned a non-MAGI renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension.

   See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid ABD Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-06-30	419	180	220	19	27

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-07-31	431	173	234	24	25
2023-08-31	1,697	787	768	142	146
2023-09-30	1,744	741	862	141	164
2023-10-31	1,038	459	490	89	44
2023-11-30	2,589	979	1,419	191	1
Percent of total receiving non-MAGI renewal form					
2023-06-30	100%	43%	53%	5%	6%
2023-07-31	100%	40%	54%	6%	6%
2023-08-31	100%	46%	45%	8%	9%
2023-09-30	100%	42%	49%	8%	9%
2023-10-31	100%	44%	47%	9%	4%
2023-11-30	100%	38%	55%	7%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: The sum of components can exceed the total because individuals can appear in more than one category. December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.
Notes applicable to tables that appear under responses to items b and c:

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

52: Of the Qualified Medicare Beneficiary ("QMB") population, how many were sent the Non-MAGI Renewal Form, both as a raw number and percentage of the overall in FY 2023 and in FY 2024, to date? How many QMB enrollees were sent the Conversion Renewal Form as a raw number and percentage of the overall QMB population in FY 2023 and in FY 2024, to date?

a. For the QMB population that was sent the Conversion Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90 day grace period in FY23 and in FY24 to date?

b. For the QMB population that was sent the non-MAGI Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90 day grace period in FY23 and in FY24 to date?

For Qualified Medicare Beneficiary (QMB) only individuals (i.e., those with Medicaid coverage limited to payment of Medicare premiums and cost sharing) required to submit each renewal form type, see columns 5 and 6 of the table below. The table reflects Medicaid enrollees required to renew beginning with June 2023, which is the first month with non-MAGI renewals due after the end of the federal COVID-19 public health emergency.

Medicaid QMB Only Beneficiaries Passively Renewed and Receiving Non-Passive Renewal Form by Form Type, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	QMB-only beneficiaries due for renewal	QMB-only beneficiaries passively renewed	QMB-only beneficiaries receiving non-passive renewal form	QMB-only beneficiaries required to complete the conversion form	QMB-only beneficiaries required to complete the non-MAGI form
Number of beneficiaries					
2023-06-30	704	3	701	659	42
2023-07-31	717	33	684	661	23
2023-08-31	1,282	44	1,238	1,194	44
2023-09-30	1,237	31	1,206	1,160	46
2023-10-31	899	51	848	791	57
2023-11-30	2,502	65	2,437	2,373	64
Percent of total receiving non-passive renewal form					
2023-06-30	100%	0%	100%	94%	6%
2023-07-31	100%	5%	95%	92%	3%
2023-08-31	100%	3%	97%	93%	3%
2023-09-30	100%	3%	97%	94%	4%
2023-10-31	100%	6%	94%	88%	6%
2023-11-30	100%	3%	97%	95%	3%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

d. See column 3 below for the number of Medicaid QMB only beneficiaries who returned a conversion renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension.

   See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid QMB Only Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	QMB-only beneficiaries required to complete the conversion renewal form (3+4+5)	Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)
Number of beneficiaries					
2023-06-30	659	346	290	23	24
2023-07-31	661	331	302	28	19
2023-08-31	1,194	654	467	73	41
2023-09-30	1,160	609	464	87	57
2023-10-31	791	383	330	78	17
2023-11-30	2,373	1,190	1,026	157	0
Percent of total receiving non-passive renewal form					
2023-06-30	100%	53%	44%	3%	4%
2023-07-31	100%	50%	46%	4%	3%
2023-08-31	100%	55%	39%	6%	3%
2023-09-30	100%	53%	40%	8%	5%
2023-10-31	100%	48%	42%	10%	2%
2023-11-30	100%	50%	43%	7%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

e. See column 3 below for the number of Medicaid QMB only beneficiaries who returned a non-MAGI renewal form before the termination of their Medicaid coverage. Most of these

individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension.

See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period.

Medicaid QMB Only Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2023 and FY 2024 to Date

1	2	3	4	5	6
Recertification Date	QMB-only beneficiaries required to complete the non-MAGI renewal form (3+4+5)	Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)
Number of beneficiaries					
2023-06-30	42	31	9	2	0
2023-07-31	23	14	9	0	1
2023-08-31	44	22	20	2	4
2023-09-30	46	29	16	1	3
2023-10-31	57	25	28	4	1
2023-11-30	64	29	30	5	0
Percent of total receiving non-passive renewal form					
2023-06-30	100%	74%	21%	5%	0%
2023-07-31	100%	61%	39%	0%	4%
2023-08-31	100%	50%	45%	5%	9%
2023-09-30	100%	63%	35%	2%	7%
2023-10-31	100%	44%	49%	7%	2%
2023-11-30	100%	45%	47%	8%	0%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: The sum of components can exceed the total because individuals can appear in more than one category. December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.
Notes applicable to tables that appear under responses to items a and b:

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

53. In the FY 2024 District Budget, the Committee provided funding to raise the personal needs allowance (PNA) from $100 to $130 per month for residents of assisted living facilities and certified residential facilities. Has this increase already been implemented? If not, what is the timeline for implementation?

a. Please provide the PNA amounts for all categories of beneficiaries that receive a PNA under the Medicaid and Alliance programs.

As detailed in agency Transmittal #23-63 (*see* Attachment 53) DHCF implemented increases in the Personal Needs Allowance (PNA) for long-term care residents effective January 1, 2024.

The PNA for an individual in a nursing facility not receiving a pension from the Department of Veterans Affairs (VA) and individuals in a nursing facility receiving a pension from the VA is increasing from $100 to $103.20. The PNA for a couple institutionalized in a facility is increasing from $200 to $206.40.

Individuals in nursing facilities who receive SSI and individuals in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) who receive SSI will also see an increase from $100 to $103.20.

The PNA for individuals in the Optional State Supplemental Payment Program (OSSP) in Assisted Living Facilities and Certified Residential Facilities has increased to $134.16 for individuals and $268.32 for couples.

54: Of the people who had their Medical Assistance terminated since the restart of renewals, how many of those people (both as a raw number and percentage of total) had their coverage terminated because DHS determined they no longer met the requirements of their existing Medical Assistance eligibility category in FY 2023 and in FY 2024, to date?

a. Of those Medicaid participants who lost their coverage because they no longer qualified under their existing eligibility group, how many / what

percentage of those participants were enrolled, in FY 2023 and in FY 2024 to date, in:

i. ABD Medicaid
ii. Long-Term Care Medicaid
iii. Children on Medicaid
iv. Parents / Caretaker Relatives
v. Childless Adult Medicaid
vi. Pregnant Individuals
vii. Qualified Medicare Beneficiary (QMB)

See column 2 of table below for the total number of beneficiaries terminated due to a determination of ineligibility. The table reflects Medicaid enrollees required to renew beginning with May 2023, which is the first month with renewals due after the end of the federal COVID-19 public health emergency.

a. See columns 3 through 10 of the table below for the number of beneficiaries determined ineligible by eligibility group.

Medicaid Beneficiaries Determined Ineligible by Eligibility Group, FY 2023 and FY 2024 to Date

1	2	3	4	5	6	7	8	9	10
Recertification Date	Determined ineligible before or after their certification period	ABD	Long-term care	Children	Parent / caretaker relatives	Child-less adults	Pregnant indivi-duals	QMB-only	Other adults
Number of beneficiaries									
2023-05-31	77	0	0	28	7	41	1	0	0
2023-06-30	353	11	13	81	70	118	0	59	1
2023-07-31	1,366	2	7	534	235	528	8	42	10
2023-08-31	1,317	15	11	516	194	507	2	65	7
2023-09-30	148	14	4	34	25	39	0	32	0
2023-10-31	929	9	3	405	120	363	4	21	4
2023-11-30	436	12	4	150	53	163	3	48	3
Percent of total determined ineligible									
2023-05-31	100%	0%	0%	36%	9%	53%	1%	0%	0%
2023-06-30	100%	3%	4%	23%	20%	33%	0%	17%	0%
2023-07-31	100%	0%	1%	39%	17%	39%	1%	3%	1%
2023-08-31	100%	1%	1%	39%	15%	38%	0%	5%	1%
2023-09-30	100%	9%	3%	23%	17%	26%	0%	22%	0%
2023-10-31	100%	1%	0%	44%	13%	39%	0%	2%	0%

1	2	3	4	5	6	7	8	9	10
Recertification Date	Determined ineligible before or after their certification period	ABD	Long-term care	Children	Parent / caretaker relatives	Child-less adults	Pregnant indivi-duals	QMB-only	Other adults
2023-11-30	100%	3%	1%	34%	12%	37%	1%	11%	1%

Source: DHCF eligibility system data extracted January 2, 2024.
Notes: December 2023 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known. ABD is Aged, Blind, or Disabled; QMB is Qualified Medicare Beneficiary; "Other adults" reflects adults excluded from other groups, such as incarcerated.

55: Of the people who had their Medical Assistance terminated since the restart of renewals, how many people who qualified for Medical Assistance in another eligibility category still had their Medical Assistance terminated for any period of time?

See response to Question 43 for information on Medicaid beneficiaries due for a renewal who were terminated for a period of time but later received coverage because they responded during their 90-day grace period.

DHCF does not currently track renewals based on whether an individual moves to another eligibility category after a renewal is processed. Future DHCF analyses will examine the extent to which individuals change eligibility categories at the time of or following a renewal.

56: Of the people who had their Medical Assistance terminated since the start of renewals, and who did have their coverage terminated for some period of time, how many were re-enrolled in another eligibility category of Medicaid without submitting a new Medicaid application in FY 2023 and in FY 2024, to date?

As noted in response to Question 43(b), DCAS reports used by DHCF to track Medicaid renewals do not currently identify individuals who were without coverage for a period of time and later file a new application beyond their 90-day grace period. Future DHCF analyses will examine the extent to which individuals change eligibility categories at the time of or following a renewal.

A deployment is scheduled for Spring 2024 to provide a streamlined process for newborns to be added as a result of reporting information at renewal.

57. Regarding new applications for Medicaid in FY 2023 and in FY 2024, to date, please provide:

a. The number of applications that were submitted through District Direct (broken down by District Direct mobile app and District Direct Website if available) online;

Month	Total applications	Online applications
Oct-22	1,077	579
Nov-22	1,040	606
Dec-22	1,057	648
Jan-23	1,278	852
Feb-23	918	597
Mar-23	1,124	765
Apr-23	860	603
May-23	1,050	768
Jun-23	1,135	831
Jul-23	1,362	986
Aug-23	1,294	1,040
Sep-23	978	848
Oct-23	965	823
Nov-23	994	881
Dec-23	1,025	868

Source: DHCF eligibility system data compiled as of January 2, 2024.
Notes: Online reflects the District Direct website and mobile app.

b. The number of these applications processed within 45 days of submission; and

Month	Percent of Applications NOT Processed Within 45 Days (MAGI) or 90 Days (Non-MAGI)
Oct-22	9%
Nov-22	9%
Dec-22	18%
Jan-23	16%
Feb-23	23%
Mar-23	30%
Apr-23	20%
May-23	13%
Jun-23	20%
Jul-23	13%
Aug-23	12%
Sep-23	22%
Oct-23	37%
Nov-23	41%
Dec-23	29%

Source: DHCF eligibility system data compiled as of January 2, 2024.
Notes: This table reflects processing time data submitted in the Performance Indicator data set to the Centers for Medicare & Medicaid Services (CMS). It follows CMS specifications and reflects all applications that have a determination in each month (it is not limited to online applications) and defines "timely" as a processing time of 45 days or less for MAGI applications and 90 days or less for non-MAGI applications.

c. For applications not processed within 45 days, please discuss the reasons for any delays and what the Department is doing to prevent such delays in the future.

During the PHE, DC Medicaid enrollment grew to over 300,000 beneficiaries. The end of the continuous enrollment requirement meant all enrolled beneficiaries needed a renewal initiated and processed between April 2023 and May 2024 – the Medicaid unwinding period. This translates to an unprecedented return to normal Medicaid eligibility operations for DHS and DHCF, at a time when many new eligibility policies, processes, and systems were being implemented for the first time. Swelling enrollment and the challenges of acclimating the case processing workforce to these changes have contributed to an expanded backlog of pending applications and renewals that are impacting the overall timeliness of Medicaid, Alliance, and ICP eligibility determinations.

To address processing issues and improve timeliness DHCF and DHS have identified the following issues and pathways to resolution.

System Integrator Issues: many states, including the District, experienced a variety of issues with the complex system integration for Releases 1 and 2. Following these Releases, the District was required to navigate a difficult transition to a new vendor and create a patchwork of fixes to the existing system throughout the development of Release 3, some of which are still in process.

- **Resolution:** Optimize Existing Technology and Deploy Enhancements
- Procure a new Operations and Maintenance vendor to seamlessly integrate new program requirements necessitated by federal law and continue to deploy fixes to reinforce existing technology.
- DCAS will execute a major upgrade to Curam technology in Summer ‘24
- Consistently deploys new releases every 8-10 weeks in DCAS to address technical issues causing application errors

Overlapping Eligibility Policies: federal eligibility policy for the SNAP, TANF, and Medicaid programs does not naturally align to support application questions that comply with the requirements for all three programs. Thus, some questions on the District’s integrated application overlap and increase the length of the application.

- **Resolution:** Improve the usability of the online application by collaborating with federal partners to fully align health and human services policies and thereby reduce the length of

the application, and establish more efficient processes for customers with questions and issues

- DHS-DHCF have engaged Code for America and working with federal partners to streamline and update the integrated application with the use of predictive technology
- DCAS is procuring a new contact center vendor and will establish integrated contact center functions to serve all health and human services programs and make it easier for customers to obtain needed information and/or action.
- DHCF and DHS will explore further utilization of 1902(e)(14) waivers to align SNAP and Medicaid eligibility policy where possible.

Application Processing and Timeliness: providing adequate training on the new system requires a continuous review and modification of business processes that has presented unanticipated challenges, and is complicated by the end of the Public Health Emergency and the numerous changes occurring in all programs

- **Resolution**: Improve application processing through the deployment of enhanced training, support and revision of business processes
- Agencies are collaborating on more targeted training delivery, simplification of workflows, and integrated help options
- Agencies have also established multiple partnerships to enhance system training and are performing a deep dive into business processes
- DHS is investigating ways to use Artificial Intelligence to further automate application processing by reducing the number of tasks customer service representatives are required to complete for processing. At the end of FY2023, DHS received ~$1M in a three-year grant to address forms and returned mail with AI.
- DHCF and DHS are also augmenting the merit workforce with contract staff to support with on-site document management, lobby services, and returned mail processing.
- The District is required by federal law to implement eligibility system functionality that will expand passive renewal capability for Non-MAGI populations; DHCF will explore expediting implementation of this system functionality to decrease the overall number of cases that will require caseworker processing.

The cumulative goal of these efforts is to see meaningful decrease in the application and renewal backlog by at least an aggregate 10% per month and total elimination of major backlogs going forward.

58. Regarding new applications for Medicaid in FY 2023 and in FY 2024, to date, please provide the number of applications submitted in person at ESA Service Centers.

The table below presents the total number of applications received each month of FY23 and FY24 YTD, along with the number and share that were submitted in-person.

Month	Total applications	Applications submitted in person	Percent of total applications submitted in person
Oct-22	1,077	365	34%
Nov-22	1,040	308	30%
Dec-22	1,057	302	29%
Jan-23	1,278	337	26%
Feb-23	918	246	27%
Mar-23	1,124	290	26%
Apr-23	860	194	23%
May-23	1,050	246	23%
Jun-23	1,135	272	24%
Jul-23	1,362	343	25%
Aug-23	1,294	224	17%
Sep-23	978	106	11%
Oct-23	965	128	13%
Nov-23	994	90	9%
Dec-23	1,025	365	11%

Source: DHCF eligibility system data compiled as of January 2, 2024.

a. For applications not based on disability, please provide:

i. The number of these applications that were processed within 45 days of submission.

See table below. It provides the percentage of MAGI applications (which reflect those that are not based on disability) processed within 45 days.

ii. For those applications that were not processed within 45 days, the reasons for any delays and what DHCF is doing to prevent such delays in the future.

See response to Question 57(c).

b. For applications based on disability, please provide:

i. The number of these applications that were processed within 90 days of submission.

See table below. It provides the percentage of non-MAGI applications (which reflect those based on disability, as well as those for individuals who are age 65 and older or in need of long-term care) processed within 90 days.

ii. For those applications that were not processed within 90 days, the reasons for any delays and what DHCF is doing to prevent such delays in the future.

See response to Question 57 item c.

Percent of Applications Processed Timely, FY 23 - FY 24 YTD

Month	Percent of MAGI Applications Processed Within 45 Days	Percent of Non-MAGI Applications Processed Within 90 Days
Oct-22	90%	94%
Nov-22	91%	92%
Dec-22	82%	92%
Jan-23	84%	86%
Feb-23	76%	98%
Mar-23	69%	89%
Apr-23	79%	90%
May-23	87%	95%
Jun-23	79%	96%
Jul-23	85%	98%
Aug-23	88%	93%
Sep-23	77%	91%
Oct-23	62%	93%
Nov-23	58%	93%
Dec-23	70%	85%

Source: DHCF eligibility system data compiled as of January 2, 2024.

Notes: This table reflects processing time data submitted in the Performance Indicator data set to the Centers for Medicare & Medicaid Services (CMS). It follows CMS specifications and reflects all applications that have a determination in each month (it is not limited to in person applications) and defines "timely" as a processing time of 45 days or less for MAGI applications and 90 days or less for non-MAGI applications.

59. At any point in FY 2023 and in FY 2024, to date, was there a backlog of applications for Medicaid awaiting processing? If so, please report:

a. The number of applications that were or are backlogged, per month, and the average length of time applications were delayed, for:

i. Applications submitted online;

ii. Applications submitted in person at the service centers; and

iii. Applications submitted through any other means;

DHCF does not currently have comprehensive data on the number of backlogged applications, which can be defined as those that are pending more than 45 days for non-disability applications and more than 90 days for those on the basis of a disability.

b. The causes of such backlog(s);

c. DHCF's efforts to reduce such backlog(s);

d. The extent to which such backlog(s) have been reduced;

e. Steps DHCF has taken since the beginning of FY 2023 or will take over the remainder of FY 2024 to investigate whether or not such backlogs exist, both for applications submitted online and for applications submitted at ESA Service Centers.

For (b) – (e), see response to Question 57(c).

60. At any point in FY 2023 or in FY 2024 to date, has DHCF encountered problems with "stuck" or "malformed" Medicaid applications?

a. If so, how many applications have been affected in FY 2023 and in FY 2024, to date?

There are currently no issues with stuck or malformed applications. Prior instances stemmed from application data feeds between DC Health Link and DCAS. The issue was resolved after deployment of Release 3 in FY2022 when new data structures were put in place.

b. What is the average number of days that it has taken households affected by this "stuck" or "malformed" error to receive a Medicaid eligibility determination?

Not applicable.

61. **In its FY 2024 Budget Report, the Committee recommends that DHCF explore creating a Medicaid Buy-In for Workers with Disabilities program so that individuals with disabilities can work, earn an income, and buy into the Medicaid**

program. What are the benefits and downsides of this program, and is DHCF considering implementing it?

Medicaid "buy-in" provides a pathway to Medicaid services and supports while also permitting people with disabilities to maximize their employment opportunities. Around the nation, "buy-in" Medicaid eligibility groups typically have the most generous income and financial eligibility standards.

Given the program is associated with a major expansion of eligibility and would require a significant investment and planning by the District. DHCF continues to analyze the administrative and programmatic requirements for developing such a program.

DC Healthcare Alliance

62. For the Health Care Alliance program, please provide enrollment and spending/costs, and utilization data, both current and projected, including statistical information by gender for FY 2023 and FY 2024, to date.

Enrollment information is updated monthly and available on the DHCF website at https://dhcf.dc.gov/eligibilitydashboard.

For costs associated with the Alliance program, please see the response to Q28.

For utilization data, please see Attachment 62. Statistical information is not broken down by gender.

63. Please describe any changes to the administration of the Alliance program during FY 2023 and FY 2024, to date.

Effective for all Alliance renewals initiated after October 1, 2022, certification periods were increased from 6 months to 12 months. The District did not implement any other major changes to administration of the Alliance benefit in FY2023.

Minor service changes aligned with changes made to similar services under Medicaid are part of ongoing maintenance to the program.

64. Please describe any changes to the administration of the Alliance program that the Department anticipates implementing during the remainder of FY 2024.

For the first time since the program's inception, effective April 1, 2024, the full array of behavioral health services will be part of the Alliance benefit. Covered behavioral health services will include mental health rehabilitation services (MHRS), adult substance use rehabilitative services (ASURS), in addition to BH services currently provided at clinics, federally-qualified health centers, and other licensed providers.

The District is not planning other major changes to implementation of the Alliance benefit in the remainder of FY24. Minor service changes aligned with changes made to similar services under Medicaid are part of ongoing maintenance to the program.

65: In FY 2023 and FY 2024, to date, what was the:

a. Average length of time for renewal of Alliance benefits;
b. Number and rate of Alliance beneficiaries whose benefits were not renewed due to changes in eligibility; and
c. Number and rate of Alliance customers whose benefits were not renewed for procedural reasons.

DHCF is working to develop additional reports that mirror those used for Medicaid renewal tracking. The trends are likely similar to those for Medicaid (e.g., see monthly reports available from DHCF and additional data presented during a joint Committee on Health and Committee on Housing roundtable held December 4, 2023).

See columns 5 and 6 in the table below for the total number and percent of Alliance and ICP beneficiaries losing coverage each month. This includes individuals due for a renewal and those who disenroll before a renewal is due (e.g., if they report a move out of the District).

Following the end of the District's public health emergency, nearly all Alliance and ICP beneficiaries were due for a renewal during the six-month period of August 2022 through January 2023. As a result, the percentage of beneficiaries losing coverage is higher during these six months (columns 5 and 6). In addition, a number of individuals were re-enrolled under a new ID number or had a gap in coverage before re-enrolling, which contributed to data showing an increase in the number of newly enrolled.

As with timeliness reports, the requested reports with data on non-renewals due to changes in eligibility versus procedural reasons are under development at this time.

Alliance and Immigrant Children's Program Enrollment by Retaining or Losing Coverage, for Months Since August 2022 Restart of Renewals

1	2	3	4	5	6
Month	Total enrolled	Ongoing enrolled and retaining coverage next month	Newly enrolled or re-enrolled after gap and retaining coverage next month	Losing coverage next month	Percent of total losing coverage next month
FY 2022					
2022-08	30,900	28,489	441	1,970	6%
2022-09	29,332	26,534	445	2,353	8%
FY 2023					
2022-10	27,555	23,418	612	3,525	13%

1	2	3	4	5	6
Month	**Total enrolled**	**Ongoing enrolled and retaining coverage next month**	**Newly enrolled or re-enrolled after gap and retaining coverage next month**	**Losing coverage next month**	**Percent of total losing coverage next month**
2022-11	24,650	21,462	712	2,476	10%
2022-12	22,930	19,322	810	2,798	12%
2023-01	21,062	17,948	992	2,122	10%
2023-02	19,732	18,342	832	558	3%
2023-03	20,141	18,616	1,001	524	3%
2023-04	20,395	19,457	802	136	1%
2023-05	21,344	20,150	1,050	144	1%
2023-06	22,003	21,051	788	164	1%
2023-07	22,540	21,603	695	242	1%
2023-08	23,075	22,041	757	277	1%
2023-09	23,396	22,575	568	253	1%
FY 2024					
2023-10	23,687	22,611	503	573	2%
2023-11	23,499	22,535	371	593	3%
2023-12	23,388	22,328	448	612	3%

Source: DHCF Medicaid Management Information System (MMIS) data extracted January 15, 2024.

Notes: Following the end of the District's public health emergency, nearly all Alliance and ICP beneficiaries were due for a renewal during the six-month period of August 2022 through January 2023. As a result, the percentage of beneficiaries losing coverage is higher during these six months (columns 5 and 6). In addition, some individuals re-enrolled under a new ID number or had a gap in coverage before re-enrolling, which contributed to an increase in the number showing as newly enrolled (column 4). Due to grace period renewals that are retroactive to an individual's certification date and ongoing processing of new applications, enrollment for recent months is likely to be higher and disenrollment is likely to be lower when run at a future date. Additional column-specific notes are provided below.

- The total enrolled (column 2) reflects all individuals with Alliance and ICP coverage during the month shown.
- Ongoing enrolled (column 3) reflects those who had DHCF coverage in the previous month.
- Newly enrolled or re-enrolled (column 4) reflects those who never had DHCF coverage in the past or returned after a gap of one or more months.
- Losing coverage (columns 5 and 6) reflects those who have no DHCF enrollment in the following month. This includes individuals due for a renewal and those who disenroll before a renewal is due (e.g., if they report a move out of the District).

66. In its FY 2024 Budget Report, the Committee made a policy recommendation to DHCF to work with hospitals and long-term care providers like skilled nursing facilities to ensure there are safe places for Alliance members to be discharged to and that there is appropriate reimbursement for those services. What changes, if any, has DHCF made to its policies and resources for Alliance members who need long-term care after being discharged from hospitals?

Long-term care (LTC) services are excluded from the scope of Alliance coverage. Significant additional funding is necessary to support a policy change that will expand coverage beyond that which is currently covered by the District.

Currently, individuals may be discharged from a hospital to receive 30 days of extended rehabilitative care in a skilled nursing facility. Thereafter, managed care plans are required to coordinate care and other covered services for their enrolled populations prior to discharge from any hospital or facility. These efforts assist in understanding the discharge needs and covered services and supplies that can be offered both during and post-discharge to support a safe transition for the resident. Early care coordination efforts help to ensure the MCOs can help put the services needed upon discharge in place.

Disability Services

67. Please provide the total number of elderly and persons with disabilities (EPD) waiver participants in FY 2023 and to date in FY 2024.

As of January 8, 2024, the enrollment in the elderly and persons with disabilities (EPD) Waiver is 5,209.

68. In FY 2023 and FY 2024, to date, how many Home Health Agencies are approved by DHCF as providers of Personal Care Aide ("PCA") hours for individuals enrolled in the Medicaid State Plan and the EPD waiver program?

a. In FY 2023 and FY 2024, to date, how many Personal Care Aides does each Home Health Agency employ?

As of January 2024, DHCF has 32 home health agencies enrolled to provide Medicaid State Plan benefits, which includes State Plan personal care aide (PCA) benefits. Of these, 23 are enrolled and approved to provide EPD Waiver benefits as well.

b. How does this total number of PCAs from all the Home Health Agencies compare to the total number of Personal Care Aides for each fiscal year, dating back to FY 2020?

DHCF does not require home health agencies to report all employed PCAs. However, PCAs employed in fee-for-service Medicaid are required to obtain a Medicaid number and enroll in the

District's provider data management system. As of January 2024, there are 7,630 individuals with Medicaid IDs enrolled as Personal Care Aides.

69. Please provide the total number of Medicaid participants who received PCA hours through the Medicaid state plan only in FY 2023 and in FY 2024, to date.
   a. Of those Medicaid participants who receive their PCA hours only through the Medicaid state plan, how many is DHCF or a Managed Care Organization ("MCO") reimbursing the Home Health Agency for the total number of approved PCA hours?
   b. Of those EPD waiver participants who receive their PCA hours only through the Medicaid state plan, for how many are DHCF or an MCO reimbursing the Home Health Agency for only some of the approved PCA hours?

As of January 2024, DHCF or its managed care plans paid for PCA solely through the Medicaid State Plan for 2,220 individuals during FY23 and for 1,663 individuals, to date, in FY24. FY24 data should be considered preliminary at this time.

With regard to subquestions (a) and (b), DHCF cannot conduct this analysis without engaging in a complex data analysis that could not be performed within the timeframe afforded. Among other factors, there are multiple reasons authorized hours may not be billed or paid for a given date of service that impact the results (incomplete electronic visit verification information, fair hearings or other appeals, changes to beneficiaries' plans of care, availability of or changes to staffing, etc.).

70. For Medicaid participants receiving PCA hours through only the Medicaid state plan, how many of those participants had their PCA hours reduced once Medicaid renewals re-started in FY 2023 and in FY 2024, to date?

DHCF does not track and categorize participants by whether they have experienced reductions in hours, and therefore cannot produce this as a data point without engaging in a complex analysis over an extended period of time. Among other factors, there are multiple data sources (assessment data, claims data, authorization data, and appeals and grievance data) from multiple delivery systems and payers (CASSIP, DCHFP, Dual Choice, and fee-for-service) required to assess changes actually effectuated (and not pending appeal) due solely to changed authorizations. Medicaid beneficiaries have the right to appeal any changes to their Medicaid benefits initiated by their Medicaid payer and, if changes are appealed on a timely basis, no changes occur until their appeals rights are exhausted.

71. Please provide the total number of EPD waiver participants who are currently receiving more than 16 hours of personal care aide (PCA) services per day, 7 days per week, broken down by:
   a. The number receiving 16-17 hours of PCA services per day, 7 days per week;
   b. The number receiving 18-19 hours of PCA services per day, 7 days per week;

c. The number receiving 20-23 hours of PCA services per day, 7 days per week; and
d. The number receiving 24 hours of PCA services per day, 7 days per week.

Based on data from 9,587 assessments completed during FY2023:

- 3.4 percent of all assessment results recommended 24 hours of personal care aide (PCA) services per day, seven days per week.
- Another 4.9 percent of assessment results recommended 17 or 18 hours of services per day, with a negligible percentage (four assessments out of the total) recommending 19 to 23 hours per day. Another 3.9 percent of assessments resulted in a recommendation of 16 hours per day.

72. Please report the number of the individuals authorized to receive DC Medicaid PCA services who did not receive all their approved EPD Waiver and/or State Plan PCA service hours due to personal care aide staffing shortages in FY 2023?

While DHCF receives complaints and grievances regarding staffing shortages and gaps, these data are anecdotal and noncomprehensive. DHCF has no comprehensive, reliable source for data capturing staffing-specific gaps in care. Claims or utilization data reflecting service delivery are impacted by other phenomena, such as services not delivered for other reasons (refusals, hospitalizations) or lack of documentation to support billing for services.

73. Please provide us with the total number of EPD waiver participants who are receiving their PCA hours through a Home Health Agency and through participant directed services, in FY 2023 and in FY 2024, to date. For each, provide:
a. How many is DHCF or an MCO reimbursing for the full number of approved PCA hours?
b. How many is DHCF or an MCO reimbursing for only some of the approved PCA hours?

DHCF or its managed care plans paid for in-home services and supports through Participant Directed Services for 1,879 EPD-enrolled participants during FY23 and 1,676 participants in FY24, to date. Home health agencies were paid for PCA for 3,143 EPD-enrolled participants during FY23 and for 2,387 participants in FY24. Some individuals transitioning between services may appear in both counts. FY24 data should be considered preliminary at this time.

This data is not currently available. Among other factors, there are multiple reasons authorized hours may not be billed or paid for a given date of service that impact the results (incomplete electronic visit verification information, fair hearings or other appeals, changes to beneficiaries' plans of care, availability of or changes to staffing, etc.).

74. How many EPD waiver participants have been terminated from the EPD waiver program each month because their recertification was not submitted on a timely basis in FY 2023 and in FY 2024, to date?

a. Of those EPD waiver participants who have had their EPD waiver coverage terminated because their recertification was not submitted timely, how many recertifications were completed during the 90 day grace period in FY 2023 and in FY 2024, to date?

b. How many EPD waiver participants have lost their EPD waiver coverage because their recertification was not timely submitted prior to the date of termination and was not submitted during the 90 day grace period in FY 2023 and in FY 2024, to date?

Among EPD Waiver participants whose certification period is more than 90 days ago (who have thus exited the 90-day grace period), an average of 409 beneficiaries were due for renewal each month and an average of 102 beneficiaries (25%) were procedurally terminated as of one month after the recertification date.

An average of eight percent of beneficiaries completed renewals in the month following their recertification date (during one-month extensions). And average of four percent of beneficiaries completed a renewal later, three percent within the grace period and another one percent since the end of the grace period. Approximately 21 percent of EPD Waiver beneficiaries due to recertify on or before September 30, 2023 remained disenrolled from the waiver as of January 2, 2024.

75. The Fiscal Year 2023 Budget Support Act of 2022 included the Direct Support Professional Payment Rate Amendment Act of 2022. Provide an update on the implementation of this subtitle, including:

a. Work toward implementation in FY 2023 and FY 2024 to date;

The Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) provider rate was updated to include the cost impact of paying Direct Service Providers (DSPs) an average of 117.6% of the living/minimum wage in CY23. DHCF established a phased-in approach for Home and Community-Based Support (HCBS) providers similar to how ICF/IID provider adjustment was successfully implemented to achieve the full 117.6% by FY2025. This was accomplished by paying a supplemental payment in CY2023 and by paying 110% above the living/minimum wage for providers that applied for the funding. Payments were made in the Winter of 2023 and then again in the Summer of 2023. The CY2024 allotment was increased to 117.6% of the living/minimum wage (meeting the goal of the legislation one year early) and is being issued in up to three allotments. The Winter allotment is being issued in January and supports three months of cost. Providers are required to submit all required reporting prior to being issued any payments. The remaining nine months will be issued in March/April once those reports have been submitted and reviewed. The third allotment will be in the Summer based on any changes that occur in the living/minimum wage.

b. An update on the State Plan Amendment or waiver process;

DHCF submitted and received approval from CMS for the SPA and waiver to fund the enhanced wage increases, allowing the District to maximize the HCBS ARPA funding by getting Medicaid match for the payments (ranging from 70% to 76% between FY23 and FY24). Beginning in FY 2025, DHCF will submit another set of State Plan and Waiver Amendments to incorporate the DSP increases into the underlying rate methodologies for the impacted programs.

c. Increases provided in FY 2023 and FY 2024, to date, for direct care professionals, including dollar amounts;

The below chart represents Provider ability to pay DSPs a rate in excess of the living wage. The increase showing an average adjustment of 110-117.6% is represented in the chart below:

Period	Living/Minimum Wage	Average Rate Adjustment	Average Marginal Increase
1/1/2023	$16.50	$18.15	$1.65
7/1/2023	$17.00	$18.70	$1.70
1/1/2024	$17.05	$20.05	$3.00
7/1/2024	$17.50	$20.58	$3.08

The following chart represents the investment the District made in CY23 and to date in CY24 to support the enhanced DSP wage increases by Provider industry:

Impacted Services	CY 2023 Estimated DSP Hours Funded	CY 2023 Estimated DSP FTE Equivalents Funded	CY 2023 Payment Amount	CY24 Forecast (117.6% of LW)
ICFIID	1,094,580	526	$8,629,743	$8,204,265*
IDD Waiver	7,741,457	3,722	$19,481,422	$26,058,430
HHA	11,918,872	5,730	$29,239,015	$39,106,193
Others (ALF, ADHP, MHRS)	77,220	37	$187,989	$231,958
Total	**20,832,129**	**10,015**	**$57,538,169**	**$73,600,845**

d. Goals and milestones related to the FY 2025 implementation of the adjusted reimbursement rate for direct care service providers and

To date, DHCF has achieved its goal of ensuring providers have the financial support to pay DSPs an enhanced wage and create career ladder opportunities within their individual businesses before establishing the assumptions within the rates. This establishes a balanced payment structure across providers and industries, prior to setting industry-wide rates. We are continuing to work with the provider communities and associations to ensure we are addressing reporting deficiencies. DHCF is focused on maximizing our use of HCBS ARPA funds and meeting the goals of coverage to pay DSPs rates that align with 117.6% of the living wage as a part of the rate methodology.

e. A copy of any required reports to the Council completed thus far.

Direct Support Professional Payment Rates Report

The completion of this annual report is dependent upon the submission of accurate and updated provider data, some of which is still outstanding and continues to be submitted by DHCF's providers. We continue to receive CY2023 provider reports, but we do not have a complete data set to provide meaningful report status. This lag means that the report has been delayed, even though DHCF is not behind in the process. We expect to deliver a more complete report in April 2024. Until such time, we hope the information shared is sufficient.

76. The Fiscal Year 2024 Budget Support Act of 2023 included a subtitle to require the Director of DHCF to file reports to the Council regarding payment pathways for certain services under Medicaid. The required reports include one on payment pathways for medical respite care for individuals experiencing homelessness, a report on value-based purchasing under Medicaid MCOs, and quarterly reporting of certain MCO metrics including enrolled beneficiaries, number of beneficiaries without a primary care physician, and utilization metrics. What is the status of these reports and what is the timeline for publication?

Medical Respite Care

DHCF has contracted with consultant, Bizzell US, to complete the report. Bizzell will conduct cross-jurisdictional analyses of respite care offerings; assess current respite care needs; assess current costs; examine the provisions of the 1115 waiver; and calculate potential costs of future respite care considering waiver parameters. This work has already begun, and a complete timeline will be finalized as requested data is produced and the volume and quality of such data can be evaluated. The Department will be sure to keep Council abreast of anticipated timeframes moving forward.

Value-Based Purchasing (VBP) Reporting

Due to unforeseen procurement disruptions throughout FY22 and the earlier part of FY23, the current MCO contracts did not start until April 1, 2023 - effectively causing a delay in the projected inception and oversight of the MCOs VBPs structure. Calendar Year 2024 will serve as the VBP baseline year for the managed care organizations (MCOs). Each MCO has operational VBP arrangements implemented within their respective provider networks as of January 2024. Throughout calendar year 2024, the MCOs' VBPs will be under ongoing performance monitoring consistent with the quality strategy. Provider claims have a runout period until the end of March; after which the MCOs will submit their initial reports. DHCF and its contracted actuary, Mercer, will conduct a 30-day quality assurance review of the data and develop a comprehensive and insightful report into the success of the program to the Council in May of 2025.

DHCF's oversight of the MCOs' VBP programs is structured to evaluate effectiveness, equity, and fairness amongst enrolled Medicaid providers. This includes ensuring providers are

incentivized for rendering appropriate and timely access to care and achievement of improved health care outcomes for the populations served.

DHCF has developed annual adoption targets the MCOs' VBP arrangements must meet. MCOs submit an annual Alternative Payment Model (APM) assessment, detailing all projected and actual VBP arrangements to DHCF which are used to evaluate and approve the arrangements according to DHCF's set targets. If a MCO's VBP arrangements fail to meet DHCF's targets in any given year, the Agency reserves the right to act according to its compliance continuum which can include Corrective Action Plans (CAPs) or sanctions for more serious concerns.

MCO Requested Metrics

DHCF is required to notify the MCOs 30 calendar days prior to implementing a new report. An official managed care report template will be developed and incorporated into the Managed Care Reports Manual effective April 1, 2024. The first quarterly report will be due from the MCOs on April 30, 2024, and after a thorough quality review, will be posted on the DHCF website in May of 2024.

Maternal Health

77. Provide an update on the work of the DHCF Maternal Health Advisory Group. Please include:

a. Group membership;

Please see Attachment 77 for the Maternal Health Advisory Group (MHAG) membership. The list pertains to the FY22 advisory group and will be updated to include new members as we convene the group in FY2024. Membership will be expected to increase to include perinatal mental health professionals and individuals with lived experiences.

b. Timeline for reconvening the group in FY 2024;

DHCF anticipates reconvening the advisory group in late February/early March 2024 and will set a recurring meeting cadence as determined by the group.

For reference, the scope of the FY22 group was set to develop and implement specific deliverables:

- The State Plan Amendment (SPA) from DHCF on extending Medicaid coverage from sixty days to twelve months postpartum.
- The State Plan Amendment to authorize doula services.
- The legislative provision that MCOs cover non-emergency transportation for Alliance and Immigrant Children's Program members.

c. Projected priorities for the Group in FY 2024.

We are seeking to broaden the purpose and objectives in order to institutionalize the group as a regular feature of the agency and also continue the momentum of the Perinatal Mental Health

Task Force (PMHTF). The purpose of the MHAG will be to provide expert advice and recommendations to the Medicaid agency on matters related to maternal health, with a focus on both physical and mental well-being. The group aims to contribute insights, expertise, and evidence-based recommendations to enhance the quality and effectiveness of Medicaid services for pregnant individuals.

Objectives:

- To develop a Medicaid maternal health framework and identify gaps, challenges, and opportunities for improvement within the Medicaid maternal health framework.
- To review and analyze current Medicaid policies and programs related to maternal health.
- To assess the impact of existing policies on the physical and mental well-being of pregnant individuals.
- To provide evidence-based recommendations for enhancing Medicaid services to better support maternal physical and mental health.
- To collaborate with healthcare professionals, community organizations, and other stakeholders to gather diverse perspectives and input.

The first set of tasks will be to develop specific solutions to better recruit and retain doula providers in the Medicaid program. The group will also work to develop an implementation plan for the PMHTF recommendations including priority setting those that are under the purview of the agency. DHCF will also solicit their input on the newest CMS model, Transforming Maternal Health (TMaH) Model, designed to focus exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP). The model will support participating state Medicaid agencies (SMAs) in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The goal of the model is to reduce disparities in access and treatment. The model aims to improve outcomes and experiences for mothers and their newborns, while also reducing overall program expenditures.

78. For each recommendation made in the Perinatal Mental Health Task Force report, please provide:
   a. Timeline for completion;
   b. Feasibility;
   c. Potential costs; and
   d. Lead Agency.

DHCF initiated a comprehensive review of recommendations immediately following their development by the Task Force, but the review is ongoing and the planning for each recommendation is not yet complete. The complexity and intricate nature of the recommendations necessitate further development and review for a thorough evaluation of feasibility and potential costs including the possibility of a rate study for recommendations pertaining to new or expanded services.

Among the recommendations, ten fall squarely within DHCF's purview while others require collaboration with sister agencies and other stakeholders. Recognizing the need for a multi-faceted approach to ensure equitable outcomes for all District residents, DHCF plans to present the recommendations to the Maternal Health Advisory Group by early March 2024. From there, the goal is to formulate a comprehensive work plan for implementing recommendations within the agency's purview and collaborating with stakeholders and sister agencies where DHCF is not the primary lead.

79. Please provide an update on the impact of the diaper bank grant program managed by DHCF. For FY 2023 and FY 2024, please provide the amount of money granted, the organizations who received grants, and the approximate number of residents served.

In FY 2023, DHCF awarded one Diaper Bank Grant in the amount of $500,000 to the Greater DC Diaper Bank. In FY 2023, the Greater DC Diaper Bank purchased and distributed a total of 3,145,350 diapers with a value of $1,258,140 to serve 9,300 babies in DC.

$344,545 of the DHCF grant was used to purchase approximately 861,362 wholesale diapers (27 percent of the total diapers distributed). The remainder of the $500,000 DHCF grant was used to support personnel and indirect expenses at the Greater DC Diaper Bank.

DHCF published a Request for Applications (RFA) for the FY 2024 Diaper Bank Grant Program on December 1, 2023 with a submission deadline of January 2, 2024. DHCF anticipates announcing a $500,000 award in coming weeks.

80. Please provide updates on the transition of the First Time Mother's home visiting program to DHCF, including a timeline for releasing the grant funds.

DHCF received a project proposal and budget for the First-Time Mother's Home Visiting Program at the end of December 2023. DHCF is currently reviewing the proposal and budget and will then work to release a Notice of Grant Award (NOGA). DHCF anticipates awarding a $225,000 grant by the end of January 2024.

81. What MCO performance measures related to maternal health are currently collected by DHCF? For each measure, please provide data on how each MCO performed in FY 2023 and FY 2024, to date.

DHCF assesses the quality of MCO performance on maternal health using standard, nationally-recognized metrics set by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), and Health and Human Services' Office of Population Affairs.[6]

[6] Prenatal and Postpartum Care (PPC) and Contraceptive Care for all women (CCW) and postpartum women (CCP)

Table 1 – HEDIS, NCQA, and OPA measures

Measure	Description
Prenatal and Postpartum Care	*Consists of two rates – see timeliness and postpartum below*
Timeliness of Prenatal Care	% of deliveries where the pregnant person had a prenatal visit during the first trimester, or on or before the enrollment start date or within 42 days of enrollment.
Postpartum Care	% of deliveries where the pregnant person had a postpartum visit on or between 7-84 days after delivery
Contraceptive Care – All Women	*Consists of two rates for two different age groups – see below*
All Women ages 15-20 years of age – LARC	% of women ages 15-20 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC)
All Women ages 21-44 years of age – LARC	% of women ages 21-44 at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC)
All Women ages 15-20 years of age – Most or Moderately Effective Contraception Method	% of women ages 15-20 at risk of unintended pregnancy who were provided a most or moderately effective method of contraception
All Women ages 21-44 years of age – Most or Moderately Effective Contraception Method	% of women ages 21-44 at risk of unintended pregnancy who were provided a most or moderately effective method of contraception
Contraceptive Care – Postpartum Women	*Consists of four rates for two different age groups – see below*
Women ages 15-20 years of age – Most or Moderately Effective Contraception – 3 days	% of women ages 15-20 who had a live birth and who were provided a most or moderately effective method of contraception within 3 days of delivery
Women ages 21-44 years of age – Most or Moderately Effective Contraception – 3 days	% of women ages 21-44 who had a live birth and who were provided a most or moderately effective method of contraception within 3 days of delivery
Women ages 15-20 years of age – Most or Moderately Effective Contraception – 60 days	% of women ages 15-20 who had a live birth and who were provided a most or moderately effective method of contraception within 60 days of delivery

Women ages 21-44 years of age – Most or Moderately Effective Contraception – 60 days	% of women ages 21-44 who had a live birth and who were provided a most or moderately effective method of contraception within 60 days of delivery
Women ages 15-20 years of age – LARC – 3 days	% of women ages 15-20 who had a live birth and who were provided a LARC within 3 days of delivery
Women ages 21-44 years of age – LARC – 3 days	% of women ages 21-44 who had a live birth and who were provided a LARC within 3 days of delivery
Women ages 15-20 years of age – LARC – 60 days	% of women ages 15-20 who had a live birth and who were provided a LARC within 60 days of delivery
Women ages 21-44 years of age – LARC – 60 days	% of women ages 21-44 who had a live birth and who were provided a LARC within 60 days of delivery

To view a detailed breakdown of each Managed Care Plan's individual performance on maternal health measures, please refer to Table 2.

Table 2. District Managed Care Plan Maternal Health Measures over Time

Measure	AmeriHealth Caritas DC			CareFirst Community Health Plan DC			Health Services for Children with Special Needs			MedStar Family Choice DC		
	MY 20 %	MY 21 %	MY22 %	MY 20 %	MY 21 %	MY 22 %	MY 20 %	MY 21 %	MY 22 %	MY 20 %	MY 21 %	MY 22 %
Prenatal and Postpartum Care												
Timeliness of Prenatal Care	84.91	86.59	82.55	76.92	76.40	77.86	76.19	82.98	66.67	-	82.00	77.12
Postpartum Care	73.97	74.09	76.01	69.66	71.29	74.45	66.67	57.45	78.57	-	69.83	65.54
LARC – Women												
Ages 15-20	3.64	2.72	2.61	2.78	2.27	1.77	3.90	4.31	3.07	-	2.27	1.95
Ages 21-44	3.70	3.54	2.96	1.23	2.37	2.17	3.50	4.40	4.17	-	2.14	2.12
Most/Moderately Effective Contraception – Women												

Ages 15-20	24.34	20.52	20.02	15.43	15.58	14.05	26.34	25.12	23.93	-	18.77	18.42
Ages 21-44	25.24	22.34	21.19	14.44	14.56	13.74	20.23	29.60	26.52	-	16.61	15.64
LARC – Postpartum												
Ages 15-20, within 3 days	3.28	6.06	1.18	0.00	2.00	9.52	8.33	-	8.33	-	4.00	2.13
Ages 21-44 within 3 days	4.31	2.74	2.63	2.35	2.95	3.54	0.00	-	0.00	-	3.04	3.23
Ages 15-20, within 60 days	11.48	14.14	17.65	22.22	16.00	14.29	12.50	-	8.33	-	16.00	14.89
Ages 21-44, within 60 days	11.08	10.45	11.13	7.06	8.23	9.58	0.00	-	8.70	-	9.11	8.37
Most/Moderately Effective Contraception – Postpartum												
Ages 15-20, within 3 days	4.92	9.09	4.71	8.33	2.00	11.90	8.33	-	8.33	-	12.00	4.26
Ages 21-44, within 3 days	13.16	13.35	13.16	14.12	10.97	10.83	14.29	-	13.04	-	12.15	12.55
Ages 15-20, within 60 days	30.33	29.29	45.88	38.89	34.00	33.33	45.83	-	25.00	-	54.00	38.30
Ages 21-44, within 60 days	36.92	37.48	40.79	30.59	28.27	29.79	28.57	-	34.78	-	31.67	32.13

Note:. Red text indicates measure fell below national average for year of interest while green text indicates measure met or exceeded national average for year of interest. Black text indicates that national average was unavailable for comparison. HEDIS data are reported on the calendar year therefore the timeframe for reporting does not align with the fiscal year. The most recent HEDIS

data available are measures from calendar year 2022. HEDIS data for calendar year 2023 will not be available until Summer or Fall of 2024.

District MCO averages for compliance with timeliness of prenatal and postpartum care measures have continually fallen below national averages since measurement year (calendar year) 2020 (see Table 3). This trend was likely impacted by the COVID-19 Public Health Emergency. Since 2019, DHCF has partnered with the MCOs to initiate a Maternal Health Focus Study, Maternal Health Performance Improvement Projects (PIPs), and launch oversight of MCO Value-Based Programs. PIPs are designed to achieve, through ongoing measurement and interventions, significant improvement in clinical or non-clinical care areas. The Maternal Health PIP focuses on pregnant and postpartum individuals and aims to encourage timely prenatal and postpartum care to achieve improvements to both maternal health and birth outcomes.

For VBP, DHCF operates in an oversight capacity to monitor and evaluate VBP arrangements that MCOs implement with their provider networks to incentivize appropriate care and improved performance in quality. DHCF holds MCOs accountable based on annual adoption targets which require MCOs to have an increasing percentage of total medical expenditures through VBP arrangements year over year. If an MCO fails to meet a target in any given year, DHCF reserves the right to act according to its compliance continuum which includes Corrective Action Plans (CAPs) and sanctions for more serious concerns. As a result of the VBP partnership, two of three MCOs have VBP arrangements specific to improving maternal health outcomes. As shown in the table below, the majority of MCO averages in the most recent measurement year met or exceeded national averages for contraceptive care measures. Areas of opportunity remain to improve timeliness of prenatal and postpartum care measures.

Table 3. District Medicaid Managed Care Averages over Time

Measure	District Managed Care Plan Average		
	MY 2020	MY 2021	MY 2022
Timeliness of Prenatal Care	79.34%	81.99%	76.05%
Postpartum Care	70.10%	68.17%	73.64%
Women ages 15-20 - LARC	3.59%	2.58%	2.35%
Women ages 21-44 – LARC	3.33%	2.84%	2.85%
Women ages 15-20 – Most/Moderately Effective Contraception	23.74%	19.19%	19.10%
Women ages 21-44 – Most/Moderately Effective Contraception	23.53%	18.68%	19.27%
Postpartum Women 15-20 – LARC in 3 days	3.30%	4.74%	5.29%
Postpartum Women 21-44 – LARC in 3 days	4.03%	2.91%	2.35%

Postpartum Women 15-20 – LARC in 60 days	13.74%	14.69%	13.79%
Postpartum Women 21-44 – LARC in 60 days	10.50%	9.65%	9.44%
Postpartum Women 15-20 – Most/Moderately Effective Contraception – 3 days	6.04%	8.06%	7.30%
Postpartum Women 21-44 – Most/Moderately Effective Contraception – 3 days	13.28%	12.56%	12.40%
Postpartum Women 15-20 – Most/Moderately Effective Contraception – 60 days	34.07%	35.55%	35.63%
Postpartum Women 21-44 – Most/Moderately Effective Contraception – 60 days	36.09%	34.12%	34.37%

Note: HEDIS measurement year operates on the calendar year. Red text indicates measure fell below national average for year of interest. Green text indicates measure met or exceeded national average for year of interest. Black text indicates that national average was unavailable for comparison.

82. Does DC Medicaid authorize payment for Community Health Workers under its current State Plan or MCO contracts? If not, has DHCF considered adding Community Health Worker services to Medicaid-reimbursable services?

Currently, Community Health Workers (CHW) are not a licensed health care provider type recognized by DC Health. Nonetheless, DHCF does provide a few pathways for payment for CHWs or comparable provider-types. For example, DHCF includes Community Health Workers in the rate formulation for Federally Qualified Health Centers under the category enabling services/CHW as a staffing cost that is a component of the medical, behavioral health, or dental service billed by health centers. Additionally, the My Health GPS care coordination program includes a requirement that the participating primary care providers include a peer navigator on their team. This staffer is defined as a health educator capable of linking beneficiaries with the health and social services they need to achieve wellness.

Further, the District requires managed care organizations (MCOs) to address the social determinants of health (SDOH) through screening, reporting, and by promoting opportunities to collaboratively or independently address SDOH or health-related social factors to provide person centered care. This work to address SOH can include payment from MCOs for some services provided by CHWs. Additionally, MCOs are encouraged to offer value-added services to improve quality of care, health outcomes, reduce costs by reducing the need for more expensive care, and promote total health wellness by addressing social factors. These value-added services may include payment for some services provided by CHWs.

Office of the Health Care Ombudsman and Bill of Rights

83. Please provide an organizational chart for the Office of the Health Care Ombudsman and Bill of Rights.

Please see Attachment 83.

84. Please provide when the Ombudsman was appointed, how they were selected, and how they meet the criteria provided in D.C. Code § 7-2071.02(c), including any additional criteria required by the Department.

The Office of Health Care Ombudsman and Bill of Rights was established in 2009 to counsel and provide assistance to uninsured District of Columbia residents and individuals insured by health benefits plans in the District of Columbia regarding matters pertaining to their health care coverage. The position for the Ombudsman is not an appointed position. Recruitment for the Ombudsman follows the DC government recruiting process. Position requirements, skills, and major duties are specified in the position description.

85. Please provide a copy of the most recent independent evaluation of the Ombudsman Program as required by D.C. Code §7-2071.03. Additionally, under this same code citation, provide narrative text regarding how the department decided whether to renew contracts based on the evaluation, and which contracts were considered.

Please see Attachment 85 for the most recent independent evaluation of the Ombudsman Program. The evaluation was completed by an academic institution, the University of the District of Columbia. The next scheduled evaluation will be conducted in FY 2024.

The Ombudsman Program does not currently operate its program utilizing any significant contracts or vendors. The evaluation did not review any contracts, so their renewal or termination was not considered.

86. Please provide a copy of the most recent annual report required to be submitted to the Council, Mayor, Department of Health, and Department of Insurance Securities and Banking in accordance with D.C. Code § 7-2071.06.

The FY22 annual report may be located on the DC Council LIMS website at https://lims.dccouncil.gov/downloads/LIMS/54088/Introduction/RC25-0096-Introduction.pdf?Id=178438

The FY23 annual report has been drafted and is awaiting finalized commercial insurer data. Once complete it will be submitted for review and publication.

87. Please provide narrative text about outreach efforts the Department undertook to promote the work of the Office of the Health Care Ombudsman and Bill of Rights, and encourage the public to utilize its services.

The Office of the Health Care Ombudsman and Bill of Right's office (OHCOBR) has an Education and Outreach subcommittee under the Advisory Board that consists of stakeholders. The Advisory Board is chaired by a member of the community and co-chaired by a staff person within the Ombudsman's office. The OHCOBR participates with the Mayor's and Council's ward activities, the Department of Aging and Community Living (DACL), District of Columbia Public and Chartered Schools (DCPCS), and various other health fairs throughout all eight wards both in-person and virtually. We also broadcasted PSAs about the OHCOBR's program on NBC4, Telemundo and local radio stations.

Health Care on Tap, created by the OHCOBR, is an outreach event that takes place with a smaller group. These events often occur within churches, community centers, and the District of Columbia's Office of Veterans Affairs. These smaller outreach events allow for a more personalized one-on-one experience.

Over the last year, we worked directly with the managed care organizations' outreach departments to conduct vital outreach and education about our program and the role we play in ensuring that District residents have access to healthcare services and resources.

88. Outline any challenges to the success of the Office that may require policy or budgetary adjustments.

Currently, there are no challenges to the success of the Office that would require policy or budgetary adjustments.

89. Provide updates on the implementation of A25-173—Expanding Access to Fertility Treatment Amendment Act of 2023, including:

a. Timeline for FFS, MCOs, and the Alliance to begin coverage for diagnosis of infertility and ovulation enhancing medication treatment, and

DHCF is adding the coverage of prescription drugs used for fertility treatment, for up to three treatment cycles during a beneficiary's lifetime, to the District's Medicaid program effective January 1, 2024. DHCF was already aligned with other provisions of the Act prior to its passage.

b. Timeline for DHCF to submit the required report to the Council after consulting with CMS on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both FFS and MCOs, including any potentially

applicable waiver authorities, and the amount of money that would need to be allocated to federal and local funds for such coverage.

DHCF's research into whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, as well as possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit, is ongoing. DHCF expects to have a finalized report to Council in Spring of 2024.

Behavioral Health

90. Please provide an update on the behavioral health carve-in, including updated timeline, and current roadblocks or challenges.

DHCF, in partnership with the Department of Behavioral Health (DBH), has completed the Planning Phase of the Behavioral Health Integration Project. We initiated Readiness and Implementation activities with three of the risk-based managed care plans (MCPs). Formal Readiness activities including Desk-top Review and On-site Review with each MCP, will start in January and conclude in February, to allow a full calendar month for Determination of Readiness and submitting our Readiness Review Report to CMS.

DHCF does not anticipate readiness challenges with the MCPs since they have been actively engaged in our behavioral health integration activities. The development of the Readiness Tool and Request for Information (RFI) produced no significant concerns at this time.

DHCF and DBH are proactively anticipating challenges that are typical of these transitions across the country, as well as those that exist locally for the District, for both providers and beneficiaries, and implementing solutions when possible. Progress made on these challenges to-date includes:

(1) Behavioral health providers acquiring, or enhancing, electronic health records to ensure preparedness for-
- efficient claims payment,
- data collection,
- information sharing across the network and interoperability with the DC HIE,
- fulfilling new clinical practice standards including use of standardized, validated screening and assessment tools.

(2) Technical Assistance programs and activities for Providers that covered a full range of topics including-
- basic and advanced business operations and strategies,
- clinical training,
- partnering effectively with Managed Care Plans.

(3) Beneficiary Engagement & Communication Planning and Activities including-
- in-person forums,
- social media,

- outreach & marketing from Government Agencies as well as the MCPs.

91. For the local portion of the Medicaid Match for mental and behavioral health services under DBH's budget, please provide spending/costs and utilization data, both actual and projected, for FY 2023 and FY 2024, to date.

Please refer to Q29 for utilization and provider-specific data.

Please refer to totality of responses from the Office of the Chief Financial Officer for spending/costs information specific to DBH's budget.

DBH spending to support Medicaid services primarily funds Mental Health Rehabilitation Services (MHRS) and Adult Substance Use Rehabilitation Services (ASURS). Please see the data for provider-types 'Clinic, Adlt Alc/Subst Abuse' and 'Mental Health Rehab Services' in the response to Q29 for total spending and utilization for FY 2023 and FY 2024 Q1.

In fiscal year 2023, DBH had $58,664,636 in local expenditures to match Medicaid funding for the behavioral health services DBH supports.

At the point the books closed for the first quarter of fiscal year 2024, DHCF had not charged DBH for the District share of the programs DBH supports. However, that amount is $13,014,177 and was charged in January 2024.

92. Please provide a narrative explanation of DHCF's role in the implementation of Mayor's Order 2023-142 "Declaration of Public Emergency: Opioid Crisis and Declaration of Public emergency: Juvenile Crime" and subsequent extensions of that order. In addition to the narrative explanation, Include for both public emergencies:

<u>Declaration of Public Emergency: Opioid Crisis ("The Order")</u>

a. DHCF's role in facilitating and participating in data sharing with other District agencies;

DHCF participates in several interagency efforts related to the Opioid Crisis where Medicaid Claims data, Diagnosis Data, and other reporting, is critical to informing the planning, intervention, and evaluation of Opioid Crisis response activities across the District. DHCF complies with all data requests from DBH, DC Health, and Fire and Emergency Medical Services (FEMS) in a timely manner.

b. Detailed accounting of expedited procurement related to the order and subsequent extensions, including details listed in question 8 of this document;

Not applicable.

c. Detailed accounting of any grants, partnerships, obligations, expenditures, or other disbursements related to the order and subsequent extensions;

Not applicable.

d. Recommendations made to the City Administrator in accordance with the order and subsequent extensions;

Most recently, DHCF began active participation in the Opioid Abatement Advisory Commission and looks forward to continued engagement in the development of recommendations to city leaders about new funding opportunities to reduce and eradicate negative effects of the Opioid Crisis for District residents.

e. Detailed accounting of any financial assistance sought from federal, private, non-profit, or other agencies of the United States government to recoup expenditures incurred, or obtain funding needed to carry out necessary actions of the order and subsequent extensions;

Not applicable.

f. Description of any activation, implementation, and coordination of mutual aid agreements between DHCF and federal, state, or local jurisdictions to assist in the District's response to the order and subsequent extensions;

DHCF has not needed additional MOUs or MOAs with the agencies listed in in the Order to comply with Order 2023-142.

g. Any other assistance by DHCF related to the order and subsequent extensions.

At this time, DHCF has no additional activities or deliverables related to Order 2023-142. DHCF will continue partnering with our contracted Managed Care Plans and Government Partners to implement and comply with Order 2023-142.

Declaration of Public Emergency: Juvenile Crime ("the Order")

a. DHCF's role in facilitating and participating in data sharing with other District agencies;

DHCF engages regularly with DYRS and will continue to use those points of engagement to support implementation and compliance with the Order. The Department also participates in the Office of the Chief Medical Examiner's (OCME) Child Fatality Review Committee which provides opportunities for information sharing, coordination, and performance improvement across all sectors and government agencies for youth at-risk in the District. DHCF complies and responds timely to all requests for data from DYRS, DMPSJ, and OCP.

b. Detailed accounting of expedited procurement related to the order and subsequent extensions, including details listed in question 8 of this document;

Not applicable.

c. Detailed accounting of any grants, partnerships, obligations, expenditures, or other disbursements related to the order and subsequent extensions;

Not applicable.

d. Recommendations made to the City Administrator in accordance with the order and subsequent extensions;

DHCF has not made any such recommendations to the City Administrator.

e. Detailed accounting of any financial assistance sought from federal, private, non-profit, or other agencies of the United States government to recoup expenditures incurred, or obtain funding needed to carry out necessary actions of the order and subsequent extensions;

Not applicable.

f. Description of any activation, implementation, and coordination of mutual aid agreements between DHCF and federal, state, or local jurisdictions to assist in the District's response to the order and subsequent extensions;

DHCF has not needed additional MOUs or MOAs with the agencies listed in the Order to comply with Order 2023-142.

g. Any other assistance by DHCF related to the order and subsequent extensions.

DHCF is on track to implement a Community Violence Prevention (CVP) benefit for Medicaid Beneficiaries effective October 1, 2024, with a State Plan Amendment submission to CMS set for July 1, 2024. This benefit is the result of ongoing collaboration with the Office of Gun Violence Prevention and other District Agencies.

Please refer to the response to Question 38 for a comprehensive description of CVP and the benefit development process.