DC Council Committee on Health
Councilmember Christina Henderson, Chair

FY2024 - FY2025 Performance Oversight Pre-Hearing Question Responses
Department of Health Care Finance

1. **Please provide the current organizational chart for the agency, with 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 2024 and FY 2025, to date.**

Response:

Please see Attachment 1 to Q1 for the current organizational chart along with the number of full-time equivalents (FTEs) at each organizational level. Attachment 2 to Q1 reflects the employee responsible for the management of each program and cost center. There have been no organizational changes since DHCF last reported.

2. Please provide the names of the primary and alternative sexual harassment officers ("SHO").

Response:

DHCF's primary SHO is Felicia Rothchild, Human Resources Officer. The alternative SHO is Portia Shorter, Deputy Chief Operating Officer.

a. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2024 and FY 2025, to date, and whether those allegations were resolved.

DHCF investigated three claims of sexual harassment in FY 2024. The first case was reported on April 3, 2024. An investigation was conducted and the agency considers the matter resolved. The second case was reported by an employee on June 4, 2024. In conducting the investigation, additional information was revealed and resulted in another investigation of harassment. A personnel action was executed, and the agency considers the matter resolved.

There has been one claim of sexual harassment for FY 2025. A sexual harassment claim was reported on October 15, 2024. DHCF conducted an investigation and the agency considers the matter resolved.

b. Has DHCF received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?

No, DCHF has not received any waiver requests regarding this matter.

i. What was the resolution of each request? Not applicable
ii. If a request was granted, are there limitations on the scope of the waiver? Not applicable

3. Please provide a list of employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2024 and FY 2025, to date, including the amount and reason.

Response:

There are no employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2024 and FY 2025.

4. **How many performance evaluations did the agency complete in FY 2024?**

    a. **How many performance improvement plans were issued in FY 2024?**
    b. **How many employees have submitted SMART Goals or other relevant workplans in FY 2025?**
    c. **How many employees have submitted SMART Goals or other relevant workplans in FY 2025?**
    d. **How many employees have submitted SMART Goals or other relevant workplans in FY 2025?**

Response:

The responses below refer to performance period October 1, 2023, through September 30, 2024. DHCF completed 212 (96.36%) performance evaluations in FY 2024.

DHCF issued three (1.35%) performance improvement plans for FY2024. All of the plans were completed satisfactorily by the respective employee(s).

As practice, employee SMART Goals (Individual Performance Plans) are submitted by the immediate supervisor. DHCF submitted 246 (89.78%) Individual Performance Plans in FY 2025.

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5. **Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2024 and FY 2025, 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.**

Response:

Please see the Attachment to Q5 for DHCF's response.

DEPARTMENT OF HEALTH CARE FINANCE
FY24-25 PERFORMANCE OVERSIGHT QUESTIONS

6. Please identify the source purpose, and amount of any funds, received by or transmitted by DHCF in FY 2024 and FY 2025, to date, including any interagency projects in which DC Health is the buyer or the seller agency.

Response:

Please see the Attachment to Q6 for DHCF's response.

7. **Please provide a complete accounting of all reprogramming received by or transferred from the agency in FY 2024 and FY 2025, to date.**

    a) **Provide a complete accounting of all reprogramming within the agency in FY 2024 and FY 2025 to date.**
    b) **For each reprogramming, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.**
    c) **Specifically regarding REPROG25-158, $28,400,000 was reprogrammed to DHCF's Health Care Finance division, Account Group 714100C (Government Subsidies and Grants). Please provide a detailed narrative explanation on the purpose of this reprogramming, including the gaps in DHCF's budget that this is intended to cover.**

Response:

Please see Attachment to Q7.

8. **Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2024 and FY 2025, to date, broken down by program and cost center:**

   i. **Grant Number/Title;**
   ii. **Approved Budget Authority;**
   iii. **Funding source.**
   iv. **Expenditures (including encumbrances and pre-encumbrances);**
   v. **Purpose of the grant;**
   vi. **Organization or agency that provided or received the grant;**
   vii. **Grant amount;**
   viii. **Grant deliverables;**
   ix. **Grant outcomes, including grantee/subgrantee performance;**
   x. **Any corrective actions taken or technical assistance provided;**
   xi. **Agency program and cost center supported by the grant;**
   xii. **Agency employee responsible for grant deliverables; and**
   xiii. **Any grants where the funds have been reduced in FY 2025, and the amount of the reduction.**
   xiv. **For grants/subgrants over $2M in Local dollars awarded by the agency in FY 2024 or FY 2025, please provide the grant agreement to the Committee.**

Response:

Please see Attachment to Q8 for the information requested for all grants awarded to DHCF during FY24 and to date in FY25. The current fiscal year expenditures are through the first quarter, December 31, 2024.

9. For each grant lapse that occurred in FY 2024, please provide:

i. A detailed statement on why the lapse occurred;
ii. Any corrective action taken by DHCF; and
iii. Whether the funds were carried over into FY 2024, and how much funding was carried over.

Response:

Department of Health Care Finance did not have any grants lapse in FY2024. However, the Money Follows the person grants was carried forward into FY2025. please refer to the response for Question 8 for further details.

10. Please provide the following information for all contracts, including modifications, active during FY 2024 and FY 2025, 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);
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 or zeroed out in FY 2025, and the amount of the reduction.

Response:

Please see Attachment to Q10.

11. Please provide a list of all Department of General Services work orders submitted in FY 2024 and FY 2025, 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).

Response:

In FY 2025 (October 2024 - January 2025), 63 service tickets were submitted, 51 were completed, 0 still open, and 12 were rejected/cancelled.

In FY 2024 (October 2023 - September 2024), 249 service tickets were submitted, 210 were completed, 0 still open, and 39 were rejected/cancelled.

Please see Attachment to Q11 for the requested full list of information.

12. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2024 and FY 2025, to date. Please include the following:

Response:

a. Revenue source name and code;

Please see the 'Parts A & D' tab of the file Attachment to Q12.

b. Description of the program that generates the funds;

Fund	Fund Description	Program Generating Revenue
1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	Reimbursement from other parties (commercial health insurance, auto & casualty insurance, estate recovery, etc.) liable for the cost of care for Medicaid beneficiaries, as well as recoveries from providers for Medicaid fraud and abuse.
1060132	BILL OF RIGHTS- (GRIEVANCE & APPEALS)	Assessments on commercial health insurers for the cost of the Health Care Ombudsman's Office.
1060138	ASSESSMENT FUND	Provider enrollment fees.
1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY	Penalties for non-compliance with the District's individual insurance mandate.

c. Cost center that the revenue in each special purpose revenue fund supports;

Please see the 'Parts C & E' tab of the file Attachment to Q12.

d. Total amount of funds generated by each source or program in FY 2024 and FY 2025, to date;

Please see the 'Parts A & D' tab of the file Attachment to Q12.

e. FY 2024 and FY 2025, to date, expenditure of funds including reprogramming, and purpose of expenditure; and

Please see the 'Parts C & E' tab of the file Attachment to Q12.

f. Fund balance at the end of FY 2024 and FY 2025, to date.

Fund balances are updated at the end of each fiscal year. Please see the table below for the FY 2024-year end fund balances for DHCF's special purpose revenue funds.

Fund	Fund Description	FY 2024 Year End Fund Balance
1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	$3,269,514.97
1060132	BILL OF RIGHTS-(GRIEVANCE & APPEALS)	$1,328,571.00
1060138	ASSESSMENT FUND	$42,917.71
1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY	$6,498,536.71

13. Please provide the DHCF capital budget for FY 2024 and FY 2025, to date, including the amount budgeted and actually spent. In addition, please provide an update on all capital projects undertaken in FY 2024 and FY 2025, to date.

Response:

Please see the Attachment to Q13 for DHCF's response.

14. Please provide the following information for all contract modifications made during FY 2024 and FY 2025, 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.

Response:

Please see Attachment to Q14.

15. **Please identify potential areas where spending pressures may exist in FY 2025. Please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize the impact on the FY 2025 budget.**

Response:

FY25 spending pressures are driven primarily by the Alliance, MCO, and Immigrant Children programs. In each case, the enrollment growth experienced subsequent to the period used for FY25 formulation increased significantly.

DHCF has taken several measures to ensure that residents are aligned with the appropriate program by, for example, using tools to ensure all persons eligible for Medicare are in fact applying to Medicare, including transitioning any Alliance enrollees that become eligible for Medicaid and Medicare. This results in cost-sharing with Medicare that reduces the amount of funds the District is required to pay for care. For those enrolled in the Alliance, the cost shifts from 100% local funding to shared cost with the federal government through Medicare or Medicaid.

DHCF is currently preparing the 1st Quarter Financial Review Process (FRP) which will determine the anticipated spending pressure due to the increased enrollment.

16. Did DHCF meet the key performance indicators set forth in the performance plan for FY 2024? For any performance indicators that were not met, please provide a narrative description of why they were not met, and corrective actions taken.

Response:

KPI	Explanation
Percent of Medicaid renewals as a part of the passive renewal process Target for FY24 70%; Actual 65.5%.	This target was narrowly missed; possible influences include adjustments to eligibility criteria as fluctuations in beneficiary circumstance such as income changes.
Percentage of Medicaid Elderly and Persons with Physical Disabilities Home and Community Based Waiver complaints investigated within 7 days of receipt of complaint. Target for FY24 86%; Actual 78%.	This target was missed due to increased complaint volume, and complex cases requiring additional documentation or coordination with other agencies. To help support timely investigations the agency intends to we will streamline processes, with additional staff and interagency coordination.
Percentage of Medicaid Elderly and person with Physical Disabilities Home and Community Based Services participants who service plans that address health & safety risks. Target: 86%; Actual: 85.8%.	Provider noncompliance with program requirements is the primary reason the indicator is below the benchmark. LTCA emphasizes education and training on addressing risk factors identified in the interRAI LTSS (long-term services and supports) assessment. DHCF's Quality Improvement Organization (QIO)contractor reviews Fee-for -Service Person Centered Service Plan (PCSP), issuing technical denials for noncompliance with the PCSP Checklist and focusing on risks and beneficiary goals before authorizing services. The oversight monitoring team conducts qualitative analyses of PCSPs using interRAI (HC) assessments and clinical notes, with LTCA tracking progress for sustained compliance. LTCA also reviews random PCSP samples to inform remediation and Continuous Quality Improvement (CQI). UHC (for DSNP) provides case manager training and quality checks to improve PCSP development.

17. **How many grievances were filed against the Department of Health Care Finance (DHCF) providers and DHCF during FY 2024? Please briefly describe the grievances filed and DHCF's response. How many of these grievances did DHCF find in favor of the beneficiary?**

Response:

Please note that neither DHCF nor the Office of the Health Care Ombudsman and Bill of Rights adjudicates cases. OHCOBR assists residents with filing administrative hearings with the Office of Administrative Hearings, which handles such adjudication, with the exception of EPD waiver reconsiderations which are a part of agency process.

In FY24, a total of 202 administrative hearing requests were filed on behalf of beneficiaries by the Office of Health Care Ombudsman and Bill of Rights (OHCOBR). Please see the break-down of these cases below:

- 114 requests were for *inaction or delay in processing an application/recertification for medical benefits*;
- 31 were for inaction or *delay in processing an application/recertification for Elderly and Persons with Disabilities (EPD) Waiver benefits*;
- 13 were for *denial of application/recertification for medical benefits*;
- 9 were for the *reduction of PCA (Personal Care Aides) services*.
- 8 were for the *termination of PCA services*;
- 6 involved the *Supplemental Nutrition Assistance Program (SNAP) benefits (delay in processing application/recertification, denial of application and overpayment)*;
- 5 were for the *denial of PCA services based on an assessment*;
- 3 were for the *denial of dental services*;
- 3 were for the *denial of medical services*;
- 3 were for *nursing home issues (payability and community spouse resource allowance)*;
- 2 were for the *denial of reimbursement/payment for medical bills*;
- 2 were for the *denial of an increase in PCA service hours*;
- 2 were for *failure to provide approved PCA services*; and
- 1 was *undetermined*.

Below is a further breakdown of the aforementioned list:

Types of Issues	
Denial of Application for SNAP Benefits	1
Denial of Community Spouse Resource Allowance	1
Denial of Dental Services	3
Denial of Increase in PCA Services	2
Denial of LOC (Level of Care) for EPD Waiver Services	2
Denial of LOC for State Plan Services	3
Denial of Medical Services - Unspecified	2
Denial of Medicaid - Excess Income/Resources	12
Denial of Private Duty Nurse	1
Denial of Reimbursement - Unspecified	1
Denial of SR Medicaid (MCO Transition)	1
Failure to Provide Approved PCA Service Hours	2
Inaction or Delay in Processing Application/Recertification for the EPD Waiver Program	31
Inaction or Delay in Processing Application/Recertification for Medical Benefits	114
Inaction or Delay in Processing Application/Recertification for SNAP Benefits	4
Nursing Home Payability	2
Overpayment of SNAP Benefits	1
Termination of PCA Services	8
Reduction of PCA Services - Assessment	9
Undetermined	1
Unpaid Medical Bills	1
Total	**202**

OHCOBR was able to determine that 167 (83%) of these hearing requests were resolved *successfully* in favor of the beneficiary, 23 (11%) were resolved in favor of the provider, 3 (2%) are still *pending*, and 9 (4%) could not be determined (DHS cases).

a. **Please provide a narrative text around grievances submitted to the Health Care Ombudsman that DHCF had a role in reviewing and taking steps to resolve those issues.**

Although hearing requests were not submitted for many issues, as they were promptly addressed, OHCOBR has received numerous complaints from *United Healthcare D-SNP* enrollees regarding several covered services, including transportation, dental, pharmacy, PCA care coordination, case management services, and access to providers. OHCOBR works closely with DHCF, Long Term Care Administration (LTCA) to efficiently resolve these concerns, and this collaboration has contributed to a decrease in filed grievances and hearing requests. Case details are documented on LTCA's Electronic Provider Programmatic Report (EPPR), enabling effective tracking and identification of recurring issues.

Any concerns raised to OHCOBR by individuals enrolled in a Managed Care Plan (MCP) are handled by OHCOBR staff. Issues beyond the scope of OHCOBR are escalated to the designated points of contact (POC) for each plan. These POCs provide swift follow-up to the affected member and relay a thorough explanation of all actions taken on their end back to OHCOBR. OHCOBR additionally collaborates with DHCF, Health Care Delivery Management Administration (HCDMA) to report and address trends that require attention and resolution.

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FY24-25 PERFORMANCE OVERSIGHT QUESTIONS

18. Provide an update on ARPA fund budgets and expenditures for FY 2024 and FY 2025, to date, including:

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

Response:

Please see Attachment to Q18.

19. Please list and explain any Memos of Understanding entered into by DHCF during FY 2024 and FY 2025, to date.

Response:

Please see Attachment to Q19.

20. For each Board or Commission overseen by DHCF, please provide:

(a) An updated list of members, including when their term started and ends;

Response:

Please refer to the DHCF website for a list of the HIE Policy Board Members: HIE Policy Board | dhcf. Term start and end dates for public members are in the table below:

Public Members	Term Start Date	Term End Date
Dr. Jessica Herstek	7/17/2019	6/25/2027
Alice Leiter	6/25/2022	6/25/2025
Dr. Eric Marshall	6/1/2018	6/25/2027
Dr. Yavar Moghimi	6/1/2018	6/25/2027
Dr. Janis Orlowski	6/11/2021	6/25/2027
Justin Palmer	1/26/2016	6/25/2027
Donna Ramos-Johnson	9/2/2018	6/25/2027
Dr. Rahul Bhat	11/2/2023	11/2/2026
Dr. James Crowe	10/19/2023	10/19/2026
Robert Longyear	10/19/2023	10/19/2026
Darryl Stewart	10/17/2024	10/17/2027

b) A list of any vacant positions

Response:

Please refer to the DHCF website for a list of the vacant HIE Policy Board member vacancies: HIE Policy Board | dhcf

c) Dates of meetings held in FY 2024 and scheduled for FY 2025, including any publicly available minutes; and

Response:

Please refer to the DHCF website for the HIE Policy Board meeting

dates and minutes: HIE Policy Board | dhcf

d) Name and contact information of DHCF staff person who is point of contact/oversees the Board/Commission

Response:

Deniz Soyer, Program Manager, Division of Digital Health, Health Care Reform & Innovation Administration, DHCF; deniz.soyer@dc.gov

21. Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY 2024 and FY 2025, 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.

Response:

1. Fiscal Year 23 Single Audit Findings, June 2024

The Single Audit is conducted on an annual basis each fiscal year. 2 C.F.R. Sec. 200.501 requires non-Federal entities that expend more than $750,000.00 on Federal awards in a fiscal year, to have a Single audit conducted for the immediately preceding fiscal year. The Single Audit reviews the non-Federal entity's financial statements, reviews internal controls over financial reporting, and compliances with federal program requirements. The FY 23 Single Audit Final Report and Findings were received by DHCF in June of 2024. There were 2 categories of findings, involving (1) Medicaid Eligibility, and (2) Medicaid Drug Rebate calculations. The findings and corrective action responses are below:

a. **Medicaid/ Eligibility Findings and DHCF Corrective Action**:
   i. **Finding:** For twenty (20) participants files, the DHS Economic Security Administration (ESA), which processes Medicaid applications, did not process the application within the required timeframe.
   ii. **DHCF Corrective Action:** As a corrective action, ESA will provide refresher training and reinforce oversight controls to ensure case workers and supervisors are processing applications within the federally required timeframes.
      - Estimated Date of Completion: July 30, 2024.
      - Status as of September 2024: Completed on May 30, 2024. This training was completed as soon as the draft finding was received.

b. **Medicaid Drug Rebate**
   i. **Finding:** In one (1) instance, out of a sample of sixty (60) drug rebates, the manufacturer did not pay the rebate within 37 days after receiving the invoice from the DHCF, and no interest was calculated and charged to the drug manufacturer.
   ii. **DHCF Corrective Action:** The drug rebate vendor's IT staff will test the calculation to see if there would have been interest calculated or if there is a system glitch that requires further attention.

iii. Estimated Date of Completion: Status as of September 2024 – action is completed. DHCF's contracted drug rebate vendor, Conduent, has recalculated the interest for all invoices for all quarters to ensure that no interest amounts were missed.

2. FY 2023 System and Organization Controls (SOC) 1 Type 2 Report, Received February 2024.

On a biennial basis, State Medicaid Agencies are required to review the system security of its automated data processing systems. States can demonstrate compliance with this requirement by obtaining a "Statement on Standards for Attestation Engagements (SSAE), Reporting on Controls at a Service Organization Control (SOC) 1, Type 2 Report." DHCF obtained a SOC 1, Type 2 report in FY 24 from the service organization, Myers and Stauffer, LLC. This report reviewed the system security of DHCF's Medicaid Management Information System (MMIS) and Provider Data Management System (PDMS), for the period of October 1, 2022-September 30, 2023. DHCF has a contract with Conduent State Healthcare Services, LLC (Conduent) to manage and maintain the MMIS, including its security controls, and a contract with Maximus Health Service Inc (Maximus) to manage and maintain the PDMS, including its security controls. Conduent, and Maximus responded directly to the findings below in their capacity as the respective contracted operators of MMIS and PDMS.

a. **Finding (MMIS):** An IT security self-assessment was not performed and submitted to Conduent Corporate during the audit period.
   i. **Conduent:** Due to the discontinuation of the Risk Susceptibility Assessment Method (RSAM) system, the HIPAA Risk Assessment was completed prior to the start of the fiscal year. The DC MMIS management team will work with Conduent's Information Security Office to ensure that the annual assessments are completed during the next fiscal year once the transition to the new system has been completed. It is anticipated that the transition will be completed by the end of the second quarter.

b. **Finding (MMIS):** The DC MMIS and Government Health Services (GHS) domains were not configured to audit process tracking for the duration of the audit period.
   i. **Conduent:** The DC MMIS domain will be decommissioned in January and the GHS domain will be decommissioned in early 2024; therefore, the need to provide audit process tracking on these two domains will not be needed.

c. **Finding (MMIS):** Passwords for Active Directory accounts in the DC MMIS domain were not changed in accordance with the Conduent Information Security Standard. Specifically, eleven enabled DC MMIS domain user and service accounts had passwords that were not flagged as expired and had not been changed over 90 days; seven of the 11 accounts had not changed their passwords in over 365 days and the accounts were configured to never expire.
   i. **Conduent:** Non-production servers on the DC MMIS domain were removed on October 21, 2023, and production servers on December 2, 2023. This domain will be decommissioned in January 2024. We are currently performing scream testing; therefore, the user/service accounts are no longer valid. The DC MMIS Systems' team will work with Conduent Networking

to ensure that all DC MMIS domain accounts have been removed from future reports.

d. **Finding (PDMS):** The MAXIMUS Records Management Policy had not been reviewed and approved in accordance with policy.

i. **Maximus:** It had not been reviewed since the initial publication date, which was November 2019. Maximus acknowledges this exception. The Maximus Data Governance team plans to publish a revision as soon as possible.

3. Unified Program Integrity Contract (UPIC), Stage 1 (of 2) Findings of Audit of Managed Care Program, Program Integrity Functions for the period of January 1, 2019 – September 30, 2022, issued in July of 2024.

SafeGaudrd Services, the UPIC contractor selected by CMS, conducted a Program Integrity audit of the following D.C. Medicaid Managed Care plans (MCPs) contracted with DHCF during the aforementioned period: Health Services for Children with Special Needs (HSCSN), AmeriHealth, and MedStar.

a. AmeriHealth Findings -Thirty-three (33) claims were identified as paid after their death, identifying a potential overpayment of $173,058.03

b. HSCSN Findings- Payments were made by HSCSN to Network Providers after the date of death for two (2) members for a potential overpayment total of $15,665.86 (Table 7- Payments made to Network Providers for Services Rendered after a Recipient's Date of Death).

c. MedStar Findings -During this review, it was found that payments were made to Network Providers after the date of death for 29 members for a potential overpayment total of $140,549.95.

i. **DHCF Response**: At the time the instant UPIC reports were issued, DHCF had already identified and recouped the capitation payments made for the deceased individuals. DHCF expects these findings to be removed from the Final Audit Report, once Stage 2 of the UPIC audit is completed, anticipated at the end of FY 25, quarter 2.

22. Please provide an update on the Cedar Hill Regional Medical Center capital project, including:

a. The total amount of funding for the project, broken down by funding source;
b. A detailed budget for the project; and
c. Whether the project is on track to meet, exceed, or be under the expected budget.

Response:

A. The total amount of funding for the project, broken down by funding source;

Breakdown of Budget by Source of Funds	Amount (MM)
District Capital	$417.3
Universal Health Services	$17.1
Total	$434.4

B. detailed budget for the project; and

Breakdown of Budget by Expenditure	Amount (MM)
Construction	$334.2
Furniture, Fixtures & Medical Equipment	$55.0
Architecture and Engineering	$17.0
IT Equipment	$13.8
Insurance, Testing, Inspections	$9.7
Microgrid and Solar	$4.7
Total	$434.4

C. The Cedar Hill Regional Medical Center GW Health remains on schedule and within budget. Currently, pending all local and federal regulatory approvals, UHS is working to open to patients between late March and mid-April 2025. The hospital is over 95% complete and will secure its conditional certificate of occupancy in late January/early February. FEMS conducts its fire and life safety review in early February, followed by DC Health's review of the pharmacy, lab, and kitchen. March is devoted to the DC Health Environmental Safety review and ends with SHPDA review.

23. Regarding the Cedar Hill Urgent Care center in Ward 8 that opened in October 2022, please provide:

a. Number of patients served in FY 2024 and FY 2025, to date, and how that number compares to projected capacity for the Urgent Care center;
b. Number of staff currently working at the center, and how that number compares to the projected needs for the center;
c. Number of patients referred to other providers or hospital from the Urgent Care center, including where they were referred and for what medical service; and
d. List of services currently provided at the Urgent Care center.

Response:

NOTE:The responses below were provided by UHS staff and do not constitute the response of DHCF in any official Medicaid provider oversight capacity, nor does this data reside within DHCF.

a. **Number of patients served since opening, and how that number compares to projected capacity for the Urgent Care center;**

	Projected	Actual
CY2023	N/A	13,881
CY2024	13,881	17,963
		+29.4% Growth YoY

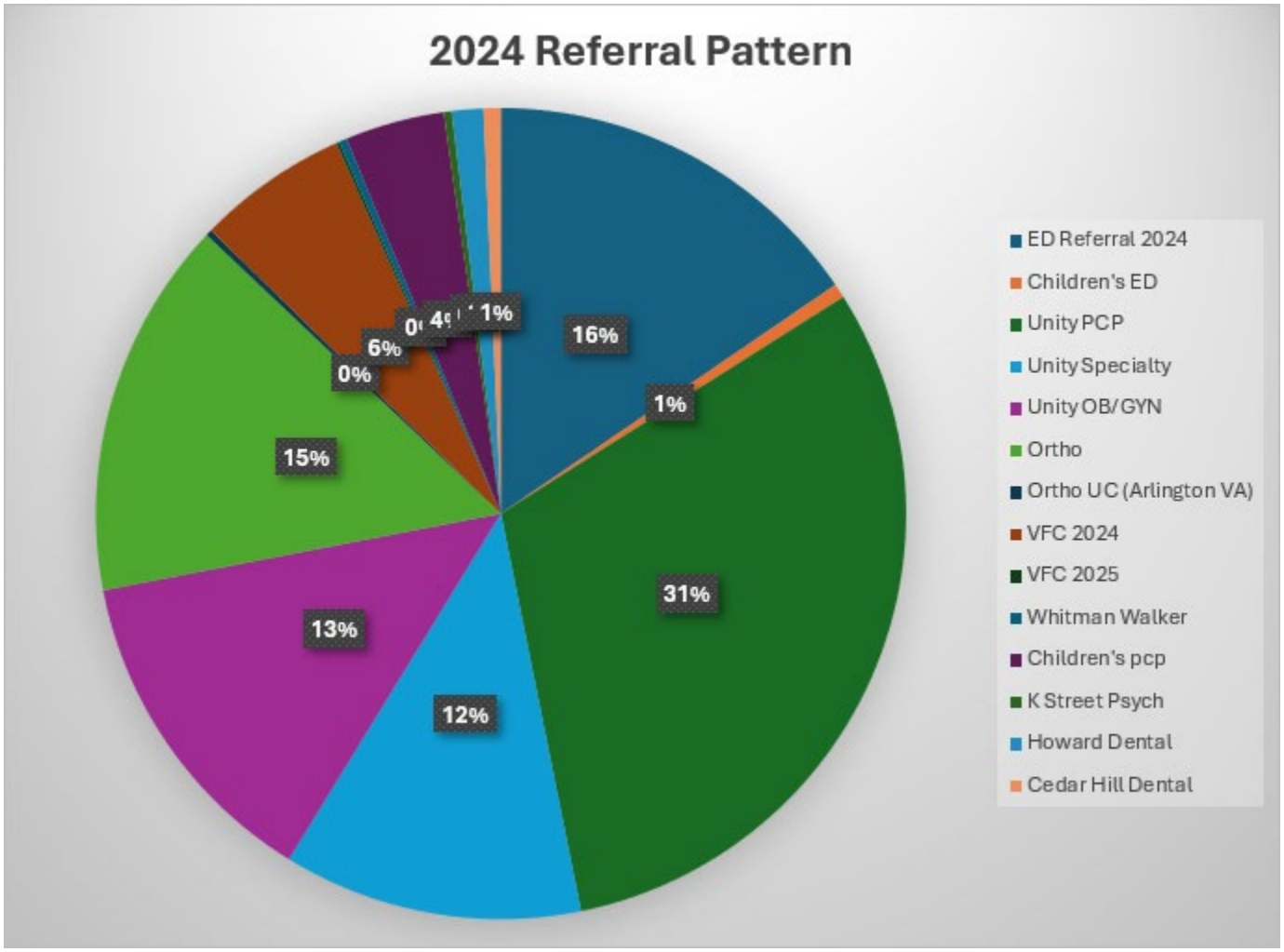
b. **Number of staff currently working at the center, and how that number compares to the projected needs for the center;**

Staff total – 12, of which 11 are DC residents. The Center has 1 Full Time (FT) Rad Tech position open / I FT Medicals Assistant Position open.

- Medical office Specialist – 2 FT / 1 PRN (3 DC Residents)
- Medical Assistants – 3 FT / 3 PRN (6 DC resident)
- Rad Techs – 1 FT / 1 PRN (2 DC Residents)
- Providers assigned – 3 (2 DC Residents)
- Medical Directors – 1 (1 DC Resident)

c. **Number of patients referred to other providers or hospitals from the Urgent Care center, including where they were referred and for what medical service; and**

There were 1,586 referrals through December 2024.



Referral Type	Total
ER	255
OB	210
Ortho	244
Primary Care	651
Specialties	226
Grand Total	**1586**

- Unity – 400 (Primary Care)
- GW Medical Faculty Associates – 310 (specialties)
- Whitman Walker – 3 (Primary Care)
- Easton Orthopedics – 60 (Orthopedics)
- Various community providers – 200 (OB), 3 (specialty services)
- Emergency Room Transfers – 167 (majority to UMC, some Howard)
- GW Hospital ER transfer - 49

Referral Type	Total
ED Referral 2024	246
Children's ED	9
Unity PCP	490
Unity Specialty	190
Unity OB/GYN	210
Ortho	240
Ortho UC (Arlington VA)	4
VFC 2024	96
VFC 2025	2
Whitman Walker	5
Children's pcp	63
K Street Psych	5
Howard Dental	20
Cedar Hill Dental	11
Total	1586

d. **List of services currently provided at the Urgent Care center.**

- Allergic reactions
- Asthma
- Ear infections
- Falls, Minor sprains, broken bones
- Persistent Cough
- Pink Eye
- Minor cuts, burns, bug bites, and animal bites
- Sinus pressures and sinus infections (headaches/pressure, stuffy/runny nose, etc…)
- Urinary Tract infections (pain when urinating)
- Point of Care Testing (Covid, Flu, Strep, RSV, Pregnancy, Mono)

24. Regarding the standalone Emergency Department to be constructed on the Fletcher- Johnson campus in Ward 7, please provide:

Response:

Note: DHCF is responsible for overseeing the construction of this site per the operating agreement between Universal Health Services (UHS), and has no oversight of current or future Cedar Hill operations.

a. **Timeline for construction and opening**;

UHS is responsible for the cost of constructing and operating the future Free Standing Emergency Department (FED). DMPED and UHS are finalizing their agreement for the FED to be located on the Fletcher-Johnson campus. DGS has entered into a contract with United Construction Services to remediate and remove the former school and prepare a PAD site with the necessary infrastructure for UHS. The contract was awarded last November, and work has begun. DGS expects to turn over the site to UHS in late 2025. UHS will construct the FED in 2026 and expects to see patients in early 2027. The DGS work ($8 million) is funded through the Fletcher Johnson capital project.

On December 23, 2024, the State Health Planning and Development Agency (SHPDA) approved Certificate of Need (CON) 2024-0-02 for UHS to operate the FED at the Fletcher Johnson location.

b. **Total funding for the project, broken down by funding source;**

Per the approved CON, UHS estimates it will cost $23.2 million to construct the FED facility.

c. **Current budget status**;

The FED itself is 100% funded by UHS. The site remediation is funded through the Fletcher Johnson Capital Project. The current remediation contract with DGS is $8 million, which includes both the future UHS site and other portions of the Fletcher Johnson campus.

d. **List of services to be provided in comparison with the Ward 8 Urgent Care center and the Cedar Hill Regional Medical Center**; and

Per the approved CON, "…the FED will have 14 treatment rooms in total. The treatment rooms are universal and can be used for any emergency service treatment. A few of the treatment rooms will be specifically designed to handle Trauma/Resuscitation patients, pediatric patients, OB/GYN patients, patients of size, and a "safer" treatment room for patients with acute behavioral health issues…The FED will have a laboratory, X-Ray, CT and medication room as well as other functions such as a nutritional area, blanket warmers, portable X-ray, and ultrasound. Finally, there is a sperate area with a separate entrance off the lobby for any outpatient ambulatory procedures such as blood collections."

e. **Patient capacity.**

Per the approved CON, the FED will have 14 treatment bays.

25. 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 2024 and FY 2025, to date.

Response:

Please see Attachment to Q25 for response.

26. For the Medicaid fee for service (FFS) and managed care programs, please provide spending/costs and utilization data, both actual and projected, for FY 2024 and FY 2025, to date.

Response:

For costs associated with the Medicaid program, please see the response to question Q25. For utilization data, please see Attachment to Q26.

27. **For FY 2024, 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.**

Response:

DHCF 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 the previous year's budget target

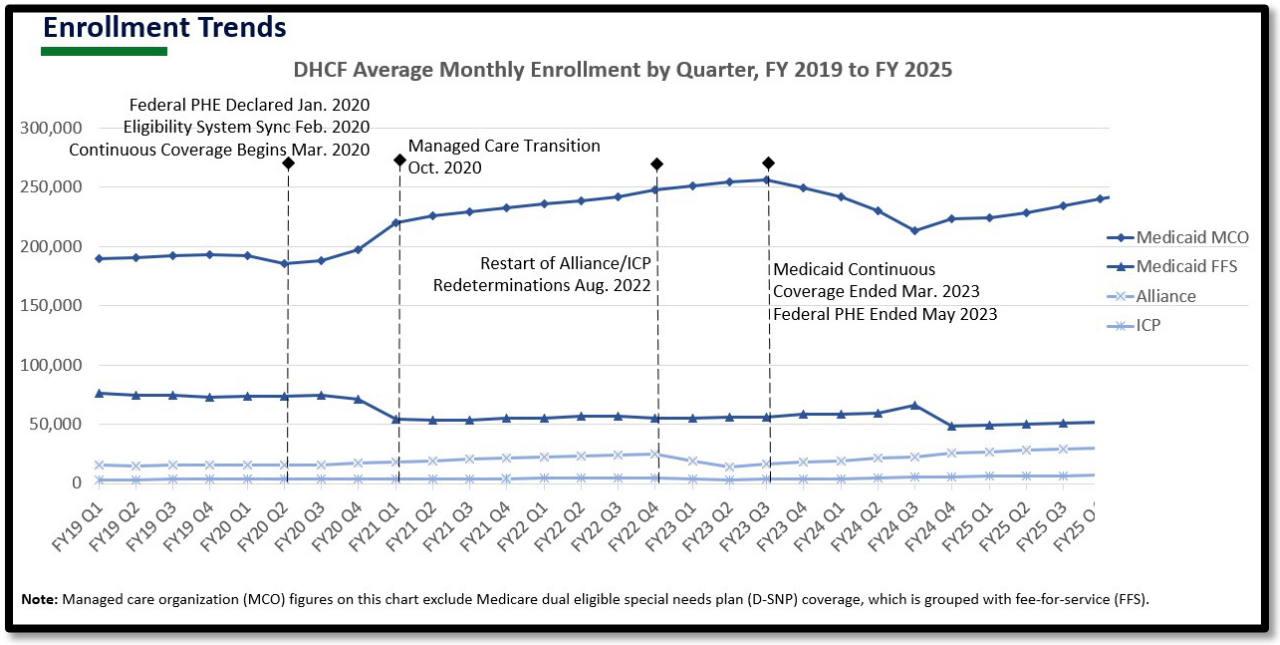
Medicaid and Alliance Enrollment Assumptions in FY25 Formulation:

- **Medicaid**
    - For Medicaid, the federal continuous coverage requirement ended on March 31, 2023. Beneficiaries began receiving renewal notices April 1, with 60 or 90 days to respond depending on their eligibility group.
    - Individuals who do not renew timely have a 90-day grace period to re-enroll retroactive to their recertification date. As a result, DHCF will not have stable enrollment figures until the grace period expires for each cohort.
    - Although FY 2025 enrollment is projected to decrease relative to FY 2024, it is still expected to exceed pre-PHE levels as some individuals who newly joined the program during the pandemic retain their coverage.

- **Alliance and Immigrant Children's Program**

- Redetermination restarted with the cohort of beneficiaries due for renewal in August 2022. They extended over 6 monthly cohorts, through January 2023, before returning to a normal cycle.
- The restart of renewals led to an initial drop in enrollment, followed by an increase as some individuals regained coverage and others newly enrolled in the programs. Growth is expected to continue through FY 2025 but is not projected to reach levels seen during the PHE.
- Projections reflect no face-to-face interview requirement and, as of FY 2023, a 12-month certification period for Alliance beneficiaries (consistent with the rules for ICP).

See chart below for visual details of enrollment through FY2025



28. Identify each District of Columbia agency that submitted Medicaid claims, indicating if it was through an MCO, including HSCSN, or FFS, in FY 2024 and FY 2025, to date, and including the following information:

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

See Attachment 1 to Q28 for the total dollar amount of claims filed by agency each month

b. The total dollar amount of claims denied per agency each month, including any pattern or common reason for the denial and the percentage and timetable of claims paid and denied within 30 and 90 days a month;

Please see Attachment 1 to Q28 for the total dollar amount of claims denied per agency each month and the timetable of claims paid and denied within 30 and 90 days.

Based on FY 24 - 25 YTD denied claims history, the most common reasons for denials were:

- **Ineligible program COS (category of service)**
- **Ineligible program code**
- **Exact duplicate claims**
- **Beneficiary Name Mismatch**
- **DC Public provider past timely filing**
- **Service covered by MCO**

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

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.

Response:

The third-party billing agents used by each of the agencies that conducted claiming to DC Medicaid as exhibited in Attachment 1 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	MDONLINE
DC Behavioral Health (DBH) (formerly Dept of Mental Health)	Within agency
DC Fire Department & Ambulance Services (FEMS)	Office Ally

Currently, 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. However, DHCF is exploring opportunities to integrate the DYRS into the ASO during FY25 – FY 26 to comply with the statutory requirements of the Section 5121 of the Consolidated Appropriations Act, 2023. DYRS will be seeking Medicaid reimbursement of certain state plan services for juvenile beneficiaries scheduled for release from youth and adult justice systems.

There are no additional 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.

29. For FY2023, FY 2024, and FY 2025 to date please detail the ways DHCF is ensuring network adequacy in the Medicaid provider network, including:

Response:

DHCF continues to track and monitor the Managed Care Organization's (MCO) provider network and compliance to the network adequacy standards prescribed in Federal Regulations. To ensure compliance, DHCF oversees the independent review of the Medicaid Managed Care program performed by an External Quality Review Organization (EQRO). Qlarant, the District's contracted EQRO evaluates participating MCO's provider networks to gauge compliance with federal and District-established standards. An annual network adequacy survey is completed as an External Quality Review (EQR) focus study.

a. Results of the most recent audit(s) related to network adequacy;

The EQRO's findings show that the MCOs demonstrated a robust provider network:

- All Managed Care Plans (MCP) achieved 100% compliance with adult and pediatric Primary Care Physician (PCP) geographic access standards. Enrollees had at least two PCPs within 5 miles or 30 minutes of their residences.
- All MCPs met adult and pediatric PCP provider-to-enrollee ratio standards. Each MCP had at least one PCP for every 500 enrollees.
- All MCPs demonstrated full compliance with DHCF's PCP provider network requirements over the last three years, as applicable.
- Based on DC averages for both Adult PCP Routine Appointment Compliance and Pediatric PCP Routine Appointment Compliance, the MCPs performed relatively well. The Adult PCP Routine Appointment Compliance average was 93% and the Pediatric PCP Routine Appointment Compliance average was 97%.

Area of Improvement:

- The DC average did not meet the 90% target for either measure, Adult PCP Urgent Appointment Compliance or Pediatric PCP Urgent Appointment Compliance. However, a positive three-year trend is noted in the Adult PCP Urgent Appointment Compliance measure: 69% (2022), 74% (2023), and 87% (2024) and a 14-percentage point improvement was observed in the Pediatric PCP Urgent Appointment Compliance measure: 74% (2023) to 88% (2024%).

b. Metrics used to measure network adequacy, including geographic proximity, provider-to-enrollee requirements, and/or timely provider appointments;

Department of Health Care Finance
FY24-25 Performance Oversight Questions

MCP Contract Reference	Contract Requirement
Provider Network	
Geographic Standards—Network Composition and Mileage & Travel Standards DCHFP: C.3.161, C.5.29.2.2.1 CASSIP: C.3.177, C.5.95	All enrollees should have access to at least 2 age-appropriate PCPs, who are within 5 miles of their residence and no more than 30 minutes travel time.
Provider-to-Enrollee Ratios DCHFP: C.5.29.2.7.11 CASSIP: C.5.100.11	The MCP must have at least 1 full-time equivalent PCP, regardless of specialty type, for every 500 enrollees, including 1 full-time equivalent PCP with pediatric training and/or experience for 500 children and adolescents through the age of 20.
Timely Access to Care	
Routine Care DCHFP: C.5.29.18.5.2, C.5.29.18.10 CASSIP: C.5.116.10	Adults should have access to a routine, well health examination within 30 days of request. Children should have access to an Early and Periodic Screening and Diagnostic Treatment (EPSDT) examination within 30 days of request.
Urgent Care DCHFP: C.3.237 CASSIP: C.5.116.6	DCHFP: Enrollees should receive urgent medical care within 24 hours of request. CASSIP: Enrollees should have access to urgent care 24 hours a day/7 day a week. [Care within 24 hours of request is used for the urgent care timely access measure.]

c. Any penalties issued or enforcement measures taken by DHCF against MCOs in relation to network adequacy;

To date, there are no penalties against MCOs related to network adequacy.

d. Please detail the breakdown and differences in the measurement and outcome of network adequacy between medical and behavioral health provider networks;

The measure for the behavioral health provider network is based on the compliance requirement of one (1) provider within 5 miles. The EQRO reviewed the available data on the quarterly GeoAccess reports and found that in 2024, all MCOs are 100% compliant.

*** There are no notable differences in measurements between medical and behavioral health.

e. Any efforts to improve the accuracy of the MCOs' Provider Directory, which was noted as an area of improvement in last year's oversight responses; and

The accuracy of the MCOs' Provider Directory has remained a moving target for improvement for each because of challenges in provider reporting. However, with DHCF's partnership and collaborative efforts with the MCOs, a new approach in reporting was introduced in 2024 that requires the organization to provide a comprehensive list of their network providers to include all provider types (e.g., medical, behavioral, dental) and any changes quarterly. The goal of the new reporting process is to collect necessary baseline data to create a provider database that would

streamline and assist in developing a consolidated Provider Directory. To date, DHCF is in the process of evaluating the data and creating a project workplan to execute the project.

f. Any changes to procedures, policies and potential changes to network adequacy measurement or enforcement in FY2023, FY 2024, and FY 2025.

There no notable changes to procedures, policies and potential changes to network adequacy measurement or enforcement in FY2023, FY2024, and FY2025 to date.

30. Please identify each incident of Medicaid abuse or fraud investigated in FY 2024 and FY 2025, to date, and any associated sanction/penalty. Please identify providers and amounts recouped for each, including any supporting documentation.

a. What problem areas or patterns have been discovered regarding fraud in the District's Medicaid program?

Response:

DHCF's Division of Program Integrity (DPI) includes an Investigations Branch, a Surveillance Utilization Review Section (SURS), a Public Assistance Reporting Information System (PARIS) Branch, 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 141 cases of alleged Medicaid fraud in FY24 and referred 14 of them to law enforcement. In FY25, as of January 15, 2025, DHCF referred an additional 4 cases to law enforcement and investigated or continues to investigate 10 additional cases of alleged Medicaid fraud (for a total of 169 cases investigated or continuing to be investigated across FY24 and FY25 to date). Please refer to **Attachment 1 to Question 30** for more details on these investigative cases.

Based on preliminary investigations that are either 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:

- Telehealth services where the claims submitted deviate from expected or reasonable billing patterns and investigations indicate that services were not provided.
- Behavioral health services claims with excessive units of service and services not provided;

- Claims submitted for services not provided by Community Support Workers (behavioral health direct service community support providers within the MHRS and ACT programs)
- 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.

Attachment 2 to Q30 details DPI: SURS' Branch's audit and oversight activities for FY24. In FY24, DPI identified $2,172,896.43 in overpayments made to Medicaid providers. Of that, DPI has recovered $570,495.86. Recoupments are typically effectuated via offsets against providers future claims or via payment plans negotiated between the provider and DHCF. Additionally, providers have appeal rights that must be exhausted before DPI begins the recoupments. As such, there is typically a lag between identifying the overpayment and beginning the recoupment, and a longer lag before all the funds are fully recouped. DPI anticipates completing the recoupment of the remaining $1,437,142.96 in FY25.

In addition to the provider activities listed in **Attachment 2 to Q30**, SURS continues to expand its oversight of the Managed Care Organizations. This includes reviewing data on overpayments identified and recovered that are reported by the MCO's on Program Integrity Monthly Reports, reviewing MCO audits for completeness and identifying potential follow-up actions, and reviewing MCO cost avoidance measures in order to validate the measures are achieving their stated goal of reducing MCO waste. These activities have required a re-balancing of SURS operations away from solely focusing on fee-for-service provider audits but are a necessary component of program integrity operations in light of the agencies' continued shift towards a more fully managed care model.

31. For each waiver program, please provide a description of and reason for any changes or planned changes in FY 2024 and FY 2025, to date, and:

a. FY 2024 and FY 2025, 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.

Response:

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.

To date, no planned changes have been implemented for FY2024 and FY2025 across the three waiver programs. The total enrollment figures, along with the gender breakdown and corresponding percentages for each program, are as follows:

- For the EPD Waiver, 4,403 beneficiaries (64%) are female, and 2,453 beneficiaries (36%) are male, resulting in a total enrollment of 6,856 beneficiaries.
- The IFS Waiver has 54 beneficiaries (50.5%) who are female and 53 beneficiaries (49.5%) who are male, with a total enrollment of 107 beneficiaries.
- For the DD Waiver, 744 beneficiaries (37%) are female, and 1,271 beneficiaries (63%) are male, bringing the total enrollment to 2,015 beneficiaries. Anticipated enrollments for all three programs are outlined in the publicly available CMS-approved waiver documents.
- There is no current cap or waiting list associated with either of the three waivers.
- Spending/costs, and utilization data for both EPD and IDD Waivers by service provided, and cost per enrollee are included in the Q31 Attachment.

32. **Please provide a list of all State Plan Amendments (SPAs) or demonstration projects <u>submitted</u> to CMS for approval in FY 2024 and FY 2025, to date, or planned for submission in the remainder of FY 2025 and in FY 2026. 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.**

    a. **Please provide a description of the stakeholder engagement performed in preparation for any SPAs or demonstration waiver applications developed for FY 2024 or FY 2025.**

<u>Response:</u>

Table 1: Approved SPAs/Waivers with a CMS Submission or Effective Date in FY24 or FY25 by Effective Date (as of January 15, 2025)

TN	Stakeholder Engagement	Description	Status	Service Change	Federal Budget Impact
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
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-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	Proposed Effective Date: 10.1.23 Approved: 1.24.24	N/A	FY24: $0 FY25: $0

		program to reimburse specialty hospitals at a rate that is fair and reasonable.	Submitted: 12.15.23		
DC-23-0012	None	Updates payment for physician-administered drugs. It will also allow the Department of Health Care Finance to reimburse the entire class of physician-administered drugs at one hundred percent (100%) of Medicare rates.	Effective: 10.1.23 Approved: 10.27.23 Submitted: 9.15.23	N/A	FY24: $257,860 FY25: $282,715
DC-23-0013	None	Updates rates for Mental Health Rehabilitative Services and Adult Substance Use Rehabilitative Services.	Effective: 10.1.23 Approved: 1.8.24 Submitted: 10.19.23	N/A	FY24: $261,189 FY25: $272,205
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 Approved: 1.25.24 Submitted: 12.29.23	N/A	FY24: $0 FY25: $0
DC-23-0015	None	The proposed changes include: 1) streamlining language that describes certain therapy modalities, which are available under the Counseling/Therapy service benefit, 2) updating supervision requirements for behavioral health providers in Federally Qualified Health Centers (consistent with District Law), 3) clarifying education and experience requirements for credentialed staff able to provide State Plan rehabilitative services, and 4) updating rates for select behavioral health services according to the fee schedule. experience requirements for credentialed staff able to provide State Plan rehabilitative services; and updates rates for select behavioral health services	Proposed Effective Date: 11.1.23 Approved: 1.22.24 Submitted: 11.14.23	N/A	FY24: $6,358,100 FY25: $7,780,943

		according to the fee schedule.			
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-23-0016	None	Provides coverage for select agents for treatment of infertility, allows the District to enter into outcome-based arrangements with manufacturers, and increases flexibility to improve access to prescription and over-the-counter drugs.	Effective: 1.1.24 Approved: 3.14.24 Submitted: 12.22.23	Adds coverage for fertility drugs.	FY24: $818,210 FY25: $282,374
DC-24-0001	None	Added Inter-professional Consultation and Collaborative Care Services as covered benefits.	Effective: 1.1.24 Approved: 3.22.24 Submitted: 2.20.24	Expands behavioral health services.	FY24: $256,886 FY25: $332,599
DC-24-0002	None	Updates Medicaid reimbursement rates for physical therapy, occupational therapy, and speech-language therapy services under the home health benefit.	Effective: 1.1.24 Approved: 5.8.24 Submitted: 3.27.24	N/A	FY24: $1,572,969 FY25: $1,970,034
DC-24-0006	None	Provides a twelve (12) month continuous eligibility period to children under age nineteen, who no longer meet eligibility requirements.	Effective: 1.1.24 Approved: 1.31.24 Submitted: 3.15.24	N/A	FY24: $8,063,850 FY25: $11,347,989
DC-24-0003	None	Provide Federally required assurances on third party liability requirements and clarifies the District's policy of not creating liens for injury settlement proceeds attributable to future medical expenses.	Effective: 2.1.24 Approved: 3.15.24 Submitted: 1.2.24	N/A	FY24: $0 FY25: $0

DC-24-0004	None	Updates reimbursement methodology for Rehabilitation Day Services and Psychosocial Rehabilitation (Clubhouse), adds a new preventive service (Attachment and Biobehavioral Catchup), and updates the structure for methadone services in opioid treatment programs.	Effective: 2.1.24 Approved: 6.13.24 Submitted: 3.28.24	Expands behavioral health services.	FY24: $5,460,630 FY25: $8,642,822
DC-24-0012	None	Establishes an emergency interim payment methodology for certain providers affected by the Change Healthcare cybersecurity incident.	Effective: 2.1.24 Approved: 6.13.24 Submitted: 4.1.24	N/A	FY24: $0 FY25: $0
DC-24-0007	None	Permanently adopts COVID-19 flexibilities for the Housing Supportive Services 1915(i) Home and Community-Based Services benefit.	Effective: 5.12.24 Approved: 5.2.24 Submitted: 4.3.24	N/A	FY24: $0 FY25: $0
DC-24-0005	None	Provide supplemental payments for direct support professionals through March 31, 2025.	Effective: 5.12.24 Approved: 5.24.24 Submitted: 4.12.24	N/A	FY24: $28,302,031 FY25: $30,096,822
DC-24-0009	None	Increases the personal needs allowance standard for eligible institutionalized long-term care residents and sets annual increased tied to the Federal Cost-of-living adjustment published by the Social Security Administration.	Effective: 5.12.24 Approved: 6.28.24 Submitted: 5.21.24	N/A	FY24: $269,435 FY25: $824,756
DC-24-0010	None	Permanently adopts changes made during the COVID-19 PHE to the My Health GPS Health Home Program, including: changes to staffing ratios, provider payment reimbursement methodologies, and the needs assessment process.	Effective: 5.12.24 Approved: 6.12.24 Submitted: 4.19.24	N/A	FY24: $0 FY25: $0

DC-24-0014	None	Updates the reimbursement re-basing schedule for Federally Qualified Health Centers.	Effective: 5.12.24 Approved: 9.17.24 Submitted: 6.28.24	N/A	FY24: $0 FY25: $0
Whole-Person Care Transformation (11-W-00331/3)	30 –day public comment period and ongoing stakeholder engagement series	Seeks authority to 1) fund BH, justice-involved reentry, and health-related social need (HRSN) services; 2) develop and maintain infrastructure to support the delivery of reentry and HRSN services	Effective: 1/1/25 Submitted: 6/6/24	Adds justice involved reentry and HRSN	?
DC-24-0011	None	Updates the reimbursement methodology for public specialty inpatient hospitals.	Effective: 5.15.24 Approved: 7.17.24 Submitted: 5.14.24	N/A	FY24: $0 FY25: $0
DC-24-0015	None	Updates the reimbursement methodology for out-of-state nursing facilities to ensure continued access to nursing facilities for District Medicaid.	Effective: 6.1.24 Approved: 8.13.24 Submitted: 6.28.24	N/A	FY24: $0 FY25: $0
DC-24-0008	None	Adds coverage for Medication Therapy Management to the fee schedule.	Effective: 7.1.24 Approved: 8.1.24 Submitted: 5.13.24	Expands pharmacy benefit.	FY24: $184,937 FY25: $760,498
DC-24-0020	None	Provides assurance for compliance with mandatory annual reporting for the My DC Health Homes core sets of quality measures.	Effective: 9.30.24 Approved: 10.9.24 Submitted: 4.19.24	N/A	FY24: $0 FY25: $0
DC-24-0021	None	Provides assurance for compliance with mandatory annual reporting for the My Health GPS Health Homes core sets of quality measures.	Effective: 9.30.24 Approved: 10.9.24 Submitted:	N/A	FY24: $0 FY25: $0

			4.19.24		
DC-24-0017	None	Provides a supplemental payment in FY 25 to eligible an eligible group practice with at least five hundred (500) physicians that are members of the group	Effective: 10.1.24 Approved: 9.17.24 Submitted: 7.1.24	N/A	FY24: $0 FY25: $3,150,000

Table 2: SPAs/Waivers Submitted to CMS in FY25, Currently under Review (as of January 15, 2025)

TN	Stakeholder Engagement	Description	Status	Service Change	Cost/(Savings)
DC-24-0019	None	Renews the Districts Adult Day Health Program 1915(i) benefit.	Effective: 4.1.25 Submitted: 9.30.24	N/A	FY25: $0 FY26: $0
DC-24-0025	None	Continues coverage for over-the-counter COVID-19 testing kits.	Effective: 10.1.24 Submitted: 12.20.24	N/A	FY24: $0 FY25: 0
DC-24-0013	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Submitted: 5.17.24	Expands coverage of maternal health services for pregnant immigrants and their children	FY24: $3,867,652
DC-24-0016	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children	See above
DC-24-0023	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children	See above

Table 3: FY25 and FY26 Anticipated SPA/Waiver Submission

SPA/Waiver	Description
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.

Community Violence Intervention	Provides coverage for community violence preventive services under the Medicaid State Plan.
Remote Patient Monitoring	Provide remote monitoring for high-risk pregnant individuals.
DC Individual and Family Support (IFS) Waiver Renewal	Renews the District's IFS waiver, expands remote support services, removes financial caps for certain services, updates reimbursement methodology for direct support workers and clarifies policies on training and certifications for providers.
DC People with Intellectual and Developmental Disabilities (IDD) Waiver Amendment	Updates reimbursement methodology for direct support workers and clarifies service delivery policies to ensure quality of care and increase provider accountability and training.
DC Elderly and Persons with Physical Disabilities (EPD) Waiver Amendment	Updates reimbursement methodology for direct support workers.

33. Please provide an update on the implementation of the State Plan Amendment to cover doula services, including:

a. The number of doulas currently receiving reimbursement.
b. The expected number of doulas to receive reimbursement in the remainder of FY 2025 and FY 2026.
c. Total reimbursements distributed to doulas in FY 2024 and FY 2025 to date;
d. A narrative explanation on how DHCF continues to make doulas as well as DC residents aware of eligibility for reimbursement;

Response:

The District of Columbia Medicaid State Plan Amendment that authorized Medicaid reimbursement for Doula services was approved by the Centers for Medicare and Medicaid Services on September 28, 2022, with an effective date of October 1, 2022. As of January 2025, there are seventeen (17) active doulas/doula groups enrolled as Medicaid providers. Total fee-for-service reimbursement for enrolled doulas/doula groups in FY2024 and FY2025 to date is $0 as most doulas/doula groups are likely contracting with and receiving reimbursement through managed care plans.

In March 2024, DHCF reconvened the Maternal Health Advisory Group (MHAG). Among other essential tasks, the group will be tasked with developing specific solutions to better recruit and retain doula providers in the Medicaid program. DHCF will review and implement feasible recommendations from the MHAG once they are finalized.

In July 2024, the District was chosen as one of six states to participate in the Institute for Medicaid Innovation's Doula Learning and Action Collaborative. The District, along with its partner states, will spend three years developing initiatives aimed at improving access to doula services and perinatal health outcomes for birthing people of color who have Medicaid health. Implementation of these initiatives should improve uptake and access to doula services in the District.

In January of 2025, the District was chosen to participate in Centers for Medicare & Medicaid Services, Transforming Maternal Health (TMaH) Model. By participating in the TMaH Model, the District will further advance the goal of building a maternal health care system that provides whole-person care. The TMaH Model can help us achieve this vision by investing in essential care delivery infrastructure and incentivizing enrolled providers to work together to address a person's physical, behavioral, and social needs. Expansion and increased awareness of doula services is key to the development of a successful Maternal Health infrastructure in the District.

Finally, DHCF issued two transmittals (#23-36 & #24-32) to expand the number of authorized Medicaid certifying entities in FY2024. These certifying entities are those deemed to provide an acceptable doula certification to qualify for enrollment with DHCF.

34. In FY 2024, DHCF shared that they were on track to implement a Community Violence Prevention benefit in Medicaid, effective October 1, 2024. Please provide an update on the status of the CVP benefit.

Response:

The State Plan Amendment for this project is still under development as DHCF continues to work with HVIP on scope and implementation, as the benefit is currently incorporated into existing grant agreements.

35. Are the District's managed care plans equipped to ensure compliance with the Salazar Decree? If not, how is DHCF working to ensure compliance?

Salazar[1] 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[2]; (4) adequate advance notice of termination from Medicaid benefits during annual renewal[3]; 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 2024, 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.

Over 90% of the children insured by Medicaid are enrolled in Medicaid managed care plans (MCPs). MCPs 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. MCPs provide on-going outreach to the beneficiaries enrolled in the health plan, informing and encouraging them to seek needed and over-due services. In order to do this appropriately, regular reports are run by the MCPs 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, MCPs are also responsible for various reporting requirements so that the District can monitor the outreach services being provided by the MCPs to the beneficiaries. This includes quarterly reports on utilization of and notice and outreach for EPSDT services. Under the Salazar Consent Decree, the MCPs are expected to meet a certain threshold of well-child visit utilization, and if not met, corrective action plans and fines are imposed on the MCPs. The MCPs continually meet all of their reporting requirements with the District, and in FY24 were placed on corrective action plans and fines were imposed.

The MCPs are compliant with all reporting deliverables and fulfill the requirements of submitting and implementing their corrective action plans and payment of fines. DHCF continues to work with the MCPs on outreach for preventive services in order to improve utilization of primary and dental care and ensure access to medical care for Medicaid-enrolled children.

36. What was the average length of time, in FY 2024, for each MCO to complete:

Response:

a. Non-urgent prior authorizations?

The following responses are identified as calendar days.

Amerigroup	AmeriHealth	HSCSN	MedStar
9.7	1.7	9	4.4

b. Urgent prior authorizations?

Amerigroup	AmeriHealth	HSCSN	MedStar
1.6	0.3	2	3.6

c. Long-term care prior authorizations?

Although long-term care services are excluded from the managed contracts administered by Amerigroup, AmeriHealth, HSCSN and MedStar, similar services are administered by the MCPs. The following lists the average length of time expended to complete prior authorizations for similar services.

*Does not report prior authorizations for long-term care services.

Amerigroup	AmeriHealth	HSCSN	MedStar
*NA	1.1	19	1.1

37. What are DHCF's projections on how DC Law 25-100, the Prior Authorization Reform Amendment Act, will affects average prior authorization wait times? Please provide an update on vendor and MCO contracts, and anticipated implementation of the law.

Response:

DHCF is unable to project the effect on average prior authorization time, but can confirm that all relevant contracts have been amended accordingly.

38. Please describe any changes to any of the MCO patient portals completed in FY 2024 and FY 2025, to date, or planned for the remainder of FY 2025.

Response:

Amerigroup

Amerigroup DC utilizes both an online portal on its enrollee website and a mobile patient portal that allows its Enrollees to independently manage their care.

There were no changes to the online portal in FY 2024.

The mobile patient portal underwent the following improvements in FY 2025:

- Launched Caregiver Access, permitting Enrollees the ability to give a caregiver access to view healthcare information;
- Redesigned and simplified the landing page to provide enrollees easier access to the most used features, such as their benefits and ID cards;
- Enabled predictive interventions for Enrollees to self-service their questions without having to make a call to the Support Team;
- Introduced a new Document Hub so Enrollees can more easily access essential health plan documents in a centralized location; and
- Added a program tile for the value-added benefits.

For the remainder of FY 2025, Amerigroup DC plans to launch the Family Link initiative, which will allow the head of a household (HOH) to manage the family's health insurance needs.

AmeriHealth

There were no substantive changes made to the AmeriHealth Caritas DC member portal in FY 2024. In FY 2025, more guidance was added to the member portal informing Enrollees how to obtain additional information related to their prior authorization requests (PAs) and appeals, to align with the requirements set forth in the Prior Authorization Reform Act.

HSCSN

HSCSN implemented the EasyConnect Health Application to provide another channel for their enrollees to access key information. Enrollees can chat with real health professionals without creating an account, enroll in personalized self-paced care programs, and use the checklist for appointment/medication reminders, blood sugar and other personal health needs.

Through use of the EasyConnect Health Application, enrollees can also perform the following activities:

- Interact with their care coordination team through HIPAA-compliant chats with customizable tools and resources.
- Access benefits and information about appeals and fair hearings, and the enrollee handbook.
- Update contact information.
- Receive documents electronically about Prior Authorizations.
- Set reminders and track health-related activities; view progress on selected activities.
- Access a rich library of medically vetted articles and other tailored resources.

In FY2025, HSCSN intends to introduce changes to improve integration, enhance regulatory compliance, and provide additional benefits to further empower enrollees and their families.

MedStar

MedStar Family Choice DC did not make any changes to its patient portal between FY 2024 and to-date FY 2025. Currently, the portal allows Enrollees to complete the following actions.

- Change primary care provider (PCP);
- Request a new enrollee ID Card;
- Review enrollee claims; and
- Review enrollee authorizations.

Presently, Medstar has no changes planned for the patient portal in FY 2025.

39. How many beneficiaries did the District currently serve through the Program for All- Inclusive Care for the Elderly (PACE) program in FY 2024 and FY 2025, to date?

Response:

a. What are the District's plan for expanding the PACE program in FY 2025 and FY 2026?

The District's enrollment in the Program of All-Inclusive Care for the Elderly (PACE) during FY 2024 and FY 2025 to date is 71 participants, consisting of 52 dual-eligible beneficiaries (Medicare/Medicaid) and 19 Medicaid-only beneficiaries.

The District continues to work collaboratively with CMS and the existing program to ensure the program's viability and sustainability. Currently, there are no plans to expand beyond the existing project site for FY 2025 and FY 2026.

40. **How does DHCF ensure that the MCOs are consistently meeting the regulatory requirements related to data reporting, quality of care, access to services, timely payment for providers?**

DHCF oversees MCO performance through a variety of activities directed by dedicated staff, including contractually-required reporting submitted on weekly, monthly, quarterly and annual bases. The reports are tailored to the contractual requirements, as appropriate, and the data is tracked and trended to determine performance outcomes. Continuous quality improvement (CQI) is a cornerstone of any health care program, and DHCF supports the MCO's efforts to achieve optimal outcomes for the enrolled population.

MCOs submit encounter data, or a representation of claims paid or denied for each enrolled beneficiary, to DHCF weekly. The encounter includes, but is not limited to, date of service, billed and paid amount, identification of the rendering provider and place of service. DHCF can assess the MCO's compliance (contractual requirement) to pay or deny 90% of all clean claims within 30 days of receipt. Failure to comply can result in freezing the MCO's enrollment (voluntary and auto-assignment), or suspension of all new enrollment, including default or auto-enrollment.

Financial data is submitted on a quarterly schedule via specified templates by each MCO. The information is reviewed and analyzed by contracted actuaries, resulting in a complete report to DHCF about the financial condition of each MCO. The quarterly report includes but is not limited to the following analyzed data.

- Net Revenue
- Net Claims and Administrative Costs
- Net Underwriting Gain/Loss
- Medical Loss Ratio (MLR)
- Risk Based Capital
- Cash and Equivalents
- Total Expenses
- Defensive Internal Ratio (number of days able to operate without accessing non-current (long-term) assets)

To further support MCO performance monitoring, Medicaid agencies administering a managed care delivery system are required to contract with a qualified External Quality Review Organization (EQRO). The EQRO performs 4 mandatory activities as defined by the Centers for Medicare and Medicaid Services (CMS).

- Validation of any performance improvement projects (PIPs) implemented by the MCOs;
- Validation of performance measures used by the MCOs;
- Ensure MCOs comply with the regulations of the Medicaid managed care program; and
- Validation of the adequacy of the MCOs' network of providers

Supplemental to the mandatory activities performed by the EQRO, DHCF chose to include the following 5 additional optional activities, as permitted by CMS, within the scope of work.

- Administration or validation of Quality-of-Care Survey (assessing enrollee's satisfaction)

- Develop Consumer Report Card on the MCOs' performance
- Complete focus studies about health care quality
- Implementation of PIPs, and
- Validation of the encounter data (evidence of claims paid by the MCOs).

In addition, DHCF employs staff whose primary function is to oversee the Medicaid managed care program. Staff hold recurring meetings with each MCO's key personnel responsible for administering all aspects of the managed care contract. These meetings are used to discuss observations of performance, either derived from analyses of reports, programmatic updates, feedback from health care providers, Medicaid beneficiaries, District-agencies and other community stakeholders. MCOs must immediately address areas of concern, based on the severity of the issue. This is done by providing DHCF with a plan of action, points of contact and a timeline to resolve identified issues. Timely access to quality care and services are ranked as top priority.

Lastly, in FY 2024, DHCF began a service delivery Compliance Program with defined monitoring protocols for service delivery within the managed care program. DHCF's Compliance Program was established to ensure consistency in operations and effective execution of all federal and District regulations. The Compliance Plan will be fully executed in FY 2025.

a. **What specific performance metrics are used to track and evaluate their compliance? And, at what cadence are these performance metrics collected and reported out?**

DHCF generally use performance metrics that are industry standards to track and evaluate the MCO's compliance. This is important for comparing performance and validation of the outcomes.

Current performance metrics used by DHCF includes the annual Healthcare Effectiveness Data Information Set (HEDIS), and the CMS-416 Report. HEDIS is a national standard used to evaluate performance of health plans' (including Medicaid MCOs) performance within specific areas or domains of care, applicable to the program's covered services for children and adults. CMS uses this report to assess both MCO's and DHCF's performance in administering Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children and adolescents, 0 through 20 years of age. Outcomes are reported each fiscal year. Both sets of metrics are reported by the MCOs and evaluated quarterly.

b. **Please include a description of any corrective action plans or penalties and the status of each MCO's compliance with each plan.**

The following actions were executed with the MCOs in FY 2024. Each action will remain under continuous monitoring for 1 year from the date of issue. Thus far, no further actions of non-compliance have been observed.

Action	Reason for Action	MCO	Issue Date
Warning Letter	Failure to oversee and be accountable for functions and responsibilities delegated to an independent contactor; and Failure to comply with reporting requirements.	MedStar	May 2024
Notice of Non-compliance	Drug utilization reviews (DURs) conducted by non-qualified staff.	MedStar	May 2024
Warning Letter	Failure to comply with the Government of the District of Columbia's HIPAA Privacy Compliance Business Associate Agreement.	HSCSN	April 2024
Warning Letter	Failure to comply with reporting requirements.	Amerigroup	September 2024

41. Please provide an update on the transition and continuity of care in services for people currently under the fee for service model to managed care.

Response:

There is no update on further transitions from fee for service to managed care. The current focus is on further developing value-based care options (e.g. maternal health through the Transforming Maternal Health initiative).

a. What is DHF's timeline for transitioning the children and youth in foster care currently being serviced by the Medicaid FFS program to the MCO program?

See above.

b. Please share DHCF's timeline for transitioning other Medicaid FFS, including special needs, and other waiver populations, to managed care.

See above.

c. How will DHCF conduct outreach to inform beneficiaries of the transition?

Not applicable.

42. Federal regulations require an annual program independent review of the Medicaid Managed Care program. Provide a copy of the review for FY 2024, or the most recent review conducted. Also include the following information:

a. The agency's response to the key findings and conclusions.
b. Action plans for addressing the review's key findings and conclusions.

Response:

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 that an MCO, or its contractors, furnished 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. The most recent review (2023) is available on DHCF's website via the following link . The 2024 ATR will be available April 2025.

The ATR must include the following, and the findings and recommendations are adopted by DHCF.

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 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.

Operational Systems Report: DHCF, in its oversight role, requires each MCO to comply with the Code of Federal Regulations (42 CFR 438 – Managed Care) and their MCO contractual requirements. To evaluate compliance, DHCF contracts with Qlarant to conduct independent reviews of each MCO. As the External Quality Review Organization (EQRO), Qlarant conducts annual compliance reviews, also known as Operational Systems Reviews (OSRs). The OSR is an External Quality Review (EQR) activity per the Code of Federal Regulations (42 CFR §438.358) designed to assess MCO compliance with structural and operational standards, which may influence the quality, timeliness, or accessibility of health care services provided to enrollees.
Qlarant's review assesses MCP compliance with applicable elements of the following CFR standards:

- Subpart A: §438.10 Information Requirements
- Subpart B: §438.56 Disenrollment Requirements and Limitations

- Subpart C: §438.100 - §438.114 Enrollee Rights and Protections
- Subpart D: §438.206 - §438.242 MCO Standards
- Subpart E: §438.330 Quality Assessment and Performance Improvement Program
- Subpart F: §438.402 - §438.424 Grievance and Appeal System

In 2024, MCOs overall compliance ranged from 96 % to 100%. MCOs were required to develop and submit Corrective Action Plans (CAPs) to address components that are partially met or areas for improvement. The components that require a CAP for 2024 are related to Grievance and Appeals standards and are specific to one (1) health plan, HSCSN. Enhanced monitoring has been established to ensure that the MCO will reach compliance by the next review.

Encounter Data Validation (EDV): Qlarant completed an EDV study of the MCOs based on an assessment of encounters incurred July 1, 2022, through June 30, 2023. Qlarant reviewed each MCO's information system and concluded all MCOs had the capability to produce accurate and complete encounter data during the study period. The findings are below:

- All MCOs demonstrated well-documented data integration and claims processing procedures and the ability to produce high quality encounter data.

- AmeriHealth, MedStar, and HSCSN met minimum sample requirements through effective medical record procurement strategies.

- AmeriHealth and Amerigroup met or exceeded the 90.0% target for submitting valid records.

- All MCOs had an overall match rate that exceeded 90.0%.

- Stakeholders can have high confidence in the encounter data of AmeriHealth and Amerigroup, as their match rates met or exceeded 95.0%.

DHCF will continue to monitor and track to ensure all MCOs apply appropriate continuous quality improvement activities and resources to achieve compliance and remain compliant within these metrics.

43. For the Medicaid FFS, MCOs, and the Alliance program, please provide a description of and reason for any changes or planned changes in FY 2024 and FY 2025, to date, regarding:

a. **Services provided and eligibility requirements in FY 2024 and FY 2025, to date;**
b. **Reimbursement rates/methodologies in FY 2024 and FY 2025, to date;**
c. **Enrollment and spending/costs, and utilization data, both current and projected, including statistical information by race, gender, ethnicity, and ward.**

Services provided and eligibility requirements

On January 1, 2024, and April 1, 2024, expanded coverage of fertility treatment, in response to **Bill 24-699 - Expanding Access to Fertility Treatment Amendment Act of 2022,** was implemented for Medicaid and Alliance beneficiaries, respectively.

In FY24, DHCF introduced an expanded service category for coverage and administration of behavioral health (BH) services to eligible managed care and Alliance populations. Implementation of these services were to begin on April 1, 2024, during the second year of the new contracts with the MCOs. Although coordinated planning occurred between the Department of Behavioral Health (DBH) and DHCF, the integration did not occur. The activity was placed on-hold until further notice.

Through the collaborative agency partnership, a comprehensive rate study for BH services enhanced rates for over forty (40) existing BH services but also introduced new services and new payment modalities that will proceed irrespective of the hold. New BH services include Attachment and Biobehavioral Catchup, Intensive Care Coordination, Psychiatric Consult to a PCP, and Collaborative Care Services.

Changes to payment modalities include Assertive Community Treatment (ACT) and Methadone clinic services, as well as standardization of all services previously coded with Human Common Procedure Coding System or HCPCS (alphanumeric) to report medical procedures and services that are now reported with Current Procedural Terminology or CPT codes (numeric), identifying medical, surgical, and diagnosed services. This creates parity and simplification for utilization management and review, in addition to unifying standards of practice and provider types across various organizations enrolled with the Medicaid Program.

Reimbursement rates/methodologies

In FY24, DHCF implemented a maximum Fee Schedule for inpatient and outpatient hospital services for MCOs administering the DC Healthy Families Program (DCHFP), DC Healthcare Alliance (Alliance) and Immigrant Children's Program (ICP), per the FY24 Budget Support Act (BSA). The Fee Schedule continues in FY 2025, to date.

Risk corridors remain in place within the DCHFP, Alliance, and CASSIP managed care programs for FY24 and FY25. This mechanism is used to minimize unanticipated gains/losses by MCOs.

Enrollment and spending/costs, and utilization data

Please see responses and attachments for questions 26 and 61.

44. The FY 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, including a report on value-based purchasing under Medicaid MCOs. During FY 2023 Performance Oversight DHCF shared that due to delays, 2024 would be the baseline year for VBP implementation for MCOs. Please share the implementation and any findings DHCF has discovered.

Response:

DHCF is in the initial phase of reviewing the independent VBP arrangements established by the Medicaid MCOs in CY 2024. Additional time is required for the MCOs to collect and incorporate claims data with dates of service through December 31, 2024. This will assist in ensuring complete and accurate data is available to evaluate the efficacy of the arrangements.

a. What are the annual adoption targets that each MCO VBP must meet?

DHCF is seeking to identify and regulate adoption targets by the end of Q1 CY 2025, once final outcomes and analysis is completed on the MCO-specific VBP arrangements. DHCF will assess the MCOs' performance (i.e., utilization, costs and other key areas) across the health care domain, the outcomes of their CY 2024 independent VBP arrangements, and programmatic priorities to develop standard requirements and goals that all MCPs must meet with their network providers.

45. Please provide an update on the FY 2025 Budget Support Act Title V Subtitles C, D, and E, Medicaid Inpatient and Outpatient Fund and Directed Payments. Please include:

a. The status of the submission to Centers for Medicare and Medicaid Services and application details;
b. Status of hiring for the FTE position at DHCF to administer this program; and
c. Description of collaboration with the Hospital Association to determine policy priorities funded through the District Retention.

Response:

a. The status of the submission to Centers for Medicare and Medicaid Services and application details;

The District submitted the Average Commercial Rate directed payment template (and the corresponding tax waiver submission) for CMS review and approval on August 15, 2024. Since submission, DHCF has received a few rounds of inquiries related to the submissions. DHCF and DC Hospital Association have collaborated on CMS requests for information, just like the two entities collaborated on the initial submissions. While federal engagement on the tax waiver submission and ACR template has been ongoing since submission, the District is anticipating a brief pause in communication during administration change over. The District hopes to have final approval of both submissions in early Spring 2025.

b. Status of hiring for the FTE position at DHCF to administer this program; and

The OCFO is currently recruiting for the Reimbursement position, which will be utilized to perform the duties of oversight of the financial responsibilities of the Average Commercial Rate (ACR) analysis. DHCF is waiting for approval from CMS before hiring the new FTE.

c. Description of collaboration with the Hospital Association to determine policy priorities funded through the District Retention.

The uses of the District Retention were established in the budget process of FY2025 and are defined in current legislation. The District retention was set aside to fund Medicaid fee-for- service payments to hospitals and hire an FTE to support implementation of the ACR. Please see below for spending allocation in the FY2025 budget:

Account Group Description	Account Description	Sum of Total Budget
CONTINUING FULL TIME	CONTINUING FULL TIME	$57,008.05
FRINGE BENEFITS - CURR PERSONNEL	MISCFRINGE BENEFITS	$12,655.79
TOTAL PERSONAL SERVICES		**$69,663.84**
INPATIENT IN STATE	MEDICAL VENDOR SERVICES	$8,688,549.00
OUTPATIENT HOSPITAL	MEDICAL VENDOR SERVICES	$12,518.00
EMERGENCY MEDICAID	MEDICAL VENDOR SERVICES	$4,470,555.00
TOTAL HOSPITAL SPENDING		**$13,171,622.00**
TOTAL RETENTION SPENDING		**$13,241,285.84**

46. Please provide the plans and efforts to date for credentialing providers with the MCOs, including telehealth providers. Please also include information including:

Response:

DHCF is evaluating options and capacity for DHCF to credential and re-credentialing all providers within the MCOs' networks, instead of maintaining that responsibility with each health plan. DHCF's evaluation includes, but is not limited to, a review of credentialing standards and guidelines, timeliness of current activities, and the impact of transitioning the process to a centralized procedure at DHCF.

a. Is there a standard or uniform credentialing process across all MCOs? If not, how does each MCO credential differently?

All MCOs administering the DC Healthy Families Program and Child and Adolescent Supplemental Security Income Program (CASSIP) are contractually obligated to at minimum, comply with the National Committee for Quality Assurance (NCQA) standards for credentialing providers. With the NCQA standard, MCOs are permitted one hundred twenty days (120) days from receipt of all required documents from a provider/facility to complete the credentialing process.

b. How long, on average, does it take for providers to become credentialed? Does it differ based on provider type? If so, please provide an explanation.

Based on the analysis of data received from the MCOs from 2023 and 2024, the average number of days for credentialing providers, upon receipt of all required information, timeliness ranges from 14 to 33 days. The longer period is due to omitted, incomplete, or expired information submitted by the provider or group. There is no difference in the process based on provider type.

47. **Does DHCF share beneficiary eligibility data for benefits, specifically SUN Bucks or free and reduced-price meals at schools, with DHS and OSSE? If not, what barriers does DHCF face in securely sharing this data?**

Response:

OSSE administers the National School Lunch Program (NSLP), and DHS administers the SUN Bucks program. DHCF oversees of the District of Columbia Access System, which houses numerous health and human services eligibility programs including Medicaid, Alliance, the Immigrant Children's Program, the Supplemental Nutrition Assistance Program (SNAP), and the Temporary Needy Assistance for Families (TANF) program. As part of the NSLP and Sun Bucks administration, OSSE and DHS identify many categorically eligible students, thus reducing the burden for those District households to apply for these programs. Families who are not identified for NSLP or SUN Bucks may apply directly for these benefits.

Utilizing information from DCAS, DHS currently shares SNAP/TANF data with OSSE to identify categorically eligible students. DHCF, DHS, and OSSE are entering into a limited data sharing agreement for SUN Bucks. Once the agreement is signed by the three agencies, OSSE will share OSSE-owned data to DHS of all public, public charter, and private school students who were enrolled at an NSLP school at any point in the school year and may be potentially eligible for SUN Bucks.

48. **Please detail all software upgrades made to the DC Access System (DCAS) in FY 2024 and FY 2025, to date, including the date of the upgrade, the problem being addressed, and the status of the upgrade (completed, pending, paused, etc.)**

Response:

See Attachment to Q48 for response.

49. Please provide spending/costs, both actual and projected, for FY 2024 and FY 2025, to date, for Information Technology Management, broken down by IT equipment and IT contracts.

Response:

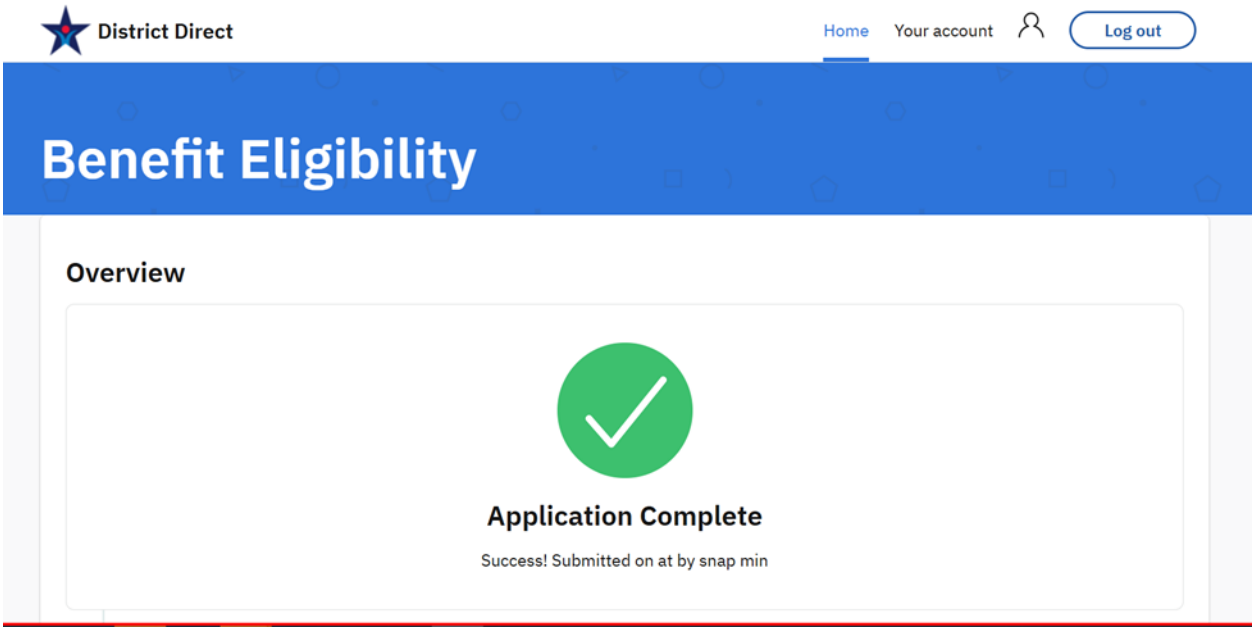
Please see the Attachment to Q49 for DHCF's response to the budget versus expenditure data for the Information Technology Management Division within the DCAS Administration.

50. Please provide the steps DHCF has taken in FY 2024 and FY 2025, to date, to address the following common complaints about the DCAS application system:

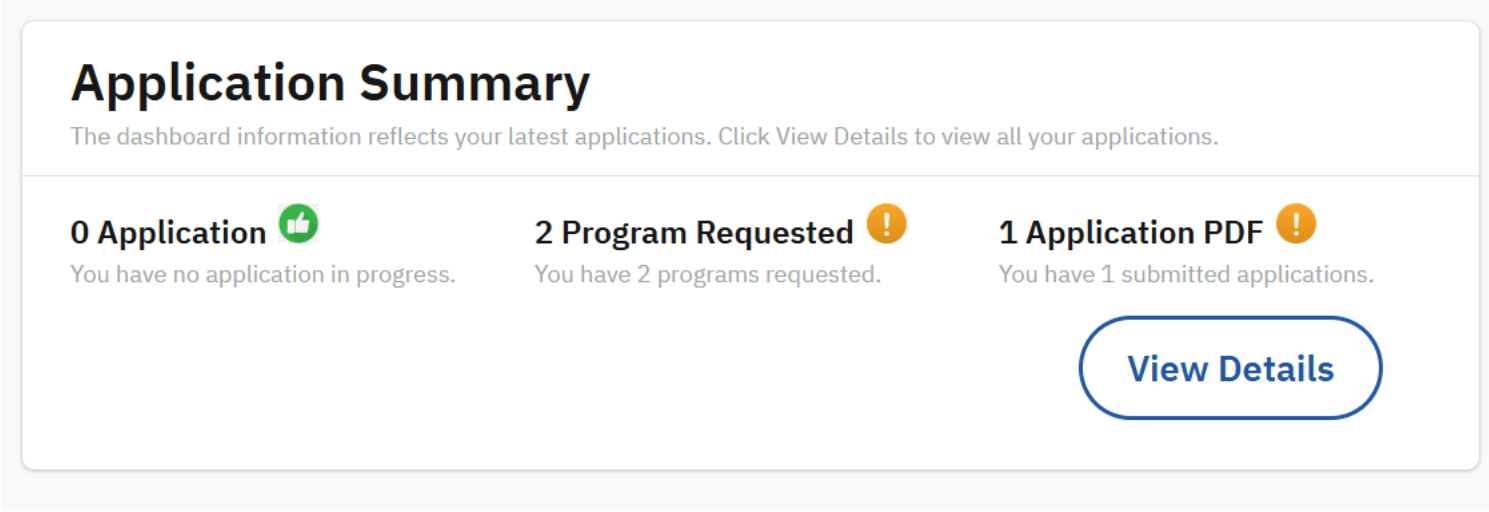
a. No confirmation of completed application;

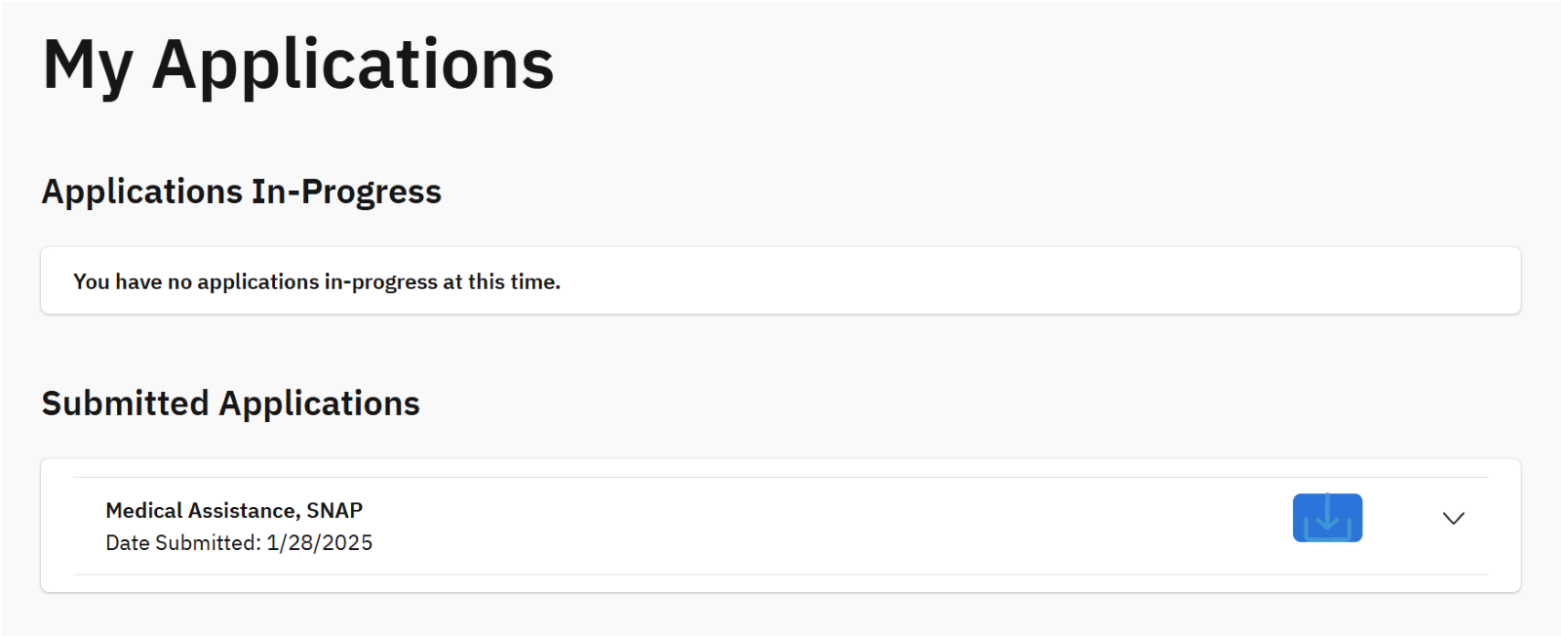
Response:

Currently, residents who complete an online or mobile application will receive confirmation that their application was submitted successfully. At the end of your submission, you will see a confirmation screen. See screenshot below.



You may also view this information in "Applications Summary" section on the home screen and can download your application in a pdf format, using the blue, download arrow, as seen in the visual below:





b. Benefits cut off when a completed application is pending

Response:

DHCF provides DHS with a report that identifies cases that are ready to be processed to further assist ESA with timely processing. As result clients who may have submitted their recertifications late or in the grace period can continue their benefits vs. submitting subsequent applications.
If a resident submits a renewal (or application within renewal cycle) through District Direct online, DCAS will identify those renewals/applications, so that the case will remain eligible until a determination is made by a caseworker. In addition, DHCF provides DHS with a report that identifies cases ready for processing to ensure applications that were submitted late or in the grace period are not terminated.

c. Length of time newborn applications are pending.

Response:

After completing a thorough root cause analysis of the issue regarding the "length of time newborn applications are pending," it was determined that the delays were not caused by system defects or technical malfunctions but were the result of operational inefficiencies. To address this, in June 2024, ESA implemented a new caseworker requirement to process newborn applications within 10 days.
Since implementation of the mandate:

- 85% of newborn applications are now completed within two days.
- The remaining 15% are finalized within one week.

51. For Medicaid enrollees required to renew manually in FY 2024 and FY 2025, 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.**

Response:

The table below reflects Medicaid enrollees required to renew manually (i.e., non-passively) in FY 2024 and FY 2025 YTD.

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 (**Modified adjusted gross income**) beneficiaries who responded during their one-month extension. Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

b. See column 4 below. This group reflects MAGI beneficiaries 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 beneficiaries 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 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	Total receiving non-passive renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	15,507	6,756	6,722	194	2,616	1,835
2023-11-30*	17,718	7,699	7,609	413	2,811	1,997
2023-12-31*	6,448	2,779	2,718	97	970	854
2024-01-31*	3,849	1,853	1,433	70	531	493
2024-02-29*	5,285	2,574	2,079	140	512	492
2024-03-31*	8,384	4,070	4,006	133	1,154	175
2024-04-30	9,347	4,677	4,488	134	1,420	48
2024-05-31	6,724	3,413	3,147	119	820	45
2024-06-30	5,717	3,045	2,613	45	1,038	14
2024-07-31	6,553	3,725	2,764	53	1,156	11
2024-08-31	6,606	4,078	2,435	73	1,011	20
2024-09-30	4,430	2,861	1,500	67	706	2
2024-10-31	5,262	3,296	1,903	58	792	5
2024-11-30	4,407	2,567	1,771	57	541	12
Percent of total receiving non-passive renewal form						
2023-10-31*	100%	44%	43%	1%	17%	12%
2023-11-30*	100%	43%	43%	2%	16%	11%
2023-12-31*	100%	43%	42%	2%	15%	13%
2024-01-31*	100%	48%	37%	2%	14%	13%
2024-02-29*	100%	49%	39%	3%	10%	9%
2024-03-31*	100%	49%	48%	2%	14%	2%
2024-04-30	100%	50%	48%	1%	15%	1%
2024-05-31	100%	51%	47%	2%	12%	1%
2024-06-30	100%	53%	46%	1%	18%	0%
2024-07-31	100%	57%	42%	1%	18%	0%
2024-08-31	100%	62%	37%	1%	15%	0%
2024-09-30	100%	65%	34%	2%	16%	0%
2024-10-31	100%	63%	36%	1%	15%	0%
2024-11-30	100%	58%	40%	1%	12%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: December 2024 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.

* Due to a system process implemented to ensure that renewals are fully recognized in DCAS, renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.

Column-specific notes are provided below.

- Column 3 includes a small number of beneficiaries 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 beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 includes non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects MAGI beneficiaries 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 2024 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.
- Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

52. For enrollees who were terminated for procedural reasons in FY 2024 and FY 2025, to date 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.**

Response:

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 (Modified adjusted gross income) beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after a one-month extension. The table reflects Medicaid enrollees required to renew in FY 2024 and FY 2025 YTD.

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 beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension for failure to manually renew). Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available. Column 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.

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 beneficiaries 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 2024 and FY 2025 to Date

1	2	3	4	5	6
	Date of renewal received is known				
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	Renewal received with an unknown date
Number of beneficiaries					
2023-10-31*	6,722	2,616	4,106	52	1,835
2023-11-30*	7,609	2,811	4,798	44	1,997
2023-12-31*	2,718	970	1,748	37	854
2024-01-31*	1,433	531	902	45	493
2024-02-29*	2,079	512	1,567	32	492
2024-03-31*	4,006	1,154	2,852	30	175
2024-04-30	4,488	1,420	3,068	30	48
2024-05-31	3,147	820	2,327	35	45
2024-06-30	2,613	1,038	1,575	31	14
2024-07-31	2,764	1,156	1,608	33	11
2024-08-31	2,435	1,011	1,424	28	20
2024-09-30	1,500	706	794	26	2
2024-10-31	1,903	792	1,111	23	5
2024-11-30	1,771	541	1,230	11	12
Percent of total terminated for failure to manually renew prior to certification end					
2023-10-31*	100%	39%	61%	N/A	N/A
2023-11-30*	100%	37%	63%	N/A	N/A
2023-12-31*	100%	36%	64%	N/A	N/A
2024-01-31*	100%	37%	63%	N/A	N/A
2024-02-29*	100%	25%	75%	N/A	N/A
2024-03-31*	100%	29%	71%	N/A	N/A
2024-04-30	100%	32%	68%	N/A	N/A
2024-05-31	100%	26%	74%	N/A	N/A
2024-06-30	100%	40%	60%	N/A	N/A
2024-07-31	100%	42%	58%	N/A	N/A
2024-08-31	100%	42%	58%	N/A	N/A
2024-09-30	100%	47%	53%	N/A	N/A
2024-10-31	100%	42%	58%	N/A	N/A
2024-11-30	100%	31%	69%	N/A	N/A

Source: DHCF eligibility system data extracted January 2, 2025.

Notes: December 2024 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.
* Due to a system process implemented to ensure that renewals are fully recognized in DCAS, renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.

- Column 2 reflects MAGI beneficiaries 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 2024 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.
- Column 6 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

53. Regarding renewal notices:

a. **Of Medicaid enrollees who have been required to renew manually in FY 2024 and FY 2025, to date, how many received pre-populated renewal forms no later than 60 days prior to the end of their certification period?**

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

Response:

a) See table below. It reflects Medicaid enrollees required to renew manually (i.e., non-passively) in FY 2024 and FY 2025 YTD.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form by Pre-Populated Status, FY 2024 and FY 2025 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
2023-10-31	15,507	12,110	11,907	203
2023-11-30	17,718	11,881	11,637	244
2023-12-31	6,448	5,178	4,952	226
2024-01-31	3,849	3,154	2,969	185
2024-02-29	5,285	2,799	2,584	215
2024-03-31	8,384	5,762	5,500	262
2024-04-30	9,347	6,763	6,496	267
2024-05-31	5,717	5,512	4,927	585
2024-06-30	6,553	6,358	5,596	762
2024-07-31	6,606	6,232	5,270	962
2024-08-31	4,430	4,133	3,155	978
2024-09-30	5,262	4,863	3,694	1,169
2024-10-31	4,407	4,198	3,527	671
2024-11-30	15,507	12,110	11,907	203

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: During the Medicaid unwinding (recertification dates May 2023 - May 2024), MAGI beneficiaries who were required to renew manually received a pre-populated renewal form and most non-MAGI beneficiaries who were required to renew manually received a conversion renewal form. Until June 2024, the data in the table reflect mostly MAGI beneficiaries since most non-MAGI beneficiaries require a conversion renewal form. December 2024 and later months are excluded because the outcomes for the one-month extensions offered to non-MAGI beneficiaries are not yet known.

Response:

b. 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 clearer and more concise messaging.

54. 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 in FY 2024 and FY 2025, to date?

Response:

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) in FY 2024 and FY 2025 YTD.

Medicaid Beneficiaries Due for Renewal by Non-Passive Renewal Form Type, FY 2024 and FY 2025 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					
2023-10-31	42,846	15,507	3,397	203	11,907
2023-11-30	29,785	17,718	5,837	244	11,637
2023-12-31	33,661	6,448	1,270	226	4,952
2024-01-31	18,379	3,849	695	185	2,969
2024-02-29	18,687	5,285	2,486	215	2,584
2024-03-31	20,386	8,384	2,622	262	5,500
2024-04-30	20,134	9,347	2,584	267	6,496
2024-05-31	15,311	6,724	2,463	271	3,990
2024-06-30	17,689	5,717	205	585	4,927
2024-07-31	21,272	6,553	195	762	5,596
2024-08-31	20,355	6,606	374	962	5,270
2024-09-30	17,046	4,430	297	978	3,155
2024-10-31	34,577	5,262	399	1,169	3,694
2024-11-30	23,591	4,407	209	671	3,527
Percent of total due for renewal					
2023-10-31	100%	36%	8%	0%	28%
2023-11-30	100%	59%	20%	1%	39%
2023-12-31	100%	19%	4%	1%	15%
2024-01-31	100%	21%	4%	1%	16%
2024-02-29	100%	28%	13%	1%	14%
2024-03-31	100%	41%	13%	1%	27%
2024-04-30	100%	46%	13%	1%	32%
2024-05-31	100%	44%	16%	2%	26%
2024-06-30	100%	32%	1%	3%	28%
2024-07-31	100%	31%	1%	4%	26%
2024-08-31	100%	32%	2%	5%	26%
2024-09-30	100%	26%	2%	6%	19%
2024-10-31	100%	15%	1%	3%	11%
2024-11-30	100%	19%	1%	3%	15%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

For each form, please include the following info for FY 2024 and FY 2025, 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.

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 beneficiaries 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 beneficiaries 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 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	Total receiving conversion renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	3,397	1,577	1,257	178	280	385
2023-11-30*	5,837	2,714	2,174	394	419	555
2023-12-31*	1,270	579	384	82	67	225
2024-01-31*	695	429	150	55	22	61
2024-02-29*	2,486	1,297	870	126	117	193
2024-03-31*	2,622	1,337	1,021	113	147	151
2024-04-30	2,584	1,407	1,015	120	153	42
2024-05-31	2,463	1,355	971	108	151	29
2024-06-30	205	108	77	18	17	2
2024-07-31	195	126	50	14	16	5
2024-08-31	374	245	99	22	28	8
2024-09-30	297	199	78	20	23	0
2024-10-31	399	240	147	11	17	1
2024-11-30	209	121	63	23	0	2
Percent of total receiving conversion renewal form						
2023-10-31*	100%	46%	37%	5%	8%	11%
2023-11-30*	100%	46%	37%	7%	7%	10%
2023-12-31*	100%	46%	30%	6%	5%	18%
2024-01-31*	100%	62%	22%	8%	3%	9%
2024-02-29*	100%	52%	35%	5%	5%	8%
2024-03-31*	100%	51%	39%	4%	6%	6%
2024-04-30	100%	54%	39%	5%	6%	2%
2024-05-31	100%	55%	39%	4%	6%	1%
2024-06-30	100%	53%	38%	9%	8%	1%
2024-07-31	100%	65%	26%	7%	8%	3%
2024-08-31	100%	66%	26%	6%	7%	2%
2024-09-30	100%	67%	26%	7%	8%	0%
2024-10-31	100%	60%	37%	3%	4%	0%
2024-11-30	100%	58%	30%	11%	0%	1%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	Total receiving non-MAGI renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	203	104	53	16	8	30
2023-11-30*	244	129	68	19	17	28
2023-12-31*	226	124	73	15	15	14
2024-01-31*	185	95	52	15	14	23
2024-02-29*	215	111	66	14	13	24
2024-03-31*	262	150	77	20	11	15
2024-04-30	267	177	75	14	14	1
2024-05-31	271	170	90	11	25	0
2024-06-30	585	451	102	27	34	5
2024-07-31	762	572	149	39	51	2
2024-08-31	962	731	179	51	41	1
2024-09-30	978	741	190	47	40	0
2024-10-31	1,169	860	261	47	35	1
2024-11-30	671	454	183	34	1	0
Percent of total receiving non-MAGI renewal form						
2023-10-31*	100%	51%	26%	8%	4%	15%
2023-11-30*	100%	53%	28%	8%	7%	11%
2023-12-31*	100%	55%	32%	7%	7%	6%
2024-01-31*	100%	51%	28%	8%	8%	12%
2024-02-29*	100%	52%	31%	7%	6%	11%
2024-03-31*	100%	57%	29%	8%	4%	6%
2024-04-30	100%	66%	28%	5%	5%	0%
2024-05-31	100%	63%	33%	4%	9%	0%
2024-06-30	100%	77%	17%	5%	6%	1%
2024-07-31	100%	75%	20%	5%	7%	0%
2024-08-31	100%	76%	19%	5%	4%	0%
2024-09-30	100%	76%	19%	5%	4%	0%
2024-10-31	100%	74%	22%	4%	3%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving D2 (MAGI) Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	Total receiving non-passive D2 (MAGI) renewal form (3+4+5+7)	Terminated for failure to manually renew 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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	11,907	5,075	5,412	0	2,328	1,420
2023-11-30*	11,637	4,856	5,367	0	2,375	1,414
2023-12-31*	4,952	2,076	2,261	0	888	615
2024-01-31*	2,969	1,329	1,231	0	495	409
2024-02-29*	2,584	1,166	1,143	0	382	275
2024-03-31*	5,500	2,583	2,908	0	996	9
2024-04-30	6,496	3,093	3,398	0	1,253	5
2024-05-31	3,990	1,888	2,086	0	644	16
2024-06-30	4,927	2,486	2,434	0	987	7
2024-07-31	5,596	3,027	2,565	0	1,089	4
2024-08-31	5,270	3,102	2,157	0	942	11
2024-09-30	3,155	1,921	1,232	0	643	2
2024-10-31	3,694	2,196	1,495	0	740	3
2024-11-30	3,527	1,992	1,525	0	540	10
Percent of total receiving D2 (MAGI) renewal form						
2023-10-31*	100%	43%	45%	0%	20%	12%
2023-11-30*	100%	42%	46%	0%	20%	12%
2023-12-31*	100%	42%	46%	0%	18%	12%
2024-01-31*	100%	45%	41%	0%	17%	14%
2024-02-29*	100%	45%	44%	0%	15%	11%
2024-03-31*	100%	47%	53%	0%	18%	0%
2024-04-30	100%	48%	52%	0%	19%	0%
2024-05-31	100%	47%	52%	0%	16%	0%
2024-06-30	100%	50%	49%	0%	20%	0%
2024-07-31	100%	54%	46%	0%	19%	0%
2024-08-31	100%	59%	41%	0%	18%	0%
2024-09-30	100%	61%	39%	0%	20%	0%
2024-10-31	100%	59%	40%	0%	20%	0%
2024-11-30	100%	56%	43%	0%	15%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: December 2024 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 with data on conversion renewal forms: The number of beneficiaries required to submit the conversion form declined after the first year of the renewal restart but are still required for some beneficiaries due to additional information required for a determination (e.g., beneficiaries gaining Medicare coverage).

Notes applicable to tables that appear under responses to items a through d:
* Due to a system process implemented to ensure that renewals are fully recognized in DCAS, renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates and we are unable to determine the columns to which they belong in the table.

- Column 3 includes a small number of beneficiaries 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 beneficiaries terminated at their certification date and/or non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 includes non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects MAGI beneficiaries 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 2024 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.
- Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

55. 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 2024 and in FY 2025, 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 FY 2024 and in FY 2025, 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 2024 and in FY 2025, 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 2024 and in FY 2025, to date?

Response:

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 in FY 2024 and FY 2025 YTD.

a. See columns 5 and 6 below.

Medicaid ABD Beneficiaries Due for Renewal by Passively Renewed and Non-Passive Renewal Form Type, FY 2024 and FY 2025 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					
2023-10-31	17,625	16,535	1,090	1,038	52
2023-11-30	4,172	1,533	2,639	2,589	50
2023-12-31	1,751	1,214	537	488	49
2024-01-31	333	290	43	20	23
2024-02-29	1,175	433	742	712	30
2024-03-31	1,220	307	913	868	45
2024-04-30	1,142	282	860	818	42
2024-05-31	1,421	555	866	838	28
2024-06-30	489	374	115	64	51
2024-07-31	440	309	131	48	83
2024-08-31	1,480	1,106	374	145	229
2024-09-30	1,160	782	378	124	254
2024-10-31	14,401	14,065	336	82	254

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**
2024-11-30	2,416	2,030	386	113	273
Percent of total due for renewal					
2023-10-31	100%	94%	6%	6%	0%
2023-11-30	100%	37%	63%	62%	1%
2023-12-31	100%	69%	31%	28%	3%
2024-01-31	100%	87%	13%	6%	7%
2024-02-29	100%	37%	63%	61%	3%
2024-03-31	100%	25%	75%	71%	4%
2024-04-30	100%	25%	75%	72%	4%
2024-05-31	100%	39%	61%	59%	2%
2024-06-30	100%	76%	24%	13%	10%
2024-07-31	100%	70%	30%	11%	19%
2024-08-31	100%	75%	25%	10%	15%
2024-09-30	100%	67%	33%	11%	22%
2024-10-31	100%	98%	2%	1%	2%
2024-11-30	100%	84%	16%	5%	11%

Source: DHCF eligibility system data extracted January 2, 2025.
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.

   Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid ABD Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	ABD beneficiaries required to complete the conversion renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	1,038	412	415	88	75	123
2023-11-30*	2,589	992	1,100	177	228	320
2023-12-31*	488	133	170	29	29	156
2024-01-31*	20	5	8	3	0	4
2024-02-29*	712	318	275	52	51	67
2024-03-31*	868	348	396	52	70	72
2024-04-30	818	389	372	46	67	11
2024-05-31	838	381	402	48	64	7
2024-06-30	64	27	30	7	3	0
2024-07-31	48	29	15	3	2	1
2024-08-31	145	104	31	8	12	2
2024-09-30	124	74	43	7	13	0
2024-10-31	82	58	22	2	3	0
2024-11-30	113	58	39	15	0	1
Percent of total receiving conversion renewal form						
2023-10-31*	100%	40%	40%	8%	7%	12%
2023-11-30*	100%	38%	42%	7%	9%	12%
2023-12-31*	100%	27%	35%	6%	6%	32%
2024-01-31*	100%	25%	40%	15%	0%	20%
2024-02-29*	100%	45%	39%	7%	7%	9%
2024-03-31*	100%	40%	46%	6%	8%	8%
2024-04-30	100%	48%	45%	6%	8%	1%
2024-05-31	100%	45%	48%	6%	8%	1%
2024-06-30	100%	42%	47%	11%	5%	0%
2024-07-31	100%	60%	31%	6%	4%	2%
2024-08-31	100%	72%	21%	6%	8%	1%
2024-09-30	100%	60%	35%	6%	10%	0%
2024-10-31	100%	71%	27%	2%	4%	0%
2024-11-30	100%	51%	35%	13%	0%	1%

Source: DHCF eligibility system data extracted January 2, 2025.
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.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid ABD Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	52	22	18	3	3	9
2023-11-30*	50	27	11	2	5	10
2023-12-31*	49	24	14	1	4	10
2024-01-31*	23	10	6	0	1	7
2024-02-29*	30	16	11	0	1	3
2024-03-31*	45	23	16	3	4	3
2024-04-30	42	22	17	3	5	0
2024-05-31	28	19	7	2	1	0
2024-06-30	51	32	14	5	5	0
2024-07-31	83	42	31	10	9	0
2024-08-31	229	159	51	19	19	0
2024-09-30	254	185	48	21	13	0
2024-10-31	254	175	64	15	9	0
2024-11-30	273	173	81	19	1	0
Percent of total receiving non-MAGI renewal form						
2023-10-31*	100%	42%	35%	6%	6%	17%
2023-11-30*	100%	54%	22%	4%	10%	20%
2023-12-31*	100%	49%	29%	2%	8%	20%
2024-01-31*	100%	43%	26%	0%	4%	30%

1	2	3	4	5	6	7
Recertification Date	ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		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)	
2024-02-29*	100%	53%	37%	0%	3%	10%
2024-03-31*	100%	51%	36%	7%	9%	7%
2024-04-30	100%	52%	40%	7%	12%	0%
2024-05-31	100%	68%	25%	7%	4%	0%
2024-06-30	100%	63%	27%	10%	10%	0%
2024-07-31	100%	51%	37%	12%	11%	0%
2024-08-31	100%	69%	22%	8%	8%	0%
2024-09-30	100%	73%	19%	8%	5%	0%
2024-10-31	100%	69%	25%	6%	4%	0%
2024-11-30	100%	63%	30%	7%	0%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: December 2024 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:
* Due to a system process implemented to ensure that renewals are fully recognized in DCAS, renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.

- Column 3 includes a small number of beneficiaries 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 2024 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.

- Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

56. 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 2024 and in FY 2025, 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 2024 and in FY 2025, 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 FY 2024 and in FY 2025, 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 FY 2024 and in FY 2025 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 in FY 2024 and FY 2025 YTD.

Medicaid QMB Only Beneficiaries Passively Renewed and Receiving Non-Passive Renewal Form by Form Type, FY 2024 and FY 2025 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					
2023-10-31	899	51	848	791	57
2023-11-30	2,502	65	2,437	2,373	64
2023-12-31	264	72	192	127	65
2024-01-31	127	84	43	12	31
2024-02-29	981	112	869	827	42
2024-03-31	1,104	89	1,015	937	78
2024-04-30	1,136	115	1,021	973	48
2024-05-31	1,017	143	874	814	60
2024-06-30	550	419	131	29	102
2024-07-31	554	280	274	65	209
2024-08-31	1,000	583	417	125	292
2024-09-30	976	573	403	69	334
2024-10-31	1,048	512	536	72	464
2024-11-30	1,750	1,279	471	93	378
Percent of total receiving non-passive renewal form					
2023-10-31	100%	6%	94%	88%	6%

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**
2023-11-30	100%	3%	97%	95%	3%
2023-12-31	100%	27%	73%	48%	25%
2024-01-31	100%	66%	34%	9%	24%
2024-02-29	100%	11%	89%	84%	4%
2024-03-31	100%	8%	92%	85%	7%
2024-04-30	100%	10%	90%	86%	4%
2024-05-31	100%	14%	86%	80%	6%
2024-06-30	100%	76%	24%	5%	19%
2024-07-31	100%	51%	49%	12%	38%
2024-08-31	100%	58%	42%	13%	29%
2024-09-30	100%	59%	41%	7%	34%
2024-10-31	100%	49%	51%	7%	44%
2024-11-30	100%	73%	27%	5%	22%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

a. 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.

   Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid QMB Only Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	QMB-only beneficiaries required to complete the conversion renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	791	395	284	53	30	59
2023-11-30*	2,373	1,194	856	153	129	170
2023-12-31*	127	55	46	10	9	16
2024-01-31*	12	5	4	2	0	1
2024-02-29*	827	386	331	47	37	63
2024-03-31*	937	445	407	42	42	43
2024-04-30	973	457	442	49	42	25
2024-05-31	814	419	349	33	37	13
2024-06-30	29	17	9	2	0	1
2024-07-31	65	44	13	5	5	3
2024-08-31	125	84	29	8	6	4
2024-09-30	69	52	14	3	1	0
2024-10-31	72	56	15	1	0	0
2024-11-30	93	60	24	8	0	1
Percent of total receiving non-passive renewal form						
2023-10-31*	100%	50%	36%	7%	4%	7%
2023-11-30*	100%	50%	36%	6%	5%	7%
2023-12-31*	100%	43%	36%	8%	7%	13%
2024-01-31*	100%	42%	33%	17%	0%	8%
2024-02-29*	100%	47%	40%	6%	4%	8%
2024-03-31*	100%	47%	43%	4%	4%	5%
2024-04-30	100%	47%	45%	5%	4%	3%
2024-05-31	100%	51%	43%	4%	5%	2%
2024-06-30	100%	59%	31%	7%	0%	3%
2024-07-31	100%	68%	20%	8%	8%	5%
2024-08-31	100%	67%	23%	6%	5%	3%
2024-09-30	100%	75%	20%	4%	1%	0%
2024-10-31	100%	78%	21%	1%	0%	0%
2024-11-30	100%	65%	26%	9%	0%	1%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

b. 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.

Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid QMB Only Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2024 and FY 2025 to Date

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	QMB-only beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	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)	Renewal received with an unknown date
Number of beneficiaries						
2023-10-31*	57	20	21	2	1	14
2023-11-30*	64	32	19	6	2	7
2023-12-31*	65	31	29	4	4	1
2024-01-31*	31	18	9	1	2	3
2024-02-29*	42	17	18	4	2	3
2024-03-31*	78	41	25	4	3	8
2024-04-30	48	34	11	3	1	0
2024-05-31	60	35	23	2	5	0
2024-06-30	102	73	23	5	6	1
2024-07-31	209	156	46	7	13	0
2024-08-31	292	218	57	17	9	0
2024-09-30	334	258	68	8	10	0
2024-10-31	464	337	115	11	14	1
2024-11-30	378	263	101	14	0	0
Percent of total receiving non-passive renewal form						
2023-10-31*	100%	35%	37%	4%	2%	25%
2023-11-30*	100%	50%	30%	9%	3%	11%
2023-12-31*	100%	48%	45%	6%	6%	2%
2024-01-31*	100%	58%	29%	3%	6%	10%

1	2	3	4	5	6	7
		Date of renewal received is known				
Recertification Date	QMB-only beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	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)	Renewal received with an unknown date
2024-02-29*	100%	40%	43%	10%	5%	7%
2024-03-31*	100%	53%	32%	5%	4%	10%
2024-04-30	100%	71%	23%	6%	2%	0%
2024-05-31	100%	58%	38%	3%	8%	0%
2024-06-30	100%	72%	23%	5%	6%	1%
2024-07-31	100%	75%	22%	3%	6%	0%
2024-08-31	100%	75%	20%	6%	3%	0%
2024-09-30	100%	77%	20%	2%	3%	0%
2024-10-31	100%	73%	25%	2%	3%	0%
2024-11-30	100%	70%	27%	4%	0%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to all tables: December 2024 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:
* Due to a system process implemented to ensure that renewals are fully recognized in DCAS, renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates and we are unable to determine the columns to which they belong in the table.

- Column 3 includes a small number of beneficiaries 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 2024 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.

- Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that renewals are fully recognized in DCAS thus far has affected recertification dates in October 2023 through March 2024 and led to an increase in renewals in these months with dates that are no longer readily available

57. Of the people who had their Medical Assistance terminated in FY 2024 and FY 2025, 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 2024 and in FY 2025, 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 2024 and in FY 2025 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)

Response:

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 in FY 2024 and FY 2025 YTD.

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 2024 and FY 2025 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	Childless adults	Pregnant individuals	QMB-only	Other adults
Number of beneficiaries									
2023-10-31	975	22	9	302	146	477	5	10	4
2023-11-30	908	29	8	260	117	458	7	23	6
2023-12-31	507	19	15	212	66	190	1	4	0
2024-01-31	497	6	45	179	120	140	1	5	1
2024-02-29	370	49	55	92	58	76	2	38	0
2024-03-31	453	11	10	64	118	223	2	24	0
2024-04-30	598	7	6	106	160	284	0	35	0
2024-05-31	394	11	7	71	115	167	2	18	3
2024-06-30	464	0	3	84	145	230	1	1	0
2024-07-31	489	1	1	110	203	167	2	4	1
2024-08-31	485	5	2	106	204	162	2	4	0
2024-09-30	191	3	3	55	87	37	0	6	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	Childless adults	Pregnant individuals	QMB-only	Other adults
2024-10-31	208	3	1	63	98	35	2	6	0
2024-11-30	121	4	0	34	59	19	0	5	0
Percent of total determined ineligible									
2023-10-31	100%	2%	1%	31%	15%	49%	1%	1%	0%
2023-11-30	100%	3%	1%	29%	13%	50%	1%	3%	1%
2023-12-31	100%	4%	3%	42%	13%	37%	0%	1%	0%
2024-01-31	100%	1%	9%	36%	24%	28%	0%	1%	0%
2024-02-29	100%	13%	15%	25%	16%	21%	1%	10%	0%
2024-03-31	100%	2%	2%	14%	26%	49%	0%	5%	0%
2024-04-30	100%	1%	1%	18%	27%	47%	0%	6%	0%
2024-05-31	100%	3%	2%	18%	29%	42%	1%	5%	1%
2024-06-30	100%	0%	1%	18%	31%	50%	0%	0%	0%
2024-07-31	100%	0%	0%	22%	42%	34%	0%	1%	0%
2024-08-31	100%	1%	0%	22%	42%	33%	0%	1%	0%
2024-09-30	100%	2%	2%	29%	46%	19%	0%	3%	0%
2024-10-31	100%	1%	0%	30%	47%	17%	1%	3%	0%
2024-11-30	100%	3%	0%	28%	49%	16%	0%	4%	0%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: December 2024 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.

58. **Regarding new applications for Medicaid in FY 2024 and in FY 2025, 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;**

Response:

Month	Total applications	Online applications
Oct-23	965	823
Nov-23	994	881
Dec-23	1,025	868
Jan-24	1,412	1,175
Feb-24	1,050	789
Mar-24	1,163	922
Apr-24	1,056	829
May-24	1,237	913
Jun-24	1,241	936
Jul-24	1,480	1,097
Aug-24	1,563	1,203
Sep-24	1,351	1,027
Oct-24	1,500	1,129
Nov-24	1,359	965
Dec-24	1,528	1,117

Source: DHCF eligibility system data compiled as of January 2, 2025.
Notes: Online reflects the District Direct website and mobile app.

b. **The number of applications submitted in person at ESA Service Centers;**

Response

The table below presents the total number of applications received each month of FY24 and FY25 YTD, along with the number and share that were submitted in-person.

Month	Total applications	Applications submitted in person
Oct-23	965	128
Nov-23	994	90

Dec-23	1,025	112
Jan-24	1,412	179
Feb-24	1,050	222
Mar-24	1,163	200
Apr-24	1,056	196
May-24	1,237	294
Jun-24	1,241	275
Jul-24	1,480	336
Aug-24	1,563	321
Sep-24	1,351	299
Oct-24	1,500	346
Nov-24	1,359	343
Dec-24	1,528	379

Source: DHCF eligibility system data compiled as of January 2, 2025.

c. **For applications not based on disability, please provide:**

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

Response:

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.**

Response:

See response to Q59.

iii. **The number of applications pending over 45 days that have not been opened.**

DHCF does not have readily available data on the number of applications pending over 45 days in part due to system processes that lead older applications to be closed (caseworkers can return later to manually open and process apps "closed" via this process). In addition, there may be applications in the CURRENT workflow system used by DHS for task management that were waiting to be worked, but not yet registered in DCAS.

d. **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 Q59.

Percent of Applications Processed Timely, FY 24 - FY 25 YTD

Month	Percent of MAGI Applications Processed Within 45 Days	Percent of Non-MAGI Applications Processed Within 90 Days
Oct-23	62%	93%
Nov-23	58%	93%
Dec-23	70%	85%
Jan-24	71%	84%
Feb-24	56%	91%
Mar-24	53%	80%
Apr-24	53%	87%
May-24	70%	93%
Jun-24	84%	99%
Jul-24	84%	95%
Aug-24	87%	94%
Sep-24	86%	92%
Oct-24	86%	93%
Nov-24	88%	94%
Dec-24	88%	98%

Source: DHCF eligibility system data compiled as of January 2, 2025.
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 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. Please provide DHCF's efforts to reduce any backlog in processing applications including a status update on the Curam technology upgrade;

a. The extent to which such backlog(s) have been reduced; and
b. Steps DHCF has taken since the beginning of FY 2024 or will take over the remainder of FY 2025

Response:

DHCF and DHS coordinate to ensure timely processing of all medical assistance applications and renewals.

DHCF coordinates with DHS to identify paper backlogs through quarterly coordination meetings and service center site visits. During unwinding, DHCF procured a staffing contract to specifically help DHS with management of paper applications, paper renewals, and the processing of returned mail at Taylor Street and H Street service centers. In addition to DHS' daily oversight of contractor work, DHCF has bi-weekly management meetings with the contractor staff to ensure resources are properly allocated to manage their workload. DHCF receives regular reports about the volume of returned mail processed and the contractor's efforts to scan and sort paper applications and renewals.

As of December 2024, the number of beneficiaries due for a renewal since the beginning of the unwinding period whose renewal has not been completed is approximately 9,000 (This includes all beneficiaries pending due in all recertification months and includes beneficiaries who responded during the grace period. This number also includes beneficiaries for whom we have requested additional verification and are awaiting response, if those beneficiaries were excluded this number would decrease substantially.). This number is down from its high during unwinding of approximately 20,000+.

In addition to pending renewals, the number of medical applications pending generally exceeds 1,000 in any given month. This figure is based on registered applications that either require an applicant response to a request for information notice or processing by a caseworker in order to receive an eligibility determination; it excludes applications not yet registered in DCAS.

Large numbers of pending cases, when not processed completely, have the ability to disrupt the polling process that happens as a component of renewal. Polling is part of the Medicaid renewal initiation process where DHCF checks electronically available information to determine the continued eligibility of enrolled beneficiaries. To mitigate this, DHCF has implemented a process that resolves all pending cases, prior to the initiation of polling. This process, along with other efficiencies, have lowered the number of cumulative outstanding renewal cases.

During the unwinding, DHCF had many Medicaid cases that were in converted status. This converted status was due to the implementation of a new eligibility system and during the initial renewal, beneficiaries had to complete a detailed renewal form in order for the agency to capture all necessary information for the renewal. Since we have completed that initial unwinding period, we have current information and are able to send out shorter pre-populated renewal forms and ex parte/passively renew an increased number of beneficiaries (especially those in Non-MAGI programs).

DHCF has seen substantial increases in the average passive renewal rates for the MAGI and non-MAGI populations between year 1 and year 2 of unwinding so far. The overall MAGI passive rate has increased roughly 18 percentage points with non-MAGI increasing approximately 40 percentage points.

Additionally, to assist beneficiaries who are renewing their coverage and simplify the renewal process for caseworkers, DHCF leveraged federal flexibility to extend existing 1902(e)(14) waivers and other eligibility processing flexibilities through the Summer of 2025.

A summary of other key steps DHCF and DHS have taken to decrease backlogs and improve processing, is summarized below:

Curam Upgrade

- DCAS completed the Version 8 Curam upgrade in July 2024. The technical upgrade offers new features that DHCF - DHS can take advantage of by continuing to streamline in app menus and providing more direct access to actions versus clicking through multiple screens. DCAS is continuing to progress on other projects to take advantage of other features that will be made available as a result of the upgrades throughout FY2025 and 2026. The main objective of the upgrade to keep our software use compliant with our vendor agreement was accomplished.

Ex Parte Process for Non-Magi Programs.

- Ex Parte or Passive renewals happens when DHCF is conducting renewals, we first attempt to renew the case using reliable information/electronic data sources without contacting the beneficiary. All MAGI programs are reviewed for the ex parte/passive process. We have expanded this to Non-MAGI cases to include Aged, Blind, and Disabled (ABD) groups and Qualified Medicare Beneficiaries (QMB).

Streamlined Renewal Process for Long Term Care Programs.

- CMS approved a progressive route for DHCF to utilize that begins the ex parte/passive renewal process for our long-term care programs. This process is broken up in three phases. The first phase started in November 2024, and we began passively renewing all Long Term Care (LTC) waiver programs. In phase 2 and 3, we will begin adding interface information automatically to DCAS to verify the level of care and improve the institutionalized calculation cost of care process to improve efficiency. By the end of phase 3, there will be an attempt to use electronic data sources to passively renew LTC programs.

Workforce Training, Augmentation, and Deployment.

- Allotted overtime hours for staff to process cases that are overdue; Extended key service center staffing contracts through Spring 2025 to help with paper and mail processing; Continued cross-program training to ensure caseworkers can be deployed to process all social services programs (SNAP, TANF, Medicaid, Alliance/ICP)

DHS Specific Activities

- DHS has been successful in decreasing the sources for incoming/received work, which tends to compete with Medicaid processing. This has been accomplished through Federal oversight partners, who permitted DHS to automatically approve 'No Reported Change- SNAP Mid Certs' specifically. This allows the approval of some forms without the manual review and processing by workers. This implemented

feature within our eligibility system, DCAS has already and continues to save DHS hundreds of manpower hours each month.

- DHS has leveraged overtime (OT) opportunities for processing staff throughout the work week and Saturdays. OT Planning tools are produced on a regular basis for intentional purposes to focus on the direct review and processing of Medical work.

- DHS Workload Management System, Current has received an overall makeover through initiated Configuration Changes to streamline and ensure Medical Work is being properly acquired/accessed by the relevant staff based on their skillsets.

- After DHS worked to get approval from its Federal oversight partners, DHCF assisted in maintaining a contracted Tier 1 Call Center. Through this achievement, DHS Staff have been able to strictly focus on the review and processing of work; not to include the high volume of calls pertaining to requests for help about District Direct password resets and/or general case inquiries.

- DHS Medical Training for the Cohorts – throughout the year, DHS has been cross-training a steady stream of staff who had previously only been able to process SNAP or TANF so they are able to work on Medicaid cases as well.

- Approximately 13 months ago, DHS created an ESA Resource Management Portal. Through this portal, at any time, ESA Staff can access policy materials, memorandums and/or shortcut links to various systems; assisting with eligibility determinations for the public assistance programs administered by the agency, which includes medical assistance programs. This has cut down on the workers relying heavily on supervisory guidance when they've been able to access this resource tool for immediate assistance.

- DHS has designed Learning Labs to address SNAP, TANF and Medical Assistance program case processing accuracy. Through these Learning Labs, identified staff with processing deficiencies are required to attend the sessions. The Supervisory/Management Staff provide the support and tutorials, which are tailored to meet the needs of the designated staff based on their known and documented deficiencies.

- DHS engages in ESA Service Center sand Specialty Unit huddle visits on a monthly basis rotation; during these visits, Medical policy information is shared via PowerPoint Presentations, the issuance of Memorandums and verbal training sessions.

60. At any point in FY 2024 or in FY 2025 to date, has DHCF encountered problems with "stuck" or "malformed" Medicaid applications?

a. If so, how many applications have been affected in FY 2024 and in FY 2025, to date?

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?

Response:

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 the deployment of Release 3 in FY2022 when new data structures were put in place.

61. For the Health Care Alliance program, please provide for FY 2024 and FY 2025, to date, data on both the projected and actual:

a. **Enrollment;**
b. **Expenditures; and**
c. **Utilization.**

Response:

Enrollment information is available on the DHCF website at https://dhcf.dc.gov/node/1180991.

For expenditures associated with the Alliance program, please see the response to Question 25.

For utilization data, please see Attachment to Q61.

62. Please describe any major changes to the administration of the Alliance program during FY 2024 and FY 2025, to date.

a) Please provide any update on the implementation of integrating behavioral health services as part of the Alliance benefit as referenced in Mayor's introduction of the FY 2025 budget.

Response:

Please refer to the response to Q82 & Q83.

b) Please describe any changes to the administration of the Alliance program that the Department anticipates implementing during the remainder of FY 2025.

Response

There are no anticipated changes to the administration of the Alliance program anticipated during the remainder of FY 2025.

63. In FY 2024 and FY 2025, to date, what was the:

a. **Average length of time for renewal of Alliance benefits;**
b. **Average length of time to match an Alliance beneficiary with an MCO after they are deemed eligible;**
c. **Number and rate of Alliance beneficiaries whose benefits were not renewed due to changes in eligibility; and**
d. **Number and rate of Alliance customers whose benefits were not renewed for procedural reasons.**

Response:

a. See column 5 below for the average length of time in days to process Alliance non-passive renewals among those processed with available dates. Renewals in column 6 are a subset of column 2 and are not included in column 5 because they are missing either the responded date or the completed date. Passive renewals are omitted from the table because the processing is automated; no action is required on the part of a beneficiary or caseworker to complete the renewal.

1	2	3	4	5	6
Recertification Date	**Alliance non-passive renewals that were processed (3+4)**	**Non-passive renewals determined eligible**	**Non-passive renewals determined ineligible**	**Average length of time (in days) to process Alliance renewals**	**Number of Alliance renewals that were processed with an unknown date**
Number of beneficiaries					
9/30/2024	154	128	26	16	27
10/31/2024	206	174	32	11	42
11/30/2024	137	112	25	7	30
Percent of the processed					
9/30/2024	100%	83%	17%	N/A	18%
10/31/2024	100%	84%	16%	N/A	20%
11/30/2024	100%	82%	18%	N/A	22%

Source: DHCF eligibility system data extracted January 2, 2025.

Notes: December 2024 and later months are excluded to align with other responses focused on Medicaid. Data before September 2024 are not readily available. Renewals in column 6 are a subset of column 2 and are not included in column 5 because they are missing either the responded date or completed date, and therefore a length of time cannot be calculated.

b. Once an Alliance beneficiary's eligibility is determined in DCAS, a record of their eligibility is transmitted to DHCF's Medicaid Management Information System (MMIS). Assignment to an MCO is generally immediate or within one day.

The MMIS will immediately assign beneficiaries to their previous MCO for up to 90 days retroactive if their eligibility is reinstated back to the date of a coverage loss (e.g., if an individual did not renew their coverage timely but did respond during the grace period); this process is referred to as provider continuity. The MMIS otherwise sends a daily file to DHCF's MCO enrollment broker for immediate auto-assignment of Alliance beneficiaries who are first-time eligibles or re-enrolling after a longer coverage gap; beneficiaries have 90 days to choose and transfer to an alternative MCO if desired.

c. See column 3 below.

d. See column 4 below.

1	2	3	4
Recertification Date	**Alliance beneficiaries receiving a non-passive renewal notice who were disenrolled at renewal (3+4)**	**Non-passive renewals determined ineligible**	**Non-passive renewals procedurally terminated**
Number of beneficiaries			
9/30/2024	126	26	100
10/31/2024	157	32	125
11/30/2024	158	25	133
Percent of the disenrolled			
9/30/2024	100%	21%	79%
10/31/2024	100%	20%	80%
11/30/2024	100%	16%	84%

Source: DHCF eligibility system data extracted January 2, 2025.
Notes: December 2024 and later months are excluded to align with other responses focused on Medicaid. Data before September 2024 are not readily available.

64. Please provide the total number of elderly and persons with disabilities (EPD) waiver participants in FY 2024 and FY 2025, to date.

Response:

As of January 13, 2025, the enrollment in the elderly and persons with disabilities (EPD) Waiver is 5,558.

65. In FY 2024 and FY 2025, 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) Though DHCF does not require home health agencies to report all employed PCAs, please share DHCF's most accurate estimate for FY 2024 and FY 2025, to date, for how many Personal Care Aides does each Home Health Agency employ?

Response:

As of January 2025, the District of Columbia Health Care Finance Agency (DHCF) has 32 home health agencies (HHAs) contracted to provide Medicaid State Plan benefits, including personal care aide (PCA) services. Of these, 23 HHAs are also approved to deliver services under the Elderly and Persons with Disabilities (EPD) Waiver. A total of 7,072 active PCAs are enrolled in the Medicaid Program, serving beneficiaries under both the State Plan and the EPD Waiver. Given the high frequency of PCAs working simultaneously for multiple HHAs, DHCF cannot determining the precise number of PCAs affiliated with each agency requires deeper analysis.

66. Please provide the following data regarding PCAs:

a) The total number of Medicaid participants who received PCA hours through the Medicaid state plan only in FY 2024 and in FY 2025, to date;

1. Of those Medicaid participants who receive their PCA hours only through the Medicaid state plan, how many receive their total number of approved PCA hours versus only some of the approved PCA hours?

b) 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 2024 and FY 2025, to date.

Response:

As of January 2025, DHCF and its managed care plans provided Personal Care Aide (PCA) services exclusively through the Medicaid State Plan for 2,738 individuals assessed for 0–8 hours of PCA services during FY24 and for 2,522 individuals to date in FY25.

Regarding sub-questions (i) and (b), DHCF is unable to complete the requested analysis due to the complexity and time-intensive nature of the data review required. Several variable factors contribute to the difficulty in reconciling authorized hours with billed or paid services for a given date of service. These include but are not limited to, incomplete electronic visit verification (EVV) data, fair hearings or appeals, adjustments to beneficiaries' plans of care, staffing availability, and other operational challenges. Recognizing these complexities, the program will explore how this data can be further analyzed and broken down in subsequent reporting cycles to provide more detailed insights.

67. 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.

Response:

Based on data from 11,544 assessments completed during FY2024:

- 3.6%: 24 hours of personal care aide (PCA) services per day, seven days a week.
- Less than 1%: 20 to 23 hours of PCA services per day, with only 5 assessments falling into this category.
- 2.5%: 18 or 19 hours of PCA services per day.
- 6.9%: for 16 to 17 hours of PCA services per day, including a subset of 4.3% specifically recommending 16 hours of PCA services per day.

68. **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 2024 and in FY 2025, 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 2024 and in FY 2025, 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 2024 and in FY 2025, to date?**

Response:

Among EPD Waiver participants whose certification period ended more than 90 days ago (and who have therefore exited the 90-day grace period), data from recertification groups due in FY 2024 (October 2023 to September 2024) show procedural terminations, grace period responses, and renewal statuses. On average, 442 beneficiaries were included per recertification period. Of these, approximately 37% (163 beneficiaries) were procedurally terminated within one month after the recertification date. During the first month of the grace period, around 3% (14 beneficiaries) submitted responses, with an additional 4% (18 beneficiaries) responding during the second- and third-months following termination. On average, 33% (145 beneficiaries) remained disenrolled after the grace period.

69. **Please provide the criteria used by DHCF and/or Managed Care Organizations, or the District Dual Choice D-SNP plan to make medical necessity determinations regarding the number of PDN hours for FY 2024 and FY 2025, if different than previous years.**

    a. **Please confirm if DHCF uses criteria created by InterQual to evaluate medical necessity determination for PDN hours.**

Response:

The medical necessity criteria remain unchanged, with DHCF continuing to use InterQual criteria, while MCOs determine medical necessity using their respective guidelines: Amerigroup applies Milliman Care Guidelines, and AmeriHealth, HSCSN, MedStar, and United Healthcare use InterQual. For long-term care, Private Duty Nursing (PDN) services are governed by DCMR Section 947.5, which deems these services medically necessary for technology-dependent beneficiaries who rely on life-sustaining technology, such as ventilators, to maintain essential bodily functions and require continuous nursing supervision for ongoing visual assessment and equipment safety. Initial reviews are conducted by licensed clinical reviewers from quality improvement organizations, using InterQual criteria, ASAM guidelines, DHCF regulations, and organizational protocols, alongside supporting documentation such as the 719A form, plan of care, medical necessity letters, and clinical records.

70. **Of the Medicaid recipients who received PDN hours in FY 2024 and FY 2025, to date, how many (raw number and percentage) received any Personal Care Aide (PCA) service hours?**

a. Of the Medicaid recipients who receive both PDN and PCA hours, how many (raw number and percentage) received their PCA services through the EPD waiver?

Response:

A total of 69 beneficiaries utilized Private Duty Nursing (PDN) services, with 56 (or 81.16%) also receiving Personal Care Aide (PCA) services concurrently. Among the 69 beneficiaries accessing PDN services, 51 (or 73.91%) are enrolled in the EPD Waiver program.

71. **How many Medicaid recipients (both State Plan and EPD waiver enrollees) received 24 hours of PDN care at any point during FY 2024 and FY 2025, to date?**

    a. **Of the recipients who received 24 hours of PDN care during FY 2024 and FY 2025 to date, how many (both as a raw number and percentage) experienced a reduction of those services at some point during the last year?**

Response:

During FY2024 and FY2025, 70 beneficiaries requested PDN services of varying frequencies, including up to 24 hours per day.

During FY2024 and FY2025, of the 70 beneficiaries who requested PDN services (for up to 24 hours per day), 53 (75.7%) received full or partial approval. 41 (58.6%) were fully approved, 17 (24.3%) were partially approved, and 12 (17.1%) were denied.

72. Of the Medicaid recipients who both: 1) received 24 hours of PDN hours and 2) experienced a reduction of those hours during FY 2024 and FY 2025 to date, how many of those individuals (both as a raw number and percentage) had their hours restored to 24 hours?

- **a. How many had some portion of their PDN hours restored, even if their hours were not restored to 24 hours?**
- **b. Of the people who had their PDN hours restored after a reduction, how many (raw number and percentage) had their hours restored after filing a reconsideration appeal?**
- **c. Of the people who had their PDN hours restored after a reduction, how many (raw number and percentage) had their hours restored after a fair hearing request at the Office of Administrative Hearings?**

Response:

In Fiscal Years 2024 and 2025, 70 beneficiaries requested PDN services with varying frequencies, including up to 24 hours per day. While 41 beneficiaries (58.6%) received full approval for their requested services, 12 (17.1%) were fully denied, and 17 (24.3%) received partial denials. Data regarding service reductions after the initial requests will need further analyses to produce, as cases involving partial and full denials are subject to ongoing administrative review and appeal processes before a final decision is reached.

The following table summarizes the outcomes of all PDN service requests during this period.

All PDN Decisions

Final Decision	Administrative		Medical Necessity		Upheld on Appeal		Modified on Appeal		Overturned on Appeal		After Fair Hearing		Decision Total
	#	%	#	%	#	%	#	%	#	%	#	%	
Approved	78	45.6%	78	45.6%					14	8.2%	1	0.6%	**171**
Partial Denial			13	38.2%	3	8.8%	18	52.9%					**34**
Denied			13	81.3%	3	18.8%							**16**
Total Decision Reason	**78**	35.3%	**104**	47.1%	**6**	2.7%	**18**	8.1%	**14**	6.3%	**1**	0.5%	**221**

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73. The Fiscal Year 2025 Budget Support Act included the Direct Support Professional Payment Rate Amendment Act of 2024. Provide an update on the implementation of this subtitle, including:

a) How many direct support professionals (DSP) total have been reimbursed in FY 2024 and FY 2025, to date; and
b) How many DSPs saw a rate increase in FY 2024; and
c) Remaining HCBS ARPA funds and how long DHCF anticipates being able to use these funds to reimburse DSPs; and
d) Timeline for implementing an FY 2026 implementation of an adjusted reimbursement rate for direct support professionals; and
e) Any anticipated challenges around implementing this subtitle and strategies to address these challenges.

Response:

a. How many direct support professionals (DSP) total have been reimbursed in FY 2024 and FY 2025, to date?

Direct support professionals are paid wages and employed by an HCBS Medicaid provider that receives reimbursement from DHCF. Therefore, this response reflects the number of DSPs that providers reported received wages within the time period. Based on the 6-month reports we have received from DD providers and HHA/EPD Waiver providers a total of 10,613 providers were reimbursed in FY2025. This number might change based on additional reports that we receive.

b. How many DSPs saw a rate increase in FY 2024?

Based on the 6-month reports we have received from DD and HHA/EPD Waiver providers, a total of 7,097 DSPs saw a rate increase in their pay. This excludes DSPs whose rates have increased only due to the increase in the Living Wage amount. This number might change based on additional reports that we receive.

c. Remaining HCBS ARPA funds and how long DHCF anticipates being able to use these funds to reimburse DSPs; and

Currently we are disbursing all the remaining funds to cover CY2025 wage enhancements, and don't expect any leftover fund.

d. Timeline for implementing an FY 2026 implementation of an adjusted reimbursement rate for direct support professionals; and

Effective January 1, 2026, we will include the DSP Wage enhancement amounts into the reimbursement rates.

e. Any anticipated challenges around implementing this subtitle and strategies to address these challenges.

Providers reporting delays which create a ripple effect, delaying reconciliation, payments, and reporting period closure. Additional challenges include lack of report submissions, slow provider responses, and errors in their reporting. These delays hinder our ability to properly forecast the payment amounts, timely disburse funds and complete settlements on time.

74. The FY 2025 Budget Support Act Title V, Subtitle H, the Healthy DC Fund Congressional Review Emergency Amendment Act of 2024, transferred $5.567 million annually out of the Healthy DC Fund to the General Fund.

Response:

a) Please describe the purpose of the Healthy DC Fund and how the funds were used in FY 2024 and in FY 2025, to date.

The Healthy DC Fund supports medical assistance programs administered by the Department of Health Care Finance. Please see DC Code section 31-3514.02. Please see the 'FY 2024' and 'FY 2025' tabs of Attachment to Q74 to see how the Healthy DC Fund was spent in FY 2025 and in FY 2025 Quarter 1.

b) Does DHCF anticipate this causing any fiscal imbalances over the next year?

No, DHCF does not anticipate that this transfer will cause any imbalances over the course of the financial plan.

75. Please provide an update on the impact of the diaper bank grant program managed by DCHF. For FY 2024 and FY 2025, please provide the amount of money granted, the organizations who received grants, and the approximate number of residents served.

Response:

In FY 2024, DHCF awarded one Diaper Bank Grant in the amount of $500,000 to the Greater DC Diaper Bank. In FY 2024, the Greater DC Diaper Bank distributed approximately 3 million diapers with an estimated value of $1.2 million to serve more than 10,000 babies in DC.

$327,840 of the DHCF grant was used to purchase approximately 820,000 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 2025 Diaper Bank Grant Program on January 3, 2025 with a submission deadline of February 3, 2025. DHCF anticipates announcing a $500,000 award in coming weeks.

76. Please provide updates on DHCF's administration of the $225,000 grant funds to support the implementation of the Nurse Family Partnership (NFP) Home Visiting Program, including grant funds spent, funds remaining, and a narrative on a strategy to support the program moving forward.

a. **Please provide any documentation regarding DHCF's oversight of this grant, including NFP's performance on quality measures pertaining to perinatal health outcomes.**
b. **Please provide an update on DHCF's status on submitting the State Plan Amendment for reimbursement of nurse-led home visiting programs per DC Law 25-506, FY 2025 Budget Support Act.**

Response:

DHCF intends to award an FY25 grant in the amount of $325,000 by the end of January 2025. DHCF is reviewing a project proposal and budget for the FY25 Grant and is preparing a Notice of Grant Award.

a. The FY24 grantee demonstrated the following outcomes:

- Enrolled 29 new program recipients
- Provided 729 home visits to 94 families
- Graduated 14 families from the program
- Met 100% model fidelity to remain in compliance with NFP evidence-based requirements
- Successfully engaged participants in care, including the following outcomes:
    - 97% attendance of recommended postpartum visits;
    - 92% and 100% received perinatal depression screening and substance use screening, respectively;
    - 95% of infants received all recommended immunizations at 12 months of age; and
    - 94% initiation of breastfeeding, with 70% continuing breastfeeding at 6 months of age.

b. DHCF does not intend to submit a State Plan Amendment for Medicaid reimbursement of home visiting programs to implement the provisions of the FY25 Budget Support Act.

77. Please share any changes to MCO performance measures related to maternal health, including perinatal mental health, currently collected by DHCF.

Response:

To better understand maternal health and birth outcomes within the District's Medicaid managed care population, DHCF contracts with Qlarant (External Quality Review Organization) to conduct a multi-year focus study. DHCF seeks to identify gaps in care and prioritize opportunities to target for achievement of Healthy People and a Healthy Community within the District. To assist DHCF in this endeavor, Qlarant analyzed the maternal health and birth outcomes of mothers who were enrolled in one of the contracted MCO's at the time of birth.

Currently, DHCF has not made any changes to the performance measures. The baseline data collected in FY 2024 will be used to determine changes to performance measures in FY 2025.

a. **For each current measure, please provide data on how each MCP performed in FY 2024 and FY 2025, to date.**

The measures and data below are from FY 2023 and reported to DHCF in September 2024. Data for FY2025 will be available in September 2025.

- Table 1 identifies the rate of early and adequate prenatal care by MCO.
- Table 2 identifies the rate of no prenatal care by MCO. (*** A lower rate is better).
- Table 3 identifies Low Birth Weight by MCO.

Table 1. Early and Adequate Prenatal Care by MCO

MCO	Frequency	Total Population	Percent
AmeriHealth	624	1,206	51.74%
Amerigroup	100	248	40.32%
CareFirst	118	266	44.36%
HSCSN	16	32	50.00%
MedStar	284	589	48.22%
No MCO Specified*	33	88	37.50%
Total	1,175	2,429	48.37%

*The DHCF enrollment file did not specify an MCO for the enrollee.

Table 2. No Prenatal Care by MCO

MCO	Frequency	Total Population	Percent
AmeriHealth	16	1,297	1.23%
Amerigroup	3	258	1.16%
CareFirst	5	289	1.73%
HSCSN	0	35	0.00%
MedStar	11	623	1.77%
No MCP Specified*	4	92	4.35%

Total	39	2,594	1.50%

*The DHCF enrollment file did not specify an MCO for the enrollee.

Table 3. Low Birth Weight by MCO

MCO	Frequency	Total Population	Percent
AmeriHealth	104	1,297	8.02%
Amerigroup	30	258	11.63%
CareFirst	32	289	11.07%
HSCSN	6	35	17.14%
MedStar	49	623	7.87%
No MCP Specified*	7	92	7.61%
Total	228	2,594	8.79%

Summary of Findings:

- On average, 48.37% of Medicaid managed care enrollees, who gave birth during FY 2023, received early and adequate prenatal care. Only AmeriHealth and HSCSN enrollees received 50% or greater of expected care. The early and adequate prenatal care rate of 48.37% compares unfavorably to the March of Dimes statistics for the District of Columbia and the United States.

- On average, 8.40% of DC Medicaid managed care births were considered preterm during FY 2023. This rate compares favorably to the District of Columbia preterm birth rate of 10.2%, and the national rate of 10.4%, as reported by the March of Dimes. However, some MCOs have opportunities for improvement. All MCOs should strive to achieve or exceed the Healthy People 2030 target of 9.4%.

- On average, 8.79% of DC Medicaid managed care newborns were considered low birth weight during FY 2023. This rate compares favorably to the District of Columbia low birth rate of 9.8%. The national average of 8.6%, as reported by the March of Dimes.

Based on this focus study, MCOs understand their barriers to improvement in prenatal care and working closely with DHCF to find strategies for improvement.

78. **Provide updates on the implementation of A25-173—Expanding Access to Fertility Treatment Amendment Act of 2023, including data on how many beneficiaries accessed these services in FY 2024 and FY 2025, to date, broken down by type of service and total expenditures for each type of service.**

Response:

On March 14, 2024, CMS approved DC SPA #23-0016, which provides DHCF the authority to reimburse for select drugs when used to promote fertility. As indicated in DHCF Transmittal 24-15 (rev.), this coverage applies to the DC Healthcare Alliance program in addition to Medicaid. Utilization and expenditures are shown below.

DHCF Beneficiaries with Infertility Diagnosis and Use of Fertility Enhancing Drugs

Fiscal year	Number of beneficiaries	Expenditures
FY 2024	26	$1,296
FY 2025 to date	9	$286

Source: DHCF's Medicaid Management Information System data extracted January 14, 2025.
Note: Covered drugs include gonadotropin-releasing hormone antagonists. Because some of the drugs can be used for multiple indications (e.g., Parkinsons and certain cancers), the data above is restricted to beneficiaries with any history of an infertility diagnosis.

79. Does DC Medicaid authorize payment for Perinatal Care Coordinators under its State Plan or MCO contracts? If not, please share if DHCF ever considered adding Perinatal Care Coordination services to Medicaid-reimbursable services, and what barriers exist to do so.

Response:

It is DHCF's understanding that Perinatal Care Coordinators (PCCs) are health professionals that support pregnant individuals by ensuring and coordinating access to medical care and other community-based resources during pregnancy and after the birth of the child.

While DHCF does not specifically reimburse PCCs, the District Medicaid program funds care coordination for all beneficiaries through managed care and specifically to pregnant women through already established Medicaid services like nurse midwives, doulas, and physician care.

To add reimbursement for PCCs to the Medicaid benefit, the District Medicaid program will need to determine certification standards, the authorized scope of care, and a reimbursement model for these professionals.

In January of 2025, the District was chosen to participate in Centers for Medicare & Medicaid Services, Transforming Maternal Health (TMaH) Model. By participating in the TMaH Model, the District will further advance the goal of building a maternal health care system that provides whole-person care. The TMaH Model can help us achieve this vision by investing in essential care delivery infrastructure and incentivizing enrolled providers to work together to address a person's physical, behavioral, and social needs.

To support the TMaH Model, DHCF, DC Health, and District of Columbia's Perinatal Quality Collaborative (DCPQC) will design an implementation plan to expand clinical improvement team participation in Alliance for Innovation on Maternal Heath (AIM) patient safety bundles from birthing hospitals to other hospitals, birth centers, Federally Qualified Health Centers (FQHCs), and community organizations. DHCF, with the support of institutional providers, midwives, doulas, perinatal community health workers (CHWs), and patient representative, can determine how PCCs or similar health professionals fit into the improved maternal health system.

80. Has DHCF considered using the 1115 waiver to make CHWs eligible for Medicaid reimbursement? Why/ why not is DHCF choosing this approach?

Response:

DHCF has reviewed the feasibility and implications of adding Community Health Workers (CHWs) as qualified providers throughout its Medicaid service array. DHCF's review aligned with DC Health's recent and ongoing efforts to establish a District certification/licensure for CHWs.

DHCF is aware that other Medicaid programs have expanded access to CHWs through incorporation of CHWs into services and treatment teams authorized under Section 1115 Demonstration programs. However, this is not the only coverage path available to states interested in adding CHWs to the Medicaid services array. States have added CHWs under their preventive services benefits and "Other licensed provider" benefits.

The District has not added a specific benefit to its Medicaid state plan for CHWs because the certification/licensure does not yet exist in the District. To add reimbursement for CHWs to the Medicaid benefit, the District Medicaid program will need to determine certification standards (in place of DC Health or in alignment with), the authorized scope of care, and a reimbursement model for these professionals.

The District Medicaid program already allows and permits reimbursement for entry level health professionals, as part of Medicaid care teams. The District covers certified peers under the community-based behavioral health benefit; the District allows for incorporation of entry level health professionals into provider costs under models like the Federally Qualified Health Center Alternative Payment Methodology; Value-Add initiatives funded via Managed Care Plans; and covers peer navigators under My Health GPS.

Additionally, promising CHW pilots have been funded by philanthropy and DC Health. DHCF will explore opportunities to provide coverage of perinatal CHW interventions as DC Health develops CHW licensure and training requirements.

81. Please provide an update on any policy guidance and reimbursement for care coordination services to help address gaps in funding for care coordination in the District.

Response

The District Medicaid program funds care coordination for all beneficiaries through managed care and specifically to pregnant women through already established Medicaid services like nurse midwives, FQHCs, My Health GPS, doulas, and physician care.

In January of 2025, the District was chosen to participate in Centers for Medicare & Medicaid Services, Transforming Maternal Health (TMaH) Model. By participating in the TMaH Model, the District will further advance the goal of building a maternal health care system that provides whole-person care. The TMaH Model can help us achieve this vision by investing in essential care delivery infrastructure and incentivizing enrolled providers to work together to address a person's physical, behavioral, and social needs.

To support the TMaH Model, DHCF and key partners will design an implementation plan to expand clinical improvement team participation in AIM patient safety bundles from birthing hospitals to other hospitals, birth centers, FQHCs, providers, and community organizations. DHCF, with the support of institutional providers, midwives, doulas, perinatal community health workers (CHWs), and patient representative, can determine how expanded care coordination efforts fit into the improved maternal health system.

82. In FY 2024, DHCF announced that it will pause its plans to fully integrate behavioral health services into managed care. What is the DHCF's revised plan and timeline to move forward the integration and whole-person care strategy for Medicaid beneficiaries?

Response

As noted in response to Question 83, DHCF is moving forward with carving-in behavioral health services into the Dual Choice program, pending fiscal impact. DHCF's focus is on the Dual Choice carve-in and there is no revised plan for the carve-in for the DC Healthy Families program currently. DHCF continues to push forward on whole-person care, primarily through the 1115 demonstration waiver renewal, the Transforming Maternal Health (TMH) initiative, and planning for certified community behavioral health clinics (CCBHCs).

83. What different bridge policies or other transition plans does DHCF anticipate for the FIDE-SNP carve-in that DHCF did not plan to pursue for the paused managed care transition?

Response

In October 2024, DHCF announced its intention to carve-in mental health and substance use disorder services into the Dual Choice program, effective January 1, 2026, pending fiscal impact.

As with any transition of services, DHCF will extend a continuity of care expectation to minimize any disruptions. DHCF anticipates bridge policies, like those considered for the carve-in to the DC Healthy Families program. It is not yet decided whether the bridge policies will be identical. For example, one bridge policy required that all managed care plans contract with all DBH-certified providers for the first eighteen months of the carve-in. Given the smaller Dual Choice population (approximately 13,000 beneficiaries) compared to the DC Healthy Families population (approximately 220,000 beneficiaries), it is unlikely the same bridge policy will be applicable. Another bridge policy required use of the Medicaid fee for service (FFS) fee schedule be used by the DC Healthy Families managed care plans for the first eighteen months. While there will likely be a similar bridge policy, it is unlikely it will be extended for eighteen months.

DHCF is considering a range of activities to ensure a smooth transition and minimize any disruption to beneficiaries and providers. These activities could include, but are not limited to, the following:

Leading up to the carve-in, DHCF will focus on ensuring readiness and engagement at multiple levels. For plan readiness, the agency will provide the plan with recurring behavioral health claims data pulls and up-to-date lists of DBH-certified providers. A Behavioral Health Readiness Review will be conducted to ensure the plan meets key requirements, including network adequacy, appropriate case manager qualifications for those who serve members with behavioral health needs, processes for incorporating behavioral health providers into the interdisciplinary care team, and comprehensive training materials for Dual Choice Enrollee Services and Care Management staff.

On the provider readiness side, DHCF plans to have the health plan conduct claims testing with behavioral health providers and provide training and support to help them navigate both Medicare and Medicaid managed care systems. The plan will be required to hold provider meetings and/or training sessions to address common concerns such as payment, privacy, and continuity of care and develop FAQs based on common questions that arise. The plan will be required to hold regular “office hours” to give providers an ongoing platform to ask questions and receive support, while Behavioral Health Provider Advocates will be available to work one-on-one with providers to resolve issues. To foster two-way communication with stakeholders and the community, the plan will participate in Behavioral Health Public Forums and community events with beneficiaries, both to provide education and to solicit feedback.

After the carve-in, the plan will be required to continue to engage and educate providers, stakeholders, and beneficiaries through ongoing office hours, technical assistance from the Behavioral Health Provider Advocates, and updates to FAQs. The plan will also regularly attend recurring Behavioral Health Provider and Public Forum meetings to field questions. In addition, DHCF will closely monitor utilization data, require monthly reporting on behavioral health metrics, and survey beneficiary experience to monitor the success of the integration.

These planned activities and requirements are intended to ensure a smooth transition and may be adjusted as further details about the carve-in and related policies emerge.

DEPARTMENT OF HEALTH CARE FINANCE
FY24-25 PERFORMANCE OVERSIGHT QUESTIONS

84. 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 2024 and FY 2025, to date, and projected for the remainder of FY 2025.

Response:

Please see the Attachment to Q84 for DHCF's response.

85. Please provide details regarding all Psychiatric Residential Treatment Facility (PRTF) placements paid for with Medicaid funds in FY 2024 and FY 2025, to date. 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 other District agencies that were involved with each youth's case.

Response:

Table 1 below reflects the delivery system in which the Psychiatric Residential Treatment Facility (PRTF) beneficiary is served at the time of placement. Each Medicaid managed care organization (MCO) is specified in the Table below. There was a total of 23 Medicaid beneficiaries placed at a PRTF in FY24.

Table 1. PRTF Beneficiaries Served:

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	4	17%
AmeriHealth Caritas DC	10	43%
Medstar Family Choice	n/a	n/a
Amerigroup DC	1	5%
HSCSN	8	35%
Total	**23**	**N=23**

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 FY24
Florida	2
Pennsylvania	2
Virginia	6
Maryland	12
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 FY24 was 7.2 months (approximately 218 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 (FFS) Medicaid. In June of FY21, a prior authorization requirement was put in place for PRTF care paid for by 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, to maximize the available resources to support monitoring HSCSN enrollees.

Table 3 (below) is based on information from DBH regarding the placement of youth in PRTFs by sister agencies. 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 them.

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

Agency	Total # Beneficiaries FY 24	Other Agency Involvement
Child and Family Services (CFSA)	4	DBH, HSCSN
District of Columbia Public School (DCPS)	1	DBH, HSCSN
Department of Youth Rehabilitation Services (DYRS)	16	DBH, HSCSN
DC Superior Court (Court Social Services)	1	DBH, HSCSN
Office of the State Superintendent of Education (OSSE)	1	DBH, HSCSN

a. Describe the Department's involvement in the District's pursuit of a local PRTF for psychiatric care for children:

DHCF participated in initial planning discussions with DBH, CFSA, DYRS, and other key stakeholders on the pursuit of a PRTF located in DC. There were no discussions in FY24 that DHCF attended. DHCF has informed the Managed Care Plans of this pursuit and will continue to inform them of any developments as they are in favor of the establishment of a PRTF in DC.

b. Please share the provider rates for adolescent inpatient/residential treatment for mental health and substance use disorder.

See Attachment to Q85**.**

86. Please provide an organizational chart for the Office of the Health Care Ombudsman.

Response:

See Attachment to Q86.

87. Please provide a copy of the most recent independent evaluation of the Ombudsman Program as required by D.C. Code §7-2071.03.

Response:

Pursuant to DC Code **§7-2071.03** the Ombudsman Program is required to undergo an annual evaluation, with the first report mandated for completion by April 12, 2007. However, due to a lack of funding, the required evaluation was not conducted as mandated. As a result, the first evaluation was not produced until 2020, covering a ten-year period from 2010 to 2024. Additional budgetary restrictions resulting in this report not being produced in 2022. DHCF has finalized a Memorandum of Understanding with the University of the District of Columbia to complete an independent evaluation to cover 2020- 2024. The work initiated on January 15, 2025, and the final report should be submitted by December 2025.

88. Please describe outreach efforts the Department undertook to promote the work of the Office of the Health Care Ombudsman and Bill of Rights and encouraged the public to utilize its services in FY 2024 and FY 2025, to date.

Response:

The Office of the Health Care Ombudsman and Bill of Rights (OHCOBR) provides outreach, education, and information about health-related services and programs that are available for the different constituents in the District. The role of the OCHOBR is to provide knowledge and to facilitate access to healthcare services and resources to District residents and members that have insurance that is regulated by the Department of Insurance, Securities and Banking (DISB).
Activities in FY2024 and 2025, to date, include:

OHCOBR assigned additional staff to participate in and coordinate outreach activities. This was due to an increase in the number of outreach activities that the Office has scheduled and additional requests from different organizations. From these requests, the team-initiated outreach activities based on the questions received and general discussion topics, and the types of assistance provided during events. OHCOBR also provided information on services at District Open Enrollment Fairs.

OHCOBR continues to partner with the Executive Office of the Mayor (EOM), District of Columbia Council, Department of Health Care Finance (DHCF), the Department of Aging and Community Living (DACL), District of Columbia Public Schools (DCPS), District of Columbia Charter Schools (DCPCS), colleges and universities, Department of Human Resources (DCHR), and various health organizations throughout the District, both in-person and virtually.

The Outreach Team presented on local radio stations: WHUR 96.3 FM and HUR Voices on Sirius XM 141, The Senior Zone on Radio One's Spirit 1340 WYCB, and Be Informed DMV on WOL's 1450 AM and 95.5 FM.
During FY 2024, the Outreach Team participated in 54 community events: Thirty events for seniors, five (5) for youths, DCPS, DCPCS, or universities, three (3) for those with disabilities, four (4) at the request of churches/religious organizations, eight (8) community resource events, and six (6) events were for a mixed population type. Thirteen of these events were initiated by the OHCOBR Outreach Team.

In the first quarter of FY 2025, the Outreach Team participated in 17 events: Eight (8) events for seniors, four (4) DCHR open enrollment events, four (4) events were for a mixed population type, and one (1) for a church/religious organization. Four (4) of these events were initiated by the OHCOBR Outreach Team.

From our community events, the Outreach Team is often asked to present to more intimate groups. These events are called Health Care on Tap and during these events, assistance is provided with billing inquiries, application processes, EPD Waiver assistance, QMB eligibility, and Medicaid eligibility status.

In addition to the outreach activities previously mentioned, the Office of the Health Care Ombudsman and Bill of Right's office (OHCOBR) Advisory Board has an Education and Outreach subcommittee that consists of stakeholders and is chaired by a member of the community and co-chaired by a staff member within the Ombudsman's office.

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

Response:

None at this time.