DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance

1. **Please provide the current organizational chart and list of FTEs, including grades and titles, for the agency, with information to the cost center level, including whether each position is filled or vacant.**

    a. **Please also 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.**
    b. **If applicable, please provide a narrative explanation of any organizational changes made during FY 2025 and FY 2026, to date.**

Response:

Please see Question 1 Attachment for the current organizational chart along with the number of full-time equivalents (FTEs) at each organizational level. Question 1a Attachment 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 a list of all FTE positions detailed <u>to</u> DHCF, broken down by program and activity for FY 2025 and FY 2026, to date. Include a narrative on specific role the detailed staff took at DHCF during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DHCF.**
    a. **Please provide a list of all FTE positions detailed <u>from</u> DHCF to another agency in FY 2025 and in FY 2026, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.**

<u>Response</u>:

Details to DHCF: None. There were no FTE positions detailed to DHCF for FY 2025 and FY 2026 to date.

Details from DHCF: Larissa Etwaroo, Special Projects Officer, was detailed to the Department of General Services, as a Project Manager effective August 10, 2025. Ms. Etwaroo is responsible for managing construction projects within the DC Health and Human Services portfolio. Ms. Etwaroo is slated to remain in this detail until March 31, 2026.

3. **Please provide a complete, up-to-date list of contract workers working directly for DHCF, by program and cost center, including the following information for each position:**
    a. **Title of position;**
    b. **Indication that the position is filled or vacant;**
    c. **Date employee began in this position;**
    d. **Whether the position must be filled to comply with federal or local law;**
    e. **If applicable, the federal or local law that requires the position to be filled;**
    f. **The entity from which they are contracted; and**
    g. **Annual cost of the contract worker.**

    Response:

    See Q3 Attachment.

4. **Please provide the following for each collective bargaining agreement that is currently in effect for DHCF employees:**
    a. **The bargaining unit (name and local number);**
    b. **The start and end date of each agreement;**
    c. **The number of employees covered;**
    d. **Whether the agency is currently bargaining;**
    e. **If currently bargaining, the anticipated completion date;**
    f. **For each agreement, the union leader's name title and contact information; and**
    g. **A copy of the ratified collective bargaining agreement.**

Response:

The following collective bargaining agreements are currently in effect for DHCF union represented employees. See Q4 Attachment.

a. Name and Local Number:
- The American Federation of State, County and Municipal Employees (AFSCME) Local 2401
- District of Columbia Nurses Associate (DCNA)
- Service Employees International Union (SEIU 1199) (Pharmacists)
- American Federation of Government Employees Local 1403 (Lawyers)

b. Start/End Date of Agreements:

Bargaining Unit Name	Start/End Date of Agreement
The American Federation of State, County and Municipal Employees Local 2401	*10/1/2021 - 9/30/2025
District of Columbia Nurses Associate (DCNA) (Nurses)	*10/1/2017 - 9/30/2020
Service Employees International Union (SEIU 1199) (Pharmacists)	*10/1/2016 - 9/30/2019
American Federation of Government Employees Local 1403 (Lawyers)	10/1/2025 - 9/30/2026

*The agreements remain in effect notwithstanding the date.

c. The number of employees covered:

Bargaining Unit Name and Number	Number of Employees Covered
The American Federation of State, County and Municipal Employees Local 2401	171
District of Columbia Nurses Associate (DCNA) (Nurses)	10
Service Employees International Union (SEIU 1199)	5

(Pharmacists)	
American Federation of Government Employees Local 1403 (Lawyers)	2

d. DHCF is not currently bargaining with any union on the respective collective bargaining agreements. Bargaining is typically managed by the Office of Labor Relations and Collective Bargaining Office.

e. Please see previous response.

f. Union Leader Information:

Bargaining Unit Name	**Leader Name/Title**	**Contact Information**
The American Federation of State, County and Municipal Employees (Local 2401)	Roger Scott, President, AFSCME Local 2401	Phone: 202.570.2948 Email: roger.scott@afscme2401.org
District of Columbia Nurses Associate (DCNA)	Gloria Jones, President, DC Nurses Association (Comp 13)	Phone: 240.494.4986 Email: gloria.jones-dinkins@dc.gov
Service Employees International Union (SEIU 1199) (Pharmacists)	Lisa Wallace, Area Vice President, SEIU Local 1199	Phone: 301.341-0000 Email: lisa.wallace@1199.org
American Federation of Government Employees Local 1403 (Lawyers)	Aaron J. Finkhousen, President, AFGE Local 1403	Phone: 202.627.0334 Email: afge1403president@gmail.com

g. Collective Bargaining Agreements are maintained with Office of Labor Relations and Collective Bargaining.

5. **Please provide the names of the primary and alternative sexual harassment officers.**
   a. **List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2025 and FY 2026, to date, and whether those allegations were 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?**
      i. **What was the resolution of each request?**
      ii. **If a request was granted, are there limitations on the scope of the waiver?**

Response:

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

a. There was one claim of sexual harassment for FY 2025. A sexual harassment claim was reported on October 15, 2024. DHCF conducted an investigation. The allegations were unsubstantiated, and the agency considers the matter resolved. There have not been any allegations to date in FY 2026.

b. No, DCHF has not received any waiver requests regarding this matter.
   i. Not applicable
   iii. Not applicable

6. **Please provide a list of employees who received bonuses, special pay, additional compensation, or hiring incentives in FY2025 and FY 2026, to date, including the amount and reason.**

Response:

There are no employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2025 and FY 2026.

7. **How many performance evaluations did the agency complete in FY 2025?**
    a. **How many performance improvement plans were issued in FY 2025?**
    b. **How many employees have submitted SMART Goals or other relevant workplans in FY 2026?**
    c. **For each question, provide the total number and the percentage of total employees.**

Response:

The responses below refer to performance period October 1, 2024, through September 30, 2025. DHCF completed 250 (92.25%) performance evaluations in FY 2025.

a. DHCF did not issue any performance improvement plans for FY 2025.

b. As practice, employee SMART Goals (Individual Performance Plans) are submitted by the immediate supervisor. DHCF submitted 260 (93.53%) Individual Performance Plans in FY 2026.
c. See responses above.

8. **Please provide the Committee with a list of all vehicles owned or leased by the agency; the purpose of the vehicle; the division the vehicle is assigned to, if applicable; and whether the vehicle is assigned to an individual employee.**

Response:

Vehicle	**Purpose of the Vehicle**	**Division/Individual Vehicle is Assigned To**
Vehicle #11533 – Honda Civic	DHCF fleet vehicle for employee use.	Assigned as needed
Vehicle #11213 – Dodge Grand Caravan	DHCF fleet vehicle for employee use.	Assigned as needed
Vehicle #15768 – Chrysler Pacifica Van	DHCF fleet vehicle for employee use.	Assigned as needed

9. **Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2025 and FY 2026, 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 Q9 Attachment.

10. **Please identify the source, purpose, and amount of any funds, received by or transmitted by DHCF in FY 2025 and FY 2026, to date, including any interagency projects in which DC Health is the buyer or seller agency.**

Response:

Please refer to Q10 Attachment.

11. **Please provide a complete accounting of all reprogramming received by or transferred from the agency in FY 2025 and FY 2026, to date.**

    a. **Provide a complete accounting of all reprogramming within the agency in FY 2025 and FY 2026, 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.**

Response:

Please see Q11 Attachment.

12. **Please provide the following information for grants/sub-grants awarded to and by the agency in FY 205 and FY 2026, to date, broken down by program and cost center:**
    a. **Grant Number/Title;**
    b. **Approved Budget Authority;**
    c. **Funding source;**
    d. **Expenditures (including encumbrances and pre-encumbrances);**
    e. **Purpose of the grant;**
    f. **Organization or agency that provided or received the grant;**
    g. **Grant amount;**
    h. **Grant deliverables;**
    i. **Grant outcomes, including grantee/subgrantee performance;**
    j. **Any corrective actions taken or technical assistance provided;**
    k. **Agency program and activity supported by the grant;**
    l. **Agency employee responsible for grant deliverables; and**
    m. **Any grants where the funds have been reduced or zeroed out in FY 2026, and the amount of the reduction.**

Response:

Please see Q12Attachment for the information requested for all grants awarded to DHCF during FY25 and to date in FY26. The current fiscal year expenditures are through the first quarter, December 31, 2025.

13. **For each grant lapse that occurred in FY 2025, please provide:**
    a. **A detailed statement on why the lapse occurred;**
    b. **Any corrective action taken by DHCF; and**
    c. **Whether the funds were carried over into FY 2026, and how much funding was carried over.**

Response:

Department of Health Care Finance did not have any grants lapse in FY2025. However, them following grants were carried forward to FY2026:

- Money Follows Person: $9,998,902 was carried over to FY26
- Transforming Maternal Health (TMaH) $1,022,943 was carried over to FY26
- Section 206 CAA-Continuity of Care: $803,149.76 was carried over to FY26.

14. **Please provide the following information for all contracts, including modifications, active during FY 2025 and FY 2026, 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 refer to Q14 Attachment.

15. **Please provide a list of all Department of General Services work orders submitted in FY 2025 and FY 2026, 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:

Please see Q15 attachment. In FY 2026 (October 2025 - January 2026), 65 service tickets were submitted, 57 were completed, 1 still open, and 7 were rejected/cancelled.

In FY 2025 (October 2024 - September 2025), 223 service tickets were submitted, 189 were completed, 0 are still open, and 34 were rejected/cancelled.

16. **Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2025 and FY 2026, to date. Please include the following:**

    a. **Revenue source name and code;**
    b. **Description of the program that generates the funds;**
    c. **Cost center that the revenue in each special purpose revenue fund supports;**
    d. **Total amount of funds generated by each source or program in FY 2025 and FY 2026, to date;**
    e. **Expenditure of funds in FY 2025 and FY 2026 to date, including reprogramming, and purpose of expenditure; and**
    f. **Fund balance at the end of FY 2025 and FY 2026, to date.**

Response:

- Please see Q16 attachment 1 tab 'Items a & b' for the response to items a and b above.
- Please see Q16 attachment 1 tab 'FY 2025 Items c d & e' for the FY 2025 responses to items c, d, and e above. Please note this is an extract of a DIFS report in which revenue is shown as a negative number.
- Please see Q16 attachment 1 tab 'FY 2026 Q1 Items c d & e' for the FY 2026 Q1 responses to items c, d, and e above. Please note this is an extract of a DIFS report in which revenue is shown as a negative number.
- In response to item f, the Assessment Fund had an FY 2025 year-end fund balance of $52,210.00, and the Individual Insurance Market Affordability & Stability fund had an FY 2025 year-end fund balance of $1,323,646.63. The other Special Purpose Revenue funds had year-end fund balances of $0.00.

17. **Please provide the DHCF capital budgets for FY 2025 and FY 2026, to date, including the amount budgeted and actually spent. In addition, please provide an update on all capital projects undertaken in FY 2025 and FY 2026, to date.**

Response:

Please see Q17 Attachment.

18. **Please provide the following information for all contract modifications made during FY 2025 and FY 2026, 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 Q14 attachment.

19. **Please identify potential areas where spending pressures may exist in the agency in FY 2026. Please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize the impact on the FY 2027 budget.**

Response:

At this time, DHCF does not project spending pressures for FY 2026.

20. **Did DHCF meet the key performance indicators set forth in the performance plan for FY 2025? For any performance indicators that were not met, please provide a narrative description of why they were not met, and corrective actions taken.**

Response:

There were three key performance indicators for FY25 that were not met by the agency.

- **Number of households served by Produce RX**

We believe our original target reflected expectations that exceeded what historical performance supports, and we are adjusting the KPI accordingly. A key barrier to meeting the initial target is the program model's reliance on clinic partners to enroll participants, which limits our ability to directly influence enrollment volume. Additionally, the summer slowdown in clinic visits significantly reduced enrollment opportunities in Q4 2025, further contributing to the gap between projected and actual performance.

- **Percent of Medicaid renewals as a result of the passive renewals process.**

This target was increased in FY25. The reason that our passive percentage for 2025 Q3 and 2025 Q4 are lower than prior quarters is largely due to two factors: (1) passive renewal rates tend to be lower in spring and summer months; (2) there was an eligibility system change that decreased the number of beneficiaries who could receive a passive renewal beginning with those due in April 2025. For these reasons we are reversing the target to 70% based on historical performance and document trends.

- **Percent of Medicaid Elderly and Persons with Physical Disabilities Home and Community-Based Waiver complaints investigated within 7 days of receipt.**

LTCA previously used DHCF's legacy CSTS system and Ombudsman data to manage complaints, but manual routing limited efficiency and responsiveness. To improve operations, LTCA expanded use of the electronic Programmatic Provider Report (ePPR), a centralized ticketing system for tracking, assigning, and resolving LTSS complaints. Full adoption began in July 2025/Q4. The ePPR now captures complaints from all inbound channels, including the LTCA hotline and OMB, which submits unclassified issues directly. As staff adjust to the system and rising complaint volume, compliance is expected to improve next quarter.

21. **Please list and explain any Memos of Understanding entered into by DHCF during FY 2025 and FY 2026, to date.**
    a. Please share any MOUs DHCF is planning to enter for the remainder of FY2026, and its purpose.

Response:

Please see Q10 attachment.

22. **For each Board, Commission, or Working Group overseen by DHCF, please provide:**
    a. **An updated list of members, including when their term started and ends;**
    b. **A list of any vacant positions;**
    c. **Dates of meetings held in FY 2025 and scheduled for FY 2026, including any publicly available minutes; and**
    d. **Name and contact information of DHCF staff person who is point of contact/oversees the Board/Commission/Working Group.**

Response:

DHCF currently oversees the Health Information Exchange Board. Detail regarding members and other positions on the HIE is below.

a.

Member Name	Seat	Term
Dr. Jaclyn Kline	Medical Provider	12/2/2025 - 6/25/2027
Dr. Eric Marshall	Medical Provider	6/25/2018 - 6/25/2027
Mr. Darryl Stewart	DC Nurses Association	8/6/2024 - 6/25/2027
Mr. Justin Palmer	DC Hospital Association	6/25/2012 - 6/25/2027
Ms. Donna Ramos-Johnson	DC Primary Care Association	6/25/2016 - 6/25/2027
Ms. Alice Leiter	Public Member with health care or IT experience	6/25/2019 - 6/25/2028
Dr. James Crowe	Public Member	10/19/2023 - 6/25/2027
Ms. Nancy Ware	Public Member	12/2/2025 - 6/25/2027
Ms. Sherilyn Pruitt	Public Member	12/2/2025 - 6/25/2027
Ms. Kelli Johnson	Public Member	12/2/2025 - 6/25/2027

Mx. Deniz Soyer – HIE Policy Board Chair	Department of Health Care Finance (DHCF)	1/30/2023 - 1/2/2027
Ms. Melisa Byrd	Department of Health Care Finance (DHCF)	1/1/2019 - 1/2/2027
Dr. Barbara Bazron	Department of Behavioral Health (DBH)	1/1/2019 - 1/2/2027

Mr. Santiago Gonzalez-Irizarry	Department of Health (DOH)	12/2/2025 - 1/2/2027
Mr. Bryan Harrison – Ex-Officio, Non-Voting	Office of the Deputy Mayor for Health and Human Services (DMHHS)	1/1/2019 - 1/2/2027

b.

Member Name	**Seat**
Vacant	Medical Provider
Vacant	Medical Provider
Vacant	Medical Provider
Vacant	Representative from a Health Plan
Vacant	Medical Society
Vacant	Office of the Chief Technology Officer (OCTO)
Vacant	Department of Human Services (DHS)

c. FY25 Meetings Held:

- October 24, 2024
- January 30, 2025
- April 24, 2025
- July 24, 2025

FY26 Meetings Held/Scheduled:

- October 23, 2025
- February 18, 2026
- May 21, 2026
- September 17, 2026

Records of meetings and materials are publicly available here:
https://dhcf.dc.gov/dchiepb

d. Iesha Reid, iesha.reid@dc.gov

23. **Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY 2025 and FY 2026, 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 2024 Single Audit Findings, June 2025
    a. Single Audit Medicaid Eligibility Finding and DHCF Corrective Action
        i. Finding: Applications were not timely processed in 3 of 132 tested files.
        ii. DHCF Corrective Action: The DCAS Division utilizes a "Pending Summary Report" (PSR) to identify applications pending determination for 30 days. Previously, this report was reviewed by applicable management on a weekly basis. In response to this finding, DCAS has increased the frequency of review of the PSR from weekly to daily. The effective date of this new cadence was October 9, 2025.
2. DC OIG Audit of D.C. Medicaid Eligibility
    a. Scope: The scope of this audit was to review DHCF and DHS' internal control over Medicaid eligibility determinations during the Public Health Emergency and unwinding of continuous coverage from April 1, 2023-June 30, 2024.
    b. Finding: In 7 out of 47 cases, the DCAS system did not consistently reflect accurate eligibility status.
    c. DHCF Response: DHCF disagreed with this finding. DCAS' categorization of "Active" simply indicates that a public assistance application has been initiated. Notwithstanding, as part of the Commanding Case Closure Initiative, DHCF will provide refresher training to staff on the appropriate procedures for proper case closure and will incorporate a check for cases with an active status but no eligibility in the supervisory review process.
3. DC OIG Audit of the Medicaid Managed Care Program
    a. Scope: DHCF's oversight of the Medicaid Managed Care health service delivery system.
    b. The DC OIG noted findings across the following 5 areas of oversight:
        i. Oversight
        ii. Data Management
        iii. Program Integrity
        iv. Access and Delivery
        v. Contract Administration
    c. Oversight Findings and Responses
        i. Finding: Policies and Procedures for Monitoring MCOs Were Incomplete.

1. Recommendation: Develop and implement comprehensive policies and procedures for all monitoring divisions including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.
2. DHCF Response: DHCF disagrees in part with this finding.
    a. DHCF's managed care division does in fact has a well-established and documented compliance monitoring program in place, but DHCF agrees that broader policies and procedures across all divisions could further strengthen the managed care program.
    b. As of July 2025, DHCF is in the process of reviewing the suite of activities that comprise its managed care compliance monitoring program and identifying the corresponding policies and procedures that need to be strengthened.
    c. Estimated Completion Date: By March 1, 2026, DHCF will have adopted the final policies and procedures that reflect its compliance monitoring program.

ii. Finding: MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies.

1. DHCF Response: DHCF disagrees with this finding.
    a. DHCF is already in compliance with 42 C.F.R. Sec. 438.608(d)(3). The applicable contract language states: C.5.33.1.6: "The Contractor shall submit *monthly* reports and a comprehensive *annual* report in a format determined by DHCF, on its recovery of overpayments, in accordance with 42 C.F.R. Sec. 438.608(d)(3)," and C.5.33.1.7: "The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments.
    b. CMS confirmed DHCF's compliance with 42 C.F.R. 438.608(d) at page 9 of its FY 22 Focused Program Integrity Review of the D.C. Medicaid Program Report, available at *https://www.cms.gov/files/document/washington-dc-fy22-focused-pi-review-report.pdf*.

d. Data Management Findings and Responses

i. Finding: DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance.

1. DHCF Response: DHCF disagrees with this finding.
    a. DC OIG states that "DHCF could not accurately determine whether MCOs reported all identified

overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR" and that "without reliable overpayment data, DHCF cannot effectively verify MCOs are identifying and recovering all overpayments."

b. First, it is important to note that the PIMR is fundamentally not a "Financial Reconciliation Report." The function of the PIMR is to consolidate key program integrity activities to facilitate agency utilization review and investigatory priorities. Encounter data validation and reconciliation are conducted on an ongoing basis by the agency through multiple other functions and the PIMR report neither guides, nor is intended to supplant these activities. DHCF, along with its contracted Actuary, have extensively reviewed its data validation activities with the DC OIG.

c. It is incorrect to state that 7,081 transaction control numbers (TCN) were missing from the FY 23 PIMR, and 7,364 TCNs were missing from the FY 24 PIMR. DHCF showed the DC OIG, in real time, all of the "missing" TCNs. The PIMR is a *retrospective* review, so the TCNs reviewed are for a *historical* period, and will not, by definition, align with *present* encounter data. The PIMR did not "fail" to include applicable TCNs. OIG initially presented DHCF with more than 11,000 TCNs it claimed were missing based on the FY2023 PIMRs. DHCF reviewed and identified all TCNs as being pulled directly from its own MMIS, so it is impossible for those claims to be missing from MMIS. DHCF met with the OIG and presented this data to the OIG, as well as sending OIG data files with all the TCNs showing that they were all present and accounted for in MMIS. DHCF has not been presented with the 7,364 TCNS allegedly missing from the FY24 PIMRs, but DHCF suspects that all those TCNs are from time periods outside of FY23, in which case they will not be found in the FY2023 claims data set that the OIG is running them up against. But they will still be found in MMIS because they come from MMIS.

ii. Finding: DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting

1. DHCF Response: DHCF disagrees with this finding.

a. The DC OIG characterized the following as "inaccuracies" in MCO overpayment reporting that "limit DHCF's ability to effectively monitor these payments," which inflates the impact of largely immaterial data:

i. One MCO PIMR had TCNs with file formatting that changed the last two digits to 00;
    1. DHCF Response: This was a one-time formatting error, whereby Excel "autocorrected" the TCNs to end in 00. Microsoft Excel has a formatting error that occasionally converts all digits greater than 15 to 15 digits, with the remaining digits being replaced by zeroes. The 17 digit TCN number's last 2 digits were therefore converted to zeroes despite the MCO having uploaded the full TCN correctly. Once this issue was identified, DHCF worked with the MCO to timely update the data with the full TCN numbers. This is not a systemic issue.

ii. Another MCO classified all overpayment recoveries as "Waste" and not "Fraud or Abuse;"
    1. DHCF Response: This is immaterial for two reasons:
        a. First, the MCOs do not make the findings of "fraud" or "abuse." Findings of fraud and abuse is determined via a separate process by the Medicaid Fraud Control Unit (MFCU), following a preliminary investigation by DHCF.
        b. Second, in the period reviewed by DC OIG, DHCF considers all of the identified overpayments properly categorized as "waste." The draft OIG Report does not identify any specific overpayment recoveries that it believes are nonetheless misclassified, so DHCF is unable to provide a further substantive response to the alleged errors.

iii. There were instances where (PIMR) TCNs had dates outside of FY23.
    1. DHCF Response: Since DHCF Program Integrity division (DPI) audit activities are retrospective, there will always be TCNs in the PIMR that are outside of the present fiscal year. This is by design.

e. Program Integrity Findings and DHCF Responses

a. Finding: DHCF Can Strengthen its Fraud Referral Processes to the MFCU. The DC OG states that "DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential

fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars."

1. DHCF Response: DHCF disagrees with this finding.
    a. DHCF has a written fraud referral policy and procedure that is based on, and consistent with, federal regulatory requirements. *See* 42 C.F.R. Sec. 455.12 *et. seq*. This document has previously been provided to the OIG. DPI has an investigations branch that conducts preliminary investigations, consistent with 42 C.F.R. Sec. 455.14, to determine if credible allegations of fraud exist, and the payment suspension committee then convenes, consistent with our written policy and federal regulations, to determine if referral to law enforcement is justified under 42. C.F.R. Sec. 455.23. This framework is structured and effective.
    b. It is unclear from the DC OIG, how it suggests DHCF can improve its MCO fraud referral procedure. The fraud referral procedure is a stand-alone procedure, distinguished from other monitoring activities, such as overpayment review. The fraud referral procedure has been reviewed, in real time, with the MCOs during a dedicated meeting. The fraud referral procedure, which was provided to the DC OIG, includes: Potential Provider Fraud and Abuse Referral Document Form; Potential Provider Fraud and Abuse Referral Web Portal Form; Assignment of a referral number from DHCF. Upon receipt of a MCO fraud referral, DHCF initiates its regulatorily required "preliminary investigation" to determine the credibility of the referral. If credible, then DHCF refers the matter to the MFCU. In addition, this finding fails to acknowledge activities undertaken by DHCF since FY2023 that are directly relevant to this finding. For example, OIG was informed of comprehensive trainings conducted by DHCF with each of the MCOs individually in FY24 that focused on properly classifying investigations as fraud/waste/abuse, instructed the MCOs on how to improve their internal investigations to identify additional fraud, and have resulted in significantly higher fraud referrals during this current FY. It is unclear to DHCF whether the activities taken since the review period OIG examined are sufficient to address OIG's concerns or, if they are not, how it failed to address those concerns.
2. The DC OIG's reference to the total number of fraud referrals in FY 23 is also incorrect, stating that "DHCF made 145 [fraud] referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between

MCO and non-MCO sources. This is incorrect, in FY 23 DHCF initiated 31 preliminary investigations, and referred 7 credible allegations of fraud to the MFCU. The "145" fraud referrals cited by the DC OIG is incorrect. In FY23, DHCF-DPI had 131 open investigations, inclusive of cases that had been opened in prior years and had not been closed due to ongoing activities, ongoing law enforcement investigations, or other reasons. Of those 131 cases, 7 cases were referred to the MFCU after DHCF determined that, pursuant to 42 C.F.R. section 455.23, credible allegations of fraud existed. None of those cases were MCO initiated investigations.

3. Regarding the alleged misclassification of waste, crucially, the OIG has not presented any evidence of improper classifications by the MCOs beyond the fact that one MCO classified all items on the PIMR as waste. Waste is a distinct and valid classification. Absent evidence that the classifications at issue were improper, DHCF cannot agree with the claim that misclassifications were made.
4. Lastly, all managed care network providers are required by federal law to be concurrently enrolled with the State Medicaid Agency. This means that every single managed care network provider, is also enrolled with DHCF. When DHCF develops its investigatory strategic plan, all enrolled providers are subject to review- managed care network providers are not excluded. DHCF determines its investigative priorities based on consideration of several factors, including but not limited to, aberrant utilization trends, or provider types/categories of services federally identified as high risk. Managed care network providers are absolutely not without oversight from DHCF- they are subject to,and not excluded from the scope of fraud investigations.

ii. Finding : DHCF's Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs

1. DHCF Response: DHCF disagrees with this finding.
2. It is unclear the sample, methodology, or data fields that were used by the DC OIG to conclude that "18/60" individuals had dual enrollment in the Alliance and Medicaid enrollment for periods ranging from two to twelve months. As was explained at length to the DC OIG, material to determining impermissible dual program enrollment, is to verify whether there are any "voided spans" during the subject enrollment period. Periods of apparent "dual enrollment, should be verified by checking if there is a corresponding "void span" in the District's Medicaid management Information System (MMIS), that retroactively voids enrollment in one of the two subject programs due to dispositive information received subsequent to initial enrollment. For example, if an individual is enrolled in the Alliance Program from July 2023-September 2024, and at any time during this enrollment period,

DHCF receives citizenship information that qualifies them for Medicaid, then the eligibility and enrollment system sends an automatic update to the claims processing system that "voids" the entirety of the Alliance span, and replaces it with a Medicaid span for the subject period. During DHCF's multiple meetings with the DC OIG, it repeatedly explained that the "voided span" data field must be considered in order to validate any conclusion of duplicate enrollment. It does not appear that the DC OIG reviewed the "voided span" data at all. In the absence of this information, it is inaccurate to conclude that an individual had duplicate enrollment.

f. Health Care Access and Service Delivery Findings and DHCF Responses
   i. Finding: Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access
      1. DHCF Response: DHCF disagrees with the methodology underlying this finding. The DC OIG's calculations are incorrect. DHCF agrees to develop a process to review a representative sample of managed care prior authorization denials and appeals, on a periodic basis.
      2. DC OIG states that in FY23, there were 19,327 denials out of 38,958 requests. However, of the 19,327 "denials," 12,674 were for services categorically not covered under the D.C. State Plan for Medicaid. There is no basis to request a prior authorization for a non-covered service. Prior authorizations are only available for denied covered services. Further, 288 "denials" were either subsequently approved, or the request was withdrawn. Therefore, the 12,674 requests for non-covered services, and 288 approved or withdrawn requests should also be excluded from the total "denials." Properly excluding these cases 12,962 cases, yields a denial of 6,365 out of 38,958 requests, or a 16% denial rate, rather than the incorrect 50% rate asserted in the Draft Audit Report.
      3. DHCF agrees to strengthen its health care access oversight by implementing a process to review, on a periodic basis, a representative sample of denied and appealed cases to identify potential, data supported access barriers for covered services. Estimated Completion Date: March 1, 2026.

g. Contract Administration
   i. Finding: DHCF Contract Administrators Did Not Complete Certification Requirements
      1. DHCF Response: DHCF disagrees with this finding.
         a. The subject Contract Administrators were previously certified and were unable to complete recertification requirements only due to lack of availability of OCP training for recertification. DHCF was unable to comply during the period of review due to reasons outside of its purview.

b. The D.C. Office of Contracts and Procurement (OCP) exclusively administers Contract Administrator (CA) training for applicable District employees. OCP did not make the applicable CA training available for District employees, during the period of review, which precluded timely completion of recertification.

c. Once the training became available, all CAs promptly enrolled and have since completed their recertification.

ii. Finding: DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs.

1. DHCF Response: DHCF disagrees with this finding.

a. All readiness reviews were completed within required timeframes and in accordance with 42 CFR § 438.66 (1)(2)(3)(4).

b. During the specific period of review in this audit, only 1 MCO, Amerigroup, which was newly procured and absent from the program for 3 years, required a readiness review.

c. Amerigroup's readiness review was completed in accordance with 42 CFR § 438.66 (1)(2)(3)(4). HSCSN, AmeriHealth, and MedStar were not subject to additional mandatory readiness reviews, as they were not newly contracted MCOs. The reviews had been completed prior to the period of review at issue in the audit.

See Q23 Attachments 1-3

24. Please list all pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants. For each case, please provide the following:

a. The case name;
b. Court where the suit was filed;
c. Case docket number;
d. Case status; and
e. A brief description of the case.

Response:

There are currently four (4) pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants. Details for each case are provided below.

1. Salazar et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 93-452
- Status: Settlement Agreement executed; awaiting final approval by the Judge
- Case Description: Concerns compliance with federal requirements governing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

2. NB et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 10-1511
- Status: Parties have filed cross-motions for summary judgment; awaiting decision by the Judge
- Case Description: Addresses whether the District must issue notice to beneficiaries when a prescription request is denied at the point of sale.

3. Ivy Brown et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 10-2250
- Status: Discovery ongoing; the District has appealed the court's ruling
- Case Description: Examines whether the District is required to transition Medicaid recipients residing in nursing facilities to a less restrictive setting.

4. MJ v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 18-1901

- Status: Discovery ongoing; the District has filed a motion for summary judgment and is awaiting the Judge's decision
- Case Description: Concerns whether the District must provide intensive community-based services to children to prevent institutionalization.

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 2025 and FY 2026, to date.**
    a. **Please provide all information related to assumptions that inform the Medicaid Provider Payment budgets**.

Response:

Please see Q25 Attachment. In general, DHCF develops fee-for-service budgets by computing the historic average cost of utilization per beneficiary and projecting that forward and then multiplying that projected per beneficiary cost by the projected number of beneficiaries. For waiver programs, DHCF uses the budget neutrality models developed as part of the waiver applications and renewals based on users, average units per user, and average cost per unit to project the budgets into the future. For managed care programs, DHCF uses the latest capitation rate projections from the department's contracted actuarial firm and modifies those for anticipated changes in policy, cost, and/or utilization. We then multiply those modified rates by the projected managed care beneficiaries.

26. **For FY 2025 and FY 2026 to date, please provide the Monthly Medicaid enrollment for both FFS and each MCO, broken down by eligibility category.**

Response:

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

27. **For FY 2025 and FY 2026, to date, please provide the following spending/cost and utilization data:**
    a. **Utilization and spending for both FFS and each MCO, broken down by eligibility category and service type;**
    b. **Average monthly capitation rate per MCO enrollee; and**
    c. **Average estimated monthly cost per FFS beneficiary, broken down by eligibility category.**

Response:

a. For costs associated with the Medicaid program, please see the response to Q25. For utilization data, please see Attachment 1 to Q27.
b. For capitation payments associated with the Medicaid program, please see the response to Q25 and for enrollment please see Q26.

   The following cost centers comprise capitation: Managed Care Organizations (MCO), Managed Care Organizations (MCO) – CHIP, MCO – Expansion Population, MCO – ABD, MCO – Newly Eligible, CASSIP, CASSIP – CHIP, Dual Choice, and Program of All-inclusive Care (PACE).

c. For FFS cost please refer to Q25 and for enrollment data please refer to Q26.

28. **Identify each District of Columbia agency that submitted Medicaid claims, indicating if it was through an MCO, including HSCSN, or FFS, in FY 2025 and FY 2026, to date, and including the following information:**

Response:

a. See Q28 Attachment for the total dollar amount of claims filed by agency each month.

b. See Q28 Attachment for the total dollar amount of claim denied per agency each month and the timetable of claims paid and denied within 30 and 90 days.
Based on FY 25 - 26 YTD denied claims history, the most common reasons for denials were:
- Procedure code/Modifier Match
- Multiple Referring Provider IDs Found
- Ineligible Program Code
- NCCI MUE Edit Bypassed
- Behavioral Health – Invalid service Provider Type
-

c. 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

d. DYRS will be integrated into the ASO in FY 2026 to comply with Section 5121 of the Consolidated Appropriations Act (CAA) of 2023, which requires State Medicaid Agencies to provide targeted case management (TCM) and screening and diagnostic services to eligible juveniles. Under this mandate, DYRS will begin seeking Medicaid reimbursement for certain state plan services delivered in the 30 days prior to a youth's release from a secure facility, as well as TCM services for at least 30 days post release. CMS clarified these requirements in State Health Official Letter #24004, issued in July 2024.

Although the statute sets an implementation date of January 1, 2025, CMS is allowing states to delay implementation until December 31, 2026, due to the operational and administrative complexity of establishing these new processes. The District's implementation timeline is no earlier than July 1, 2026, with HCRIA leading the effort. DYRS will manage Medicaid claiming for the covered services, supported by ASO's technical and operational expertise.

Currently, there are no additional opportunities to integrate other District agencies into the ASO. This is due to several factors, including agencies procuring their own billing vendors, discontinuing enrollment with DC Medicaid, or no longer providing Medicaid reimbursable services.

29. **For FY 2025 and FY 2026, to date, please provide the following data related to network adequacy in the Medicaid provider network:**
    a. **Results of the most recent audit(s) related to network adequacy;**
    b. **Metrics used to measure network adequacy, including geographic proximity, provider-to-enrollee requirements, and/or timely provider appointments and how FFS and MCO providers meet or do not meet these metrics;**
    c. **Any penalties issued or enforcement measures taken by DHCF against MCOs in relation to network adequacy;**
    d. **Status update on DHCF's efforts to create a consolidated Provider Directory, which was noted as a plan in FY 2024's performance oversight responses; and**
    e. **Any current or future changes to procedures and policies related to network adequacy measurement or enforcement in FY 2025 and FY 2026, to date.**

Response:

DHCF tracks and monitors its Managed Care Plans' (MCPs) provider network and compliance according to network adequacy standards prescribed in Federal Regulations. Qlarant, the District's contracted External Quality Review Organization (EQRO), evaluates provider networks to gauge compliance, including conducting an annual network adequacy survey. The goal is to ensure MCP enrollees have adequate access to health care including preventative, diagnostic and treatment services through an evaluation of provider availability, provider directory accuracy, and timely access to appointments and services for enrollees.

In addition, in FY25 DHCF collected data to enhance oversight of MCP's provider networks including the following:

- Network Provider Report: This quarterly report collects information about each MCP's entire network of providers to include provider types and specialty.
- Provider Termination Report: This monthly report details provider terminations (providers who left the network) in order to monitor changes in the MCPs' networks.

a. Based on reviewed data, all MCPs demonstrated sufficient provider networks including compliance with the following:

- Adult and pediatric primary care geographic access standards.
- Adult and pediatric primary care provider-to-enrollee ratio standards.
- Primary care provider network requirements.
- Aggregate rates for Adult PCP routine appointment (88%) and Pediatric PCP routine appointment compliance (94%)
- Aggregate rates for Adult PCP urgent appointments (88%) and Pediatric PCP urgent appointments (87%)

b. The table below lists the modified metrics used to measure network adequacy.

Table 1: Network Adequacy Matrix

MCP Contract Reference	Contract Requirement	Compliance Status
Provider Network		
Geographic Standards Mileage and Travel Standards DCHFP: C.3.161 CASSIP: C.3.177	A source of treatment within five (5) miles of an Enrollee's residence or no more than thirty (30) minutes Travel Time by public transportation, unless specified in the Contract.	Met
Geographic Standards: Mileage and Travel DCHFP: C.5.29.8.1.6 CASSIP: C.5.107.1.7	Psychiatric Residential Treatment Facilities and Substance Use Disorder Residential treatment facilities at all ASAM levels of care within 30 miles from the enrollee's residence OR 60 minutes travel time by public transportation.	Met
Provider -to -Enrollee Ratio: Primary Care Provider (PCP): DCHF: C.5.29.2.7.11 CASSIP: C.5.100.11	At least one (1) full-time equivalent PCP, regardless of specialty type, for every five hundred (500) Enrollees, and there must be one (1) full-time equivalent PCP with pediatric training and/or experience for every five hundred (500) children and adolescents through the age of twenty (20) within the Mileage and Time Travel Standards.	Met
Provider-to-Enrollee Ratio: Dental Provider DCHFP: C.5.29.2.7.11.1 CASSIP: C.5.100.11.1	At least one (1) full-time equivalent dentist for every seven hundred and fifty (750) children and adolescent who serves the pediatric population through the age of twenty (20) within the Mileage and Time Travel Standards.	Met
Timely Access to Care		
Routine Primary Care DCHFP: C.5.29.18.5.2, C.5.29.18.10 CASSIP: C.5.116.10	Adult and children enrollees should have access to a routine, well health examination within 30 days of request	MCP performance declined in both measures. ***Adult: Decreased from 93% to 88% Children: 97% to 94%

Urgent Primary Care DCHFP: C.3.237 CASSIP: C.5.116.6	Adults and children enrollees should have access to urgent medical care within 24 hours of request.	*** A marginal decline was noted in the Pediatric PCP Urgent Appointment Compliance measure (from 88% to 87%).

*** *DC aggregate is the combined performance of the four (4) MCPs – AmeriHealth Caritas DC, Health Services for Children with Special Needs, MedStar Family Choice DC and Wellpoint DC (formerly Amerigroup DC). DHCF will address issues specific to each MCP, accordingly.*

c. None.

d. DHCF successfully collected data needed to develop and create the consolidated Provider Directory and expects to conclude this work soon.

e. The 2024 CMS Managed care Rule includes a new requirement for availability of telehealth, telemedicine, e-visits, and other technological access. Contract modifications to align with the new requirements are in progress with implementation planned for Q2 FY26

30. **Please identify each incident of Medicaid abuse or fraud investigated in FY 2025 and FY 2026, to date, and any associated sanction/penalty. Please identify providers and amounts recouped for each, including any supporting documentation.**

Response:

DHCF's Division of Program Integrity (DPI) includes an Investigations Branch, two Surveillance Utilization Review Sections (SURS), a Public Assistance Reporting Information System (PARIS) Branch, and a Data Analytics Research Team (DART). The Investigations Branch primarily focuses on the investigation of fraud based on external referrals and information or data mining obtained from various sources. SURS focuses on audits of providers to ensure proper billing utilization. The two 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 or concurrent fraud 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 engages in significant collaborative efforts with law enforcement agencies, including the FBI, Medicaid Fraud Control Unit (MFCU), and US Attorney's Office.

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

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

DHCF investigated or continues to investigate 55 cases of alleged Medicaid fraud in FY25. In FY25, 17 cases were referred to law enforcement. As of January 08, 2026, DHCF referred an additional three (3) cases to law enforcement and investigated or continues to investigate 11 additional cases of alleged Medicaid fraud in FY26 (for a total of 66 cases investigated or continuing to be investigated across FY25 and FY26 to date). Please refer to **Question 30 Attachment 1** for more details on these investigative cases.

Federal regulation 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. After the completion of a preliminary investigation, the agency makes referrals to law enforcement, when appropriate.

Attachment 2 to Q30 details DPI SURS' Branch's audit and oversight activities for FY25 through January 2026. Overpayment recoupments are typically effectuated via offsets against 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.

In addition to the provider activities listed in Attachment 2 to Q30, SURS significantly expanded its oversight of the Managed Care Organizations during FY25. This included reviewing data on overpayments identified and recovered that are reported by the MCO's on the 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.

Furthermore, DPI's SURS unit expanded its Provider Awareness Letter (PAL) activities during FY25. The PAL program consists of data analysis of a broad swatch of Medicaid provider claims activity to identify outliers for targeted provider education and interactions with the goal of strengthening provider compliance with agency regulations and best practices. Identified providers receive a PAL from DPI-SURS indicating that their billing behavior deviates from peer utilization levels and requires the provider to engage in self-audit and review activities to ensure appropriate billing behavior is taking place. The goal is to improve provider operations. Preliminary analysis by DPI indicates significant reduction in provider utilization levels with no evidence of reduction in quality-of-care metrics.

31. **For each waiver program, please provide:**
    - **a. A description of and reason for any changes or planned changes in FY 2025 and FY 2026, to date:**
    - **b. Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by gender, for FY 2025 and FY 2026, to date; and**
    - **c. Enrollment cap, number of vacancies, or number of people on the waiting list, if applicable.**

Response:

a. None
b. See Attachment 1 to Q31 that includes all currently available enrollment and gender-based statistical data for each waiver program for FY 2025 and FY 2026 to date. Analysis of utilization by service type, spending, and cost-per-enrollee both current and projected are still being finalized. These components require additional validation to ensure accuracy. The Long-Term Care Program is working with the Office of Rates, Reimbursement and Financial Analysis to complete the remaining cost and utilization analyses. The full set of validated data will be provided once this review is complete to support program oversight and reporting.
c. Currently, the 1915(c) Waiver programs do not have an enrollment cap or waitlist.

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

Response:

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
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: TBD Approved: Under Review Submitted: 6.6.24	Adds justice involved reentry and HRSN
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 Approved: 1.17.25 Submitted: 5.17.24	Expands coverage of maternal health services for pregnant immigrants and their children
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 Approved: 1.17.25 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
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
DC-24-0019	None	Renews the Districts Adult Day Health Program 1915(i) benefit.	Effective: 4.1.25 Approved: 3.10.25 Submitted: 9.30.24	N/A
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
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: 4.19.24	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
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 Approved: 1.17.25 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children
DC-24-0025	None	Extended coverage of all FDA-approved over-the-counter COVID-19 test and test kits under purchased prior to September 30, 2025 (one year beyond the federally required time period of September 30, 2024).	Effective: 10.1.24 Approved: 8.28.25 Submitted: 12.20.24	Ends coverage of over-the-counter COVID-19 test effective 10.1.25.
DC-25-0001	None	Updates the fee schedule reimbursement rates for home health services.	Effective: 1.1.25 Approved: 4.10.25 Submitted: 2.4.25	N/A
DC-25-0002	None	Provides assurances in accordance with federally mandated quality reporting requirements for the Child Core Set and the behavioral health quality measures on the Adult Core Set outlined in 42 CFR 431.16 and 437.10 through 437.15.	Effective: 12.31.24 Approved: 3.14.25 Submitted: 2.25.25	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0003	None	Permits the District of Columbia Medicaid program to provide the Targeted Case Management and EPSDT benefits to justice-involved youth as described in section 5121 of the CAA, 2023. The effective date for this benefit is January 1, 2025.	Effective: 12.31.24 Approved: Under Review Submitted: 2.25.25	Provides access to Medicaid services for thirty (30) days prior to and thirty (30) days following release.
DC-25-0004	None	Provides an extension of the exception to the requirement of having a Recovery Audit Contractor (RAC) for an additional two (2) years, through May 31, 2027.	Effective: 6.1.25 Approved: 6.18.25 Submitted: 5.5.25	N/A
DC-25-0005	None	Permits the District of Columbia Medicaid Program to reimburse certain high-cost curative therapy drug products under fee-for-service (FFS).	Effective: 1.1.26 Approved: Under Review Submitted: 10.23.25	
DC-25-0006	None	Updates fee schedule rates for home health services.	Effective: 7.1.25 Approved: 10.2.25 Submitted: 7.14.25	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0007	None	Permits the District of Columbia Medicaid Program to exclude certain high-cost curative therapy drug products from the DRG reimbursement system and shall be reimbursed under fee-for-service (FFS).	Effective: 1.1.26 Approved: Under Review Submitted: 10.27.25	
DC-25-0008	None	Permits the District of Columbia Medicaid Program to exclude certain high-cost curative therapy drug products from the EAPG classification system.	Effective: 1.1.26 Approved: Under Review Submitted: 10.27.25	
DC-25-0009	None	Complies with actions implemented in Section 201 of the Consolidated Appropriations Act, 2024, which made the mandatory Medication-Assisted Treatment (MAT) for opioid use disorders (OUD) benefit permanent by amending Section 1905(a)(29) of the Social Security Act (the Act) to remove the end date of September 30, 2025.	Effective: 10.1.25 Approved: Under Review Submitted: 12.29.25	N/A
DC-25-0010	None	Updates rates for adult and pediatric dental services.	Effective: 10.1.25 Approved: Under Review Submitted: 12.16.25	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0012	None	Complies with the mandatory exception of the Medicaid clinic services benefit "four walls" requirement for Indian Health Services (IHS) and Tribal clinics and elects the optional exceptions for behavioral health clinics and clinics located in rural areas.	Effective: 6.1.25 Approved: 11.12.25 Submitted: 8.26.25	
DC-25-0013	None	Discontinues coverage of the optional eligibility group serving individuals with MAGI-based income above 133 percent of the federal poverty level (FPL); and reduce the income eligibility standard of its mandatory eligibility group serving parents and other caretaker relatives from 216 percent of the FPL to 133 percent of the FPL.	Effective: 1.1.26 Approved: 11.18.25 Submitted: 8.21.25	
DC-25-0014	None	For CHIP, demonstrates compliance with Section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act) and mental health parity requirements set forth at 42 CFR 457.496.	Effective: 10.1.24 Approved: Under Review Submitted: 9.30.25	None
DC-25-0015	None	Clarifies coverage requirements for Private Duty Nursing (PDN) ordered by and provided under the direction of a physician by registered nurses (RNs) and licensed practical nurses (LPNs), by removing the requirement that a beneficiary be "technology dependent" to receive PDN services.	Effective: 10.1.26 Approved: 11.18.25 Submitted: 8.21.25	

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0017	None	Removes individuals under age sixty-five (65) with income over one hundred thirty three percent (133%) of the federal poverty level (FPL) from the Section 1932(a) Managed Care SPA.	Effective: 1.1.26 Approved: 12.4.25 Submitted: 9.24.25	
DC Individual and Family Support (IFS) Waiver Renewal	Thirty (30) day public comment period and stakeholder meetings.	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.	Effective: 10.1.25 Approved: 9.30.25 Submitted: 7.18.25	See HCBS IFS Waiver 2025 Renewal | dds.
DC People with Intellectual and Developmental Disabilities (IDD) Waiver Amendment	Two (2) thirty (30) day comment periods and stakeholder meetings.	Updates reimbursement methodology for direct support workers and clarifies service delivery policies to ensure quality of care and increase provider accountability and training.	Effective: TBD Approved: Under Review Submitted: 12.16.25	See HCBS IDD Waiver 2025 Amendment | dds.

Table 2: FY25 and FY26 Anticipated SPA/Waiver Submissions

SPA/Waiver	Description
Adult Day Health Program	Changes the rate rebasing schedule for Adult Day Health Program services
Federally Qualified Health Centers	Changes the rate rebasing schedule for federally qualified health centers.

33. **In the FY 2024 performance oversight responses, DHCF stated that the agency is working with the Hospital Based Violence Intervention Program (HVIP) on scope and implementation of the Community Violence Prevention benefit, effective October 1, 2024. Please provide an update on the status of the CVP benefit.**

    Response: The SPA has not been submitted to CMS due to ongoing interagency discussions and policy development around implementation and alignment with grant models.

34. **Please provide an update on how the DHCF is working with the District's managed care plans to ensure compliance with the Salazar Decree.**
    a. **Please share any corrective action plans that were issued in FY 2025 and FY 2026 to date, how much in fines were issued by MCO, and whether the MCOs are meeting the standards of their CAPs.**

Response:

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 Parties had been engaged in settlement discussions to explore the District's exit strategy since 2022, and on October 31, 2025, the Parties reached a settlement agreement that was submitted to the Court and remains pending preliminary approval. The Settlement Agreement is not final until the judge holds a fairness hearing and approves. If it is approved, the consent decree will be vacated, and the Settlement Agreement will govern the District's obligations until the case is dismissed in October 2027.

In 2025, the District submitted all required reports to the Court under the consent decree and will continue to do so until the Settlement Agreement is final and the consent decree is vacated. Although 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. In FY25, all four MCPs paid the fines imposed and were placed on corrective action plans, which are provided in the four corresponding attachments. (See Attachments 1 through 4 to Q34)

The fines imposed in FY25 were:

--AmeriHealth Caritas DC: $360,045
--Health Services for Children with Special Needs: $17,640
--MedStar Family Choice DC: $246,780
--Wellpoint DC (formerly Amerigroup DC): $227,655.

The MCPs are compliant with reporting deliverables and requirements to submit and implement their corrective action plans (CAPs) and payment of fines. DHCF's Division of Children's Health Services (DCHS) 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.

35. **Please provide the average length of time, in FY 2025 and FY2026, to date, for each MCO and FFS to complete:**
    a. Non-urgent prior authorizations;
    b. Urgent prior authorizations; and
    c. Long-term care prior authorizations.

Response:

Please see the response times (in days or hours) below, as well as the definitions per the *Prior Authorization Reform Amendment Act of 2023* (The Act).

a. Non-urgent prior authorizations, defined as:
All Prior Authorizations not meeting the definition of "urgent" per The Act.

The following reflects time in **business days.**

FY 2025				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
0.64	5	6.88	1.79	1.33

FY 2026				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
0.27	3	1.73	2.16	1.71

b. Urgent prior authorizations, as defined as:
"(A) A health care service that, in the opinion of a physician with knowledge of the enrollee's medical condition, if not receiving an expedited approval:
(i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or
(ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization review; or
(B) Medication assisted treatment.:

The following reflects time in **hours.**

FY 2025				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
26.40	62	53	11.61	30

FY 2026				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
7.71	11	24	57.25	20

c. Long-term care prior authorizations.

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

The following reflects time in **days.**

FY 2025				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
3.65	15	6	1.43	6

FY2026				
AmeriHealth	**HSCSN**	**MedStar**	**Wellpoint**	**FFS**
2.62	6	1	0.75	3

* Please note that Wellpoint's FY26 data above does not include dental service prior authorization data, which is still pending final internal aggregation.

36. **Please describe changes to any of the MCO and FFS patient portals completed in FY 2025 and FY 2026, to date, and planned changes for the remainder of FY 2026.**

Response:

DHCF does not operate a patient portal for FFS beneficiaries.

AmeriHealth:

There were no material changes to the AmeriHealth Caritas DC portal in FY 2025. In FY 2026, AmeriHealth has indicated that it will improve the registration/sign-up process for enrollees who don't have their Medicaid and/or AmeriHealth ID number. AmeriHealth also plans to add a short new enrollee welcome survey that will allow all new enrollees to share any immediate transition of care, upcoming procedures or treatments, health concerns, or related needs that they may have.

HSCSN:

FY25
HSCSN enriched their shareable educational care programs, on demand articles and relevant links to include all relevant chronic diseases, pediatric and young adult content. Additionally, the patient portal grew with new programming, educational material specific to conditions, and information in Spanish. HSCSN also built out quick shareable links to all web-based plan materials.

FY26
For the coming year, HSCSN's Case Managers will have new technology solutions including integration with the Nurse Triage Line.

MedStar:

There have been no changes made to the MedStar Family Choice DC Enrollee Portal in FY2025 and FY2026 to date. There are also no planned changes for the remainder of FY2026.

Wellpoint:

Website
• June 2025: The enrollee website portal went through branding changes beginning in May with a banner sharing that Amerigroup DC would be becoming Wellpoint DC. The portal transitioned from Amerigroup branding to Wellpoint DC in June in preparation. In July all branding was complete. Contact information and updates related to the brand change were provided.

• December 2025: The portal was updated to incorporate messaging on changes to the Medicaid, Alliance and Immigrant Children's Programs (ICP). Alliance enrollees were

notified that their care would transition out of managed care to the Medicaid fee-for-service. All enrollees were asked to ensure they review all updates received by mail or District Direct. It also guided enrollees to DHCF's website where additional guidance and detail on changes were listed.

• December 2025: Updates made to include information on data breach as follows: "Important member notice: Learn about a security incident at Conduent, a Wellpoint DC service provider."

Sydney Health App
• October 2024: Enrollees will see a message on the pharmacy landing page stating if they have a CarelonRx pharmacy prescription to fill.

• March 2025: All eligible Medicaid BioPlus Specialty enrollees will have the digital BioPlus experience where a enrollee can reschedule their prescription and track their shipment.

• May 2025: Enrollees will be able to utilize chatbot in Spanish when digital profile has language selected.

• June 2025: DC Medicaid market was rebranded to the Wellpoint DC brand. A message was displayed for 4 to 6 weeks before the brand change is effective so they will know that it is coming.

• September 2025: Enabled Modernized Security through the OKTA Security efforts.

• December 2025: Family Link - The head of household (HOH) with more than one family member on a Medicaid plan must manage multiple online accounts; one for each family member. Five family members equals five online accounts managed by the head of household. We will make it more user friendly for the HOH to access their minor account(s) by login through their own account.

• December 2025: Introduced a new dashboard landing page for DC Medicaid enrollees on secure Medicaid Web Portal and SH App.

37. **Please provide on the following for the FY 2025 Budget Support Act Title V Subtitles C, D, and E, Medicaid Inpatient and Outpatient Fund and Directed Payments:**
    a. **The status of the submission to Centers for Medicare and Medicaid Services and application details both for FY2025 and FY 2026;**
    b. **Status of hiring for the FTE position at DHCF to administer this program; and**
    c. **List of policy priorities funded through the District Retention as determined through collaboration with the Hospital Association and a plan for implementing the priorities**.

Response:

a. The FY2025 State Directed Payment (SDP) and Tax Waiver have both been approved by the Centers for Medicare and Medicaid Services (CMS). The District received approval for the Tax Waiver on June 27, 2025, and SDP Preprint approval on September 9, 2025. The District made a first directed payment to Managed Care Providers (MCP) on October 20, 2025, for hospital claims incurred and paid through August 31, 2025. Lastly, the District included the approved provider tax in assessments sent to hospitals for the first quarter of FY 2026. The FY2026 SDP and Tax Waiver are currently in review by CMS. The SDP Preprint, Tax Waiver, and corresponding documents were all submitted to CMS on June 30, 2025. The District has received and responded to CMS feedback on 3 occasions concerning the Preprint and once on the Tax Waiver.
b. The OCFO has hired and filled the Reimbursement position, which oversees the financial responsibilities of the Average Commercial Rate (ACR) analysis.
c. The uses of the District Retention were established and codified through the FY25 budget process. The District retention was set aside to fund Medicaid fee-for-service payments to hospitals and hire an FTE to support implementation of the A CR. Please see table below for spending allocation in the FY25 and FY26.

Account Group Description	Account Description	FY2025 Budget	FY2026 Budget
CONTINUING FULL TIME	CONTINUING FULL TIME	$57,008.05	$33,191.95
FRINGE BENEFITS - CURR PERSONNEL	MISCFRINGE BENEFITS	$12,655.79	$7,700.53
TOTAL PERSONAL SERVICES		**$69,663.84**	**$40,892.48**
INPATIENT IN STATE	MEDICAL VENDOR SERVICES	$8,688,549.00	
OUTPATIENT HOSPITAL	MEDICAL VENDOR SERVICES	$12,518.00	
EMERGENCY	MEDICAL	$4,470,555.00	

MEDICAID	VENDOR SERVICES		
GOVERNMENT SUBSIDIES & GRANTS	MEDICAL VENDOR SERVICES		$8,170,786.00
GOVERNMENT SUBSIDIES & GRANTS	MEDICAL VENDOR SERVICES		$11,062,021.00
TOTAL HOSPITAL SPENDING		**$13,171,622.00**	**$19,232,807.00**
TOTAL RETENTION SPENDING		**$13,241,285.84**	**$19,273,699.48**

For the FY26 Budget, total District Retention was budgeted at $19,232,807. These amounts were included within line items 70200-Managed Care Organizations (MCO) (HT0) cost centers and HT0.Inpatient Hospital Directed Payments Provider Fee Fund and HT0. Outpatient Hospital Directed Payments Provider Fee Fund projects. The line items totaled $35,537,024.96 and $52,826,215.26 for inpatient and outpatient, respectively. Additionally, FY 2026 BSA Title VII Subtitle I transferred $5,031,741 of District Retention from the Outpatient Directed Payment Fund to the Local fund.

38. **Please provide the following data regarding the MCOs, including any changes from FY 2024 and reasons for the change for FY 2025 and FY 2026, to date:**
    a. Eligibility requirements;
    b. Services provided per MCO including value-add services; and
    c. Reimbursement rates and methodologies per clinical specialty.

Response:

a. Effective October 2025, DHCF transitioned eligible persons enrolled in the DC Healthcare Alliance and Immigrant Children's Program from managed care and transitioned to Fee-for-service (FFS) Medicaid.

Effective October 2025, DHCF extended eligibility through the *CHIP Unborn Child* Option, renamed locally as From-Conception-to-End-of-Pregnancy (FCEP). This eligibility pathway extends coverage of prenatal, labor and delivery, and postpartum care to pregnant individuals up to 324% of the FPL. For additional eligibility requirements see Pregnant Individuals

Effective January 2026, Childless adults and parent/caregiver relatives ages 21 years and older with incomes at or above 138% of the federal poverty level (FPL) will no longer be eligible for Medicaid. D.C. Medicaid Income Eligibility Changes Effective January 1, 2026

b. Each MCO delivers a core set of Medicaid-covered services listed here- Medicaid Covered Services.In FY2025, DHCF added Cell and Gene Therapies (CGT) and discontinued coverage for COVID-19 Testing Kits. The MCPs scope of coverage is outlined below.

New Cell and Gene Therapies (CGT)

Lyfgenia and Casgevy are FDA-approved CGT medications indicated for the treatment of sickle cell disease for patients aged 12 years and older. These medications must be administered exclusively at inpatient facilities that are qualified treatment centers. The Medicaid FFS program is responsible for reimbursement of approved inpatient CGT medications provided to eligible beneficiaries enrolled in DC Medicaid. The medication component of these therapies will be carved-out of the Diagnosis Related Treatment Group (DRG) bundled payment methodology and reimbursed separately under the fee-for service (FFS) Medicaid program.

MCPs are responsible for all other healthcare costs associated with CGTs, such as administration, inpatient stays, or other supportive care, like transportation. Providers must submit claims for these healthcare services directly to the beneficiaries' MCP for reimbursement.
For CGTs administered on an outpatient basis, FFS also reimburses for the medication, while MCPs are responsible for all other treatment and support needs, for their enrollees.

COVID-19 Testing Kits

DHCF's authority to cover testing kits expired in September 2024, at which time DHCF

requested a one-year extension. DHCF discontinued reimbursement for testing kits in September 2025.

FY2025 Value-added Benefits per Managed Care Plan

MCP	Value-Add Benefit	Description	Projected Enrollment Participation
AmeriHealth	Medically Tailored Meals/Groceries	Meal Delivery, Nutritionist Consult & Coaching	6300
	Respite Care with Temporary Housing	Temporary Housing with Care Coordination Post Inpatient Discharge	Unknown
	Healthy Housing Advocacy	Legal Assistance with Housing Conditions that Trigger Asthma	Unknown
	Chiropractic Services	Joint manipulation to reduce pain, correct alignment, and improve function.	Unknown
HSCSN	Fitness Training	Personal training up to 12 visits, ages 6 years and older.	200
	Home Modifications & Adaptions	Permanent alterations to support access, safety, and independence.	Unknown
	Medication Therapy Management	Expert, comprehensive, ongoing review of Enrollees' medication regimen by Pharmacists.	Unknown
	Paid Caregiver	Services typically provided by a Personal Care Aide but provided by a Natural Network member with training.	20
	Skilled Nursing for Caregiver Relief	Respite care for the family/caregiver.	120
	Summer Programs	Camps with varied focus dependent on the needs of the enrollee.	150
	Wellness Center	Access to Care Management services and a Benefits Manager, Educational Groups	Unlimited
MedStar Family Choice	Culinary and Nutrition Cooking Program	Nutrition consultation, Educational Workshops, Cooking Classes	130

	Community Wellness Center	Access to Care Management services and a Benefits Manager, Educational Groups	600
	Meal Delivery	18 meals per week for enrollees with 12 Qualifying conditions.	Unknown
	Tooth Care	Application of Silver Diamine Fluoride	Unknown
	The Goal Standard Fitness	Fitness Videos and Interactive Sessions	400
Wellpoint (formerly Amerigroup)	Active & Fit	Online Fitness Videos and Newsletters, Weight Watchers Vouchers, Gym Membership.	50% of enrollees
	Farm to Table Produce	Food delivery	6% of enrollees
	GED Assistance	Covers cost of the exam.	Unlimited

c. MCPs negotiate rates in agreements with Providers. The DHCF Medicaid Fee Schedule is a reference for negotiations.

39. **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?**
    a. **What specific performance metrics are used to track and evaluate their compliance?**
    b. **At what cadence are these performance metrics collected and reported back to DHCF?**
    c. **Please include a description of any corrective action plans or penalties and the status of each MCO's compliance with each plan**

Response:

DHCF oversees MCP performance through a variety of activities directed by dedicated staff, including contractually required reporting submitted on a weekly, monthly, quarterly and annual basis. 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 MCP's efforts to achieve optimal outcomes for the enrolled population.

MCPs submit encounter data, or a representation of claims paid or denied for each enrolled beneficiary, to DHCF weekly. The encounter data 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 MCP'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 MCP'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 MCP. The information is reviewed and analyzed by contracted actuaries, resulting in a complete report to DHCF about the financial condition of each MCP. 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 MCP 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 MCPs;
- Validation of performance measures used by the MCPs;
- Ensure MCPs comply with the regulations of the Medicaid managed care program; and
- Validation of the adequacy of the MCPs' 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)
- Developing a Consumer Report Card on the MCPs' performance
- Complete focus studies about health care quality
- Implementation of Performance Improvement Plans, and
- Encounter Data Validation (Medical Records review)

In addition, DHCF employs staff whose primary function is to oversee the Medicaid managed care program. Staff hold recurring meetings with each MCP's key personnel responsible for administering all aspects of the managed care contract. These meetings are used to discuss observations of performance, derived from analyses of reports, programmatic updates, feedback from health care providers, Medicaid beneficiaries, District-agencies and other community stakeholders. MCPs 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.

a. DHCF generally uses industry standard performance metrics to track and evaluate the MCP's compliance. This is important for comparing performance and validation of the outcomes.

   Current performance metrics used by DHCF include 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 MCPs) performance within specific areas or domains of care, applicable to the program's covered services for children and adults.

   CMS uses the 416 Report to assess both MCP'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 MCPs 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.

   AmeriHealth Caritas, DC
   No current Compliance violations noted.

Health Services for Children with Special Needs, DC (HSCSN)

Notices of non-compliance were issued in December 2025.

MedStar Family Choice, DC (MedStar)

Warning letters and a notice of non-compliance were issued in December 2025.

Wellpoint, DC

Corrective Action Plan issued in connection in July 2025.

40. **DHCF stated in its FY 2024 performance oversight responses that it is no longer transitioning beneficiaries, including children and youth in foster care, from fee for service to managed care. Please provide a rationale for this decision.**

Response:

DHCF initially announced Medicaid reform efforts in 2019, with a focus of Transitioning most Medicaid beneficiaries into the managed care delivery system over a five-year period. The first phase was executed in October 2020 when DHCF mandated that specific adult populations be enrolled in managed care.

Other efforts to require Medicaid enrollment into managed care, including children and youth in foster care and individuals receiving long-term services and supports, did not move forward because DHCF reprioritized efforts. This included developing and implementing a special needs plan for adults dually enrolled in Medicaid and Medicare (known as Dual Choice) and the program of all-inclusive care for the elderly (PACE). This path allowed DHCF to gain experience in establishing managed care or managed care-like programs for populations with special needs. Additionally, DHCF pursued carving-in behavioral health services into managed care, which was paused in February 2024.

41. **Federal regulations require an annual program independent review of the Medicaid Managed Care program. Please provide a copy of the review for FY 2025, or the most recent review conducted. Also include the following information:**
    a. **The agency's response to the key findings and conclusions; and**
    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 to be performed by an External Quality Review Organization (EQRO). To comply with the requirement, the Department of Health Care Finance (DHCF) contracts with Qlarant, an external quality review organization (EQRO), to conduct annual, independent reviews of the District's MCPs, as required in the Code of Federal Regulations (42 CFR §438.350). Qlarant assesses MCP compliance with federal and DHCF specific requirements by conducting several audit reviews including;

• Performance Improvement Project (PIP) Validation
• Performance Measure Validation (PMV)
• Compliance Review also referenced as Operational Systems Review (OSR)
• Network Adequacy Validation (NAV)
• Encounter Data Validation (EDV)
• Network Adequacy Survey Focus Study
• Maternal Health and Birth Outcomes Focus Study

The most recent review is the 2024 Annual Technical Report (ATR) that can be found by clicking here OR provided as an attachment. The 2025 ATR will be available April 2026.

a. Key findings and MCP performance for the four (4) participating Managed Care Plans (AmeriHealth, MedStar, Wellpoint formerly Amerigroup, and HSCSN) are below.

- **Performance Improvement Project Validation.** The MCPs conducted two PIPs each and reported performance measure results for MY2023 (MY: Measurement Year), as applicable. All MCPs were required to participate in a new Behavioral Health PIP and report baseline performance, as applicable. Amerigroup (AGP) was unable to report baseline performance due to the April 1, 2023, contract effective date. The MCPs' overall PIP validation scores ranged from 85.7%-100%. The DCHFP MCPs restarted their Maternal Health PIP. The MCPs reported baseline performance, as applicable, with AGP unable to report baseline performance due to the contract start period. Overall validation scores ranged from 94.6%-100%. HSCSN, reported second measurement results for the Childhood Obesity Management and Prevention PIP. The MCP achieved mixed results in the PIP measures and received an overall validation score of 84.0%.

- **Performance Measure Validation.** Qlarant conducted two PMV audits during 2024. The first audit focused on validating the accuracy of select PIP and CMS Adult and Child Core Set measures. The second audit focused on validating the accuracy of Early and Periodic

Screening, Diagnostic, and Treatment (EPSDT) measures. Information Systems Capabilities Assessments (ISCAs) determined that the MCPs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. MCPs received overall PMV ratings of 100% for the PIP and Core measures and 100% for the EPSDT measures.

- **Operational Systems Review.** Qlarant conducted a comprehensive OSR in 2024. The MCPs provided evidence of having operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. MCP scores ranged from 96-100% (rounded from 99.72%). All MCPs were required to develop and implement corrective action plans (CAPs) to address noncompliance with standards, most of which related to the Grievance and Appeal System Standard.

- **Network Adequacy Validation**. All MCPs demonstrated high confidence in how they calculate and report compliance with the District's provider network adequacy standards. All MCPs received a high confidence rating in each indicator they reported, except MFC, receiving a moderate confidence rating in one pharmacy indicator. All MCPs failed to report all required indicators to DHCF. Each MCP omitted between three and 17 indicators. MCPs must include these indicators in their future reports. Reporting all required indicators provides DHCF with a complete picture of MCPs' compliance levels.

- **Encounter Data Validation.** A medical record review resulted in an overall encounter data accuracy rate of 94.5%, a 4.7 percentage point improvement over the previous annual MCP average of 89.8%. Individual MCP performance ranged from 90.9%-97.6%. Insufficient documentation in the medical record was the most frequent contribution to noncompliance.

- **Network Adequacy Survey Focus Study.** All MCPs have robust provider networks and demonstrated compliance with geographic and provider-to-enrollee requirements, as applicable. During 2024, DCHFP and CASSIP MCP performance ranged from 77%-100% for timely access to routine and urgent care for both adults and children. Performance improved over the last year for adult access to routine and urgent appointments and pediatric access to routine and urgent appointments. Overall provider directory accuracy declined with the DCHFP and CASSIP MCP average dropping from 56% to 41% in MY 2024.

- **Maternal Health and Birth Outcomes Focus Study.** The first annual assessment was conducted in 2024. On average, 48% of Managed Care enrollees received early and adequate prenatal care. Birth mothers aged 40-49 years were most frequently the recipients of this care. Correlations between early and adequate prenatal care and birth outcomes were identified by MCP, birthing person's age, and District Ward. More than half of Medicaid managed care enrollee births are to residents in Wards 7 and 8, where early and adequate prenatal care rates were 49% and 45%, respectively. An analysis of race and ethnicity was not completed as a result of limitations in the data. The study will continue to identify trends and possible impacts of interventions.

Based on these findings, Qlarant's conclusions are as follows:

- In terms of quality and timely access to care, on average, MCPs are meeting requirements

and demonstrating their commitment to quality improvement.

- In most instances, stakeholders can have high confidence in their compliance with federal regulations and DHCF contract requirements.
- While PIP performance measure results were mixed, there were signs of improvement in timely access to PCP appointments. MCP HEDIS and CAHPS performance, on average, did not compare favorably to national average benchmarks.
- Overall, MCPs improved compliance with structural and operational standards in the OSR. Qlarant attributes this improvement to DHCF's enhanced quality improvement approach and closely monitoring MCP performance and compliance, and as needed, corrective actions.

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

DHCF continues to monitor and track MCP performance to ensure all MCPs remain compliant, in addition to partnering with the MCPs to develop strategies and plans of action for opportunities for improvement.

42. **DHCF shared in its FY 2024 performance oversight responses that they are in the initial phases of reviewing the Value Based Payment (VBP) arrangements established by the MCOs. Please share what DHCF has done in FY 2025 and FY 2026 to prepare the report on Medicaid MCO value-based purchasing, and an anticipated publication date for the report.**
    a. Please share what the annual adoption targets that each MCO VBP must meet are.

Response:

In FY2025, DHCF developed a Value-Based Purchasing (VBP) Framework for Medicaid managed care plans (MCPs). In support of public reporting and ongoing VBP oversight, the Framework defines the overall structure and performance expectations (including priority domains, standardized measure alignment, and monitoring requirements), streamlines DHCF's collection of MCP-submitted VBP data, and specifies the data sources DHCF will use for annual performance monitoring.

In December 2025, DHCF collected projected FY2026 data for the MCPs' VBP arrangements to support program oversight and public reporting in advance of implementation, which will begin for MCPs on January 1, 2026. The anticipated publication date for the CY2025 VBP report is September 2026. This allows for a customary claims' run-out period to collect a comprehensive data set of information.

a. DHCF has established target levels for the share of total medical expenditures that must be under VBP arrangements and has specified the applicable Health Care Payment Learning and Action Network (HCP-LAN) categories. The chart below summarizes the targets for CY2026 and CY2027.

Calendar Year	Required Percentage of Total Medical Expenditures Through VBP Arrangements (2C or Above)
2026	**50%***
*For purposes of satisfying the requirement that 50% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must: • Ensure at least one-half (25%) of qualifying total medical expenditures are through models in LAN categories 3–4 • Ensure at least one-quarter (12.5%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, or primary/preventive care domain • Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)	
2027	**60%****
**For purposes of satisfying the requirement that 60% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must: • Ensure at least one-half (30%) of qualifying total medical expenditures are through models in LAN categories 3–4 • Ensure at least one-quarter (15%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, or primary/preventive care domain • Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)	

43. **Please provide FY 2025 and FY 2026 to date accreditation status for each MCO and any other entities that DHCF requires accreditation for, including what entity is performing the accreditation and their accreditation standards.**

Response:

The District's Managed Care Plans are contractually obligated to be accredited by National Committee on Quality Assurance (NCQA), an independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. Table 1 below lists each MCPs' accreditation type and achievement date. NCQA's accreditation spans 3 years.

Table 1: Managed Care Plan Accreditation

Managed Care Plan	Accreditation Type	Date Received
AmeriHealth Caritas DC	NCQA Health Equity	May 2024
	NCQA Case Management	August 2023
	NCQA Health Plan	October 2024
MedStar Family Choice	NCQA Health Plan	February 2023
	NCQA Case Management	February 2025
Wellpoint, formerly Amerigroup	NCQA Health Plan	June 2025
	NCQA Health Equity	November 2025
HSCSN	NCQA Health Plan	August 2024
	NCQA Case Management	July 2024

44. **For FY 2025, and FY 2026, to date, please provide the following data for the Alliance program:**
    a. **Monthly enrollment data;**
    b. **Monthly spending on services; and**
    c. **Utilization of services, broken down by service type.**

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 1 to Q44.

45. **In FY 2025 and FY 2026, 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 were deemed eligible (in FY 2025 only);**
    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					
10/31/2024	241	186	55	12	70
11/30/2024	191	140	51	0	59
12/31/2024	263	195	68	7	63
1/31/2025	98	74	24	9	31
2/28/2025	18	14	4	9	4
3/31/2025	82	73	9	14	13
4/30/2025	636	571	65	10	127
5/31/2025	485	448	37	14	80
6/30/2025	490	453	37	17	79
7/31/2025	607	545	62	22	89
8/31/2025	623	565	58	26	119
9/30/2025	680	557	123	22	131
10/31/2025	1,232	1,063	169	21	177
11/30/2025	723	623	100	21	122
12/31/2025	525	422	103	6	62
Percent of the processed					
10/31/2024	100%	77%	23%	N/A	29%
11/30/2024	100%	73%	27%	N/A	31%

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**
12/31/2024	100%	74%	26%	N/A	24%
1/31/2025	100%	76%	24%	N/A	32%
2/28/2025	100%	78%	22%	N/A	22%
3/31/2025	100%	89%	11%	N/A	16%
4/30/2025	100%	90%	10%	N/A	20%
5/31/2025	100%	92%	8%	N/A	16%
6/30/2025	100%	92%	8%	N/A	16%
7/31/2025	100%	90%	10%	N/A	15%
8/31/2025	100%	91%	9%	N/A	19%
9/30/2025	100%	82%	18%	N/A	19%
10/31/2025	100%	86%	14%	N/A	14%
11/30/2025	100%	86%	14%	N/A	17%
12/31/2025	100%	80%	20%	N/A	12%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: All columns in the table increase for those due in April 2025 and beyond due to eligibility system changes that require most Alliance beneficiaries to actively respond to a renewal notice in order to retain coverage. 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.

As of FY 2026, Alliance beneficiaries receive coverage under a fee-for-service model, so the MCO assignment process is no longer applicable.

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			
10/31/2024	154	55	99
11/30/2024	145	51	94
12/31/2024	176	68	108
1/31/2025	63	24	39
2/28/2025	16	4	12
3/31/2025	67	9	58
4/30/2025	675	65	610
5/31/2025	561	37	524
6/30/2025	616	37	579
7/31/2025	728	62	666
8/31/2025	790	58	732
9/30/2025	940	123	817
10/31/2025	1,286	169	1,117
11/30/2025	1,309	100	1,209
12/31/2025	1,979	103	1,876
Percent of the disenrolled			
10/31/2024	100%	36%	64%
11/30/2024	100%	35%	65%
12/31/2024	100%	39%	61%
1/31/2025	100%	38%	62%
2/28/2025	100%	25%	75%
3/31/2025	100%	13%	87%
4/30/2025	100%	10%	90%
5/31/2025	100%	7%	93%
6/30/2025	100%	6%	94%
7/31/2025	100%	9%	91%
8/31/2025	100%	7%	93%
9/30/2025	100%	13%	87%
10/31/2025	100%	13%	87%
11/30/2025	100%	8%	92%
12/31/2025	100%	5%	95%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: All columns in the table increase for those due in April 2025 and beyond due to eligibility system changes that require most Alliance beneficiaries to actively respond to a renewal notice in order to retain coverage.

46. **Please describe the process that an Alliance enrollee who become pregnant and qualifies for Medicaid coverage would need to take. Please include:**
    - **a. Who the enrollee would need to inform;**
    - **b. What forms they may need to complete, and within what specified time frame;**
    - **c. Income requirements;**
    - **d. Services an enrollee can expect during the pregnancy and post-partum period including length of coverage;**
    - **e. How DHCF will notify the enrollee that their coverage is ending; and**
    - **f. What coverage is available to both the parent and their child after pregnancy-related Medicaid coverage ends.**

Response:

District of Columbia Medicaid provides **two** types of medical coverage to pregnant individuals with income up to 319% of the federal poverty level (FPL) plus a 5% income disregard. **CHIP From Conception to End of Pregnancy** (previously known as Unborn Child) **and Medicaid** for pregnant individuals. See eligibility criteria below:

CHIP From-Conception-to-End-of-Pregnancy (FCEP)

- Pregnant
- DC Resident
- Regardless of immigration status
- Meet income requirements (319% FPL)
- Not enrolled or eligible for Medicaid or Medicare

Medicaid Program

- Pregnant
- DC Resident
- US Citizen or eligible immigration status
- Meet income requirements (319% FPL)

Each eligibility category provides comprehensive coverage, including care related the pregnancy, labor, and delivery and any complications that may occur during pregnancy, as well as post-partum care which begins on the date the pregnancy ends. CHIP From Conception to End of Pregnancy offers an additional **two (2) months** post-partum care, and Medicaid offers an additional **twelve (12) months** of post-partum care.

Once the birth is reported, the child will automatically enroll in Medicaid until their first birthday, at which time they will need to be redetermined for Medicaid eligibility.

Current Alliance/Medicaid enrollees need to report a change of circumstances to be enrolled in CHIP From Conception to End of Pregnancy/Medicaid for Pregnant Individuals. Residents can report your pregnancy through all available methods, such as District Direct, phone, fax, mail or in-person. Beneficiaries are to report that they are pregnant and the expected due date (or date of conception). No additional verification is needed.

Residents who are not currently enrolled in a DHCF administered program need to apply to be

determined eligible. Residents can apply for health coverage through District Direct, phone, fax,
mail or in person. If eligible, coverage will begin the first month of application.
Once coverage ends, residents will be redetermined for alternative coverage under Alliance or Medicaid. If the resident qualifies for additional coverage, they will receive notice altering them
to a change in eligibility. If the resident does not qualify for further coverage, they will receive a
notice of adverse action. Residents over the age of 26 who applied after October 1, 2025 are not
eligible for enrollment into the Alliance program due to the enrollment moratorium.

47. **Please describe how DHCF is working with DBH to transition Alliance beneficiaries out of coverage who are losing access to critical behavioral health and substance use services like ACT teams, and what coverage will still be covered locally.**

Response:

Alliance beneficiaries who were over 138% of the FPL lost coverage on 9/30/2025 and are no longer covered for DBH services. Former Alliance beneficiaries who were lawfully present and successfully transferred to the Healthy DC Plan after 9/30/2025, have access to mental and behavioral health.
Former Alliance beneficiaries who were over 138% of the FPL and are undocumented may be able to access mental or behavioral health services under Emergency Medicaid if the episode qualifies for emergent under the policy.

48. **How many beneficiaries were in the middle any type of any type of care or treatment plan in FY 2025 who lost Alliance coverage in FY 2026 that DHCF extended benefits to cover care?**
    a. **Please share the number of beneficiaries per treatment category (for examples, Cancer care, oral surgery, substance use treatment, treatment for a serious mental illness, etc.) and how long coverage was extended.**

Response:

Benefit/Service	Number of beneficiaries	MCO benefit or Value Add
Chiropractic	1	Value Add
Dental	5	MCO
Hearing	0	MCO
Home Health	6	MCO
Infusion	1	
NEMT*	0	MCO
Podiatry	0	MCO
Skilled Nursing- Rehab	0	MCO
Vision(optometry/glasses)	0	MCO

* NEMT-non emergent transportation

Dental coverage was extended to cover patients until the completion of their treatment Home health Hospice, Skilled Nursing-Rehab, podiatry, hearing, vision was afforded a 30-day bridge until October 30th to complete any treatment in progress. These are the only benefits which were terminated as of October 1, 2026. Non emergent transportation was not extended for 30 days since it was a benefit only offered by the managed care plans.

49. **Please detail all software upgrades made to the DC Access System (DCAS) in FY 2025 and FY 2026, to date, including the date of the upgrade, the problem being addressed, and the status of the upgrade (completed, pending, paused, etc.)**

Response:

Project	Purpose	Date	Status
OHS/OUD Upgrade to v12.2.1.4	To address security updates and enhance system stability	Jan 1st, 2024	Completed
Upgrade Curam from v7.0.11.0_iFix3 to v8.1.1.0	To ensure compliance with Merative releases and integration with other compliant systems.	July 7th 2024	Completed
Upgrade Weblogic Server from 12.2.1.4 to 14.1.1.0	To support Curam Product upgrade and enhance system stability	July 7th 2024	Completed
Informatica Upgrade 10.4.1 to 10.5.5	The upgrade to Informatica V10.5.5 will enhance system stability, reduce processing errors, and improve data exchange efficiency with external agencies such as SSA, CMS, and IRS. This leads to optimized operations, minimizing delays, and ensuring compliance with data-sharing standards, offering long-term operational savings and improved service reliability.	June 8th 2024	Completed
Batch Scheduler Migration (Control M)	Transition batch scheduling operations from UC4 to Control-M, enhancing job scheduling efficiency, monitoring, and automation capabilities.	March 05th, 2025	Completed
Mongo DB Upgrade v7.0.0.8	To enhance performance, security, and access to new features and to keep up with vendor EOL dates.	Aug 15th, 2025	Completed
AWS Cloud Migration	Migrate the DCAS (Curám) application from an on-premises environment to AWS Cloud to enhance scalability, flexibility, and performance.	Sep 01st, 2025	Completed
RHEL Upgrade 7.9 to 8.10	To access improved performance, enhanced security, and the latest features while extending hardware life and modernizing the environment.	Sep 01st, 2025	Completed
Migrate to OCTO Cloud Splunk v9.3.2411.121	To monitor security, including threat detection and fraud as well as Security Information and Event Management (SIEM) activity.	Sep 01st, 2025	Completed
Oracle IAM Upgrade & Migration	Enhance and modernize the Oracle Identity and Access Management (OIAM) environment through a	Dec 21st, 2025	Completed

	comprehensive upgrade and migration.		

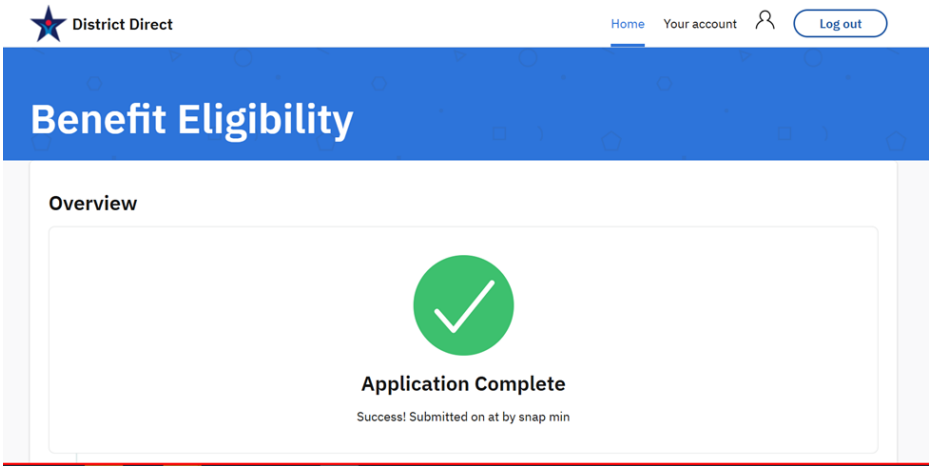
50. **Please provide spending/costs, both actual and projected, for FY 2025 and FY 2026, to date, for Information Technology Management, broken down by IT equipment and IT contracts.**

Response:
Please see Q50 Attachment.

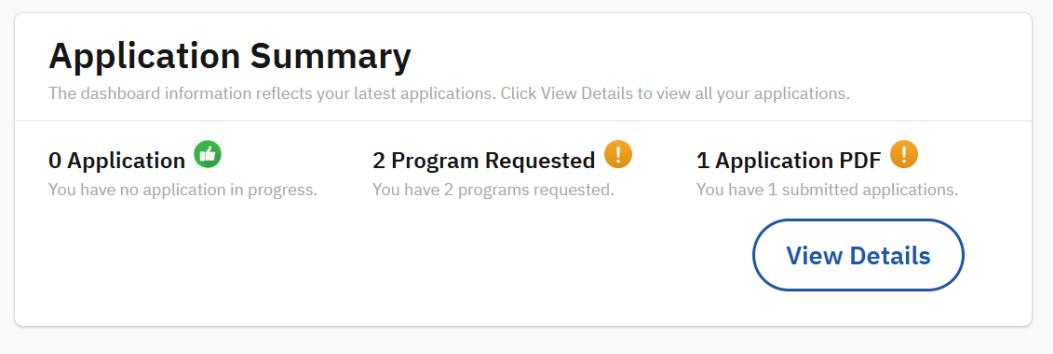
51. **Please provide the steps DHCF has taken in FY 2025 and FY 2026, to date, to address the following common complaints about the DCAS application system including:**
    a. No confirmation of completed application; and
    b. Benefits cut off when a completed application is pending.

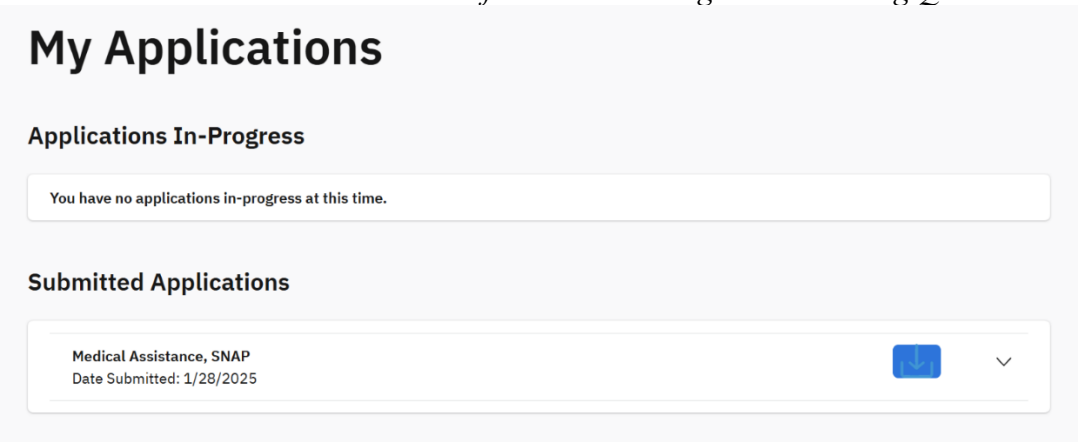
Response:

a. 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:





Response:

b. 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.

52. **Please describe how DCAS used Amazon Web Services in FY 2025 and FY 2026, to date.**

Response:

DCAS leverages Amazon Web Services (AWS) cloud infrastructure to host and operate DCAS environments previously maintained on on-premises systems. This cloud modernization enables us to support more scalable and resilient system operations, a faster response to policy or programmatic changes, and improved system performance during peak demand periods, including centralized management of production, testing and development environments.

In addition, AWS supports our security and compliance framework, including encryption, access controls, and continuous monitoring, strengthening DCAS's alignment with federal and District security requirements.

53. **For Medicaid enrollees required to renew manually in FY 2025 and FY 2026 to date, please provide, broken out by month:**
    a. **The number and percentage of enrollees that returned renewal forms prior to the end of their certification period;**
    b. **The number and percentage of enrollees that were terminated for failure to manually renew prior to end of their certification period; and**
    c. **The number and percentage of enrollees 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 2025 and FY 2026 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 included 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 through the March 2025 cohort who responded during their one-month extension. The one-month extension stopped with the April 2025 cohort. Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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 through the March 2025 cohort. Beginning with the April 2025 cohort, all beneficiaries are terminated at their certification date because the one-month extension for non-MAGI beneficiaries ended.

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 through the March 2025 cohort terminated after the one- month extension who returned a renewal form during their 90-day grace period. Beginning with the April 2025 cohort, all beneficiaries are terminated at their certification date because the one-month extension for non-MAGI beneficiaries ended.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**Total receiving non-passive 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 reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**	
Number of beneficiaries						
2024-10-31*	5,350	3,113	1,577	56	990	604
2024-11-30*	4,479	2,425	1,493	63	907	498
2024-12-31*	3,703	1,879	1,440	15	729	369
2025-01-31*	2,713	1,407	988	21	536	297
2025-02-28*	2,653	1,418	925	40	444	270
2025-03-31*	3,136	1,845	1,190	36	631	65
2025-04-30	6,243	3,118	3,096		1,495	29
2025-05-31	4,601	2,308	2,280		895	13
2025-06-30	5,804	2,968	2,791		1,293	45
2025-07-31	6,906	3,756	3,116		1,393	34
2025-08-31	6,166	3,392	2,728		1,374	46
2025-09-30	2,905	1,553	1,346		523	6
2025-10-31	3,810	2,067	1,733		666	10
2025-11-30	4,078	2,075	1,990		569	13
2025-12-31	4,614	2,029	2,575		35	10
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	58%	29%	1%	19%	11%
2024-11-30*	100%	54%	33%	1%	20%	11%
2024-12-31*	100%	51%	39%	0%	20%	10%
2025-01-31*	100%	52%	36%	1%	20%	11%
2025-02-28*	100%	53%	35%	2%	17%	10%
2025-03-31*	100%	59%	38%	1%	20%	2%
2025-04-30	100%	50%	50%		24%	0%
2025-05-31	100%	50%	50%		19%	0%
2025-06-30	100%	51%	48%		22%	1%
2025-07-31	100%	54%	45%		20%	0%
2025-08-31	100%	55%	44%		22%	1%
2025-09-30	100%	53%	46%		18%	0%
2025-10-31	100%	54%	45%		17%	0%
2025-11-30	100%	51%	49%		14%	0%
2025-12-31	100%	44%	56%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.
* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to the beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to many 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 (through the 3/2025 cohort).
- Column 4 reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 includes non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- 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 (through the 3/2025 cohort). 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 October 2025 and later 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 existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

54. **For enrollees who were terminated for procedural reasons in FY 2025 and FY 2026, 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. It reflects non-MAGI beneficiaries in a cohort through March 2025 terminated after a one-month extension and non-MAGI beneficiaries in a cohort starting in April 2025 or later terminated at their certification date because the one-month extension ended. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 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. Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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.

Medicaid Beneficiaries Terminated for Failure to Manually Review and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6
Recertification Date	**Date of renewal received is known**				**Renewal received with an unknown date**
	Terminated for failure to manually renew prior to the end of their certification period	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period**	**Lost coverage at the end of their certification period and were not able to regain coverage during the 90-day grace period following the end of their certification period**	**Average number of days into the grace period the renewal was submitted**	
Number of beneficiaries					
2024-10-31*	1,577	990	587	57	604
2024-11-30*	1,493	907	586	40	498
2024-12-31*	1,440	729	711	37	369
2025-01-31*	988	536	452	32	297
2025-02-28*	925	444	481	32	270
2025-03-31*	1,190	631	559	29	65
2025-04-30	3,096	1,495	1,601	32	29
2025-05-31	2,280	895	1,385	32	13
2025-06-30	2,791	1,293	1,498	28	45
2025-	3,116	1,393	1,723	29	34

07-31					
2025-08-31	2,728	1,374	1,354	27	46
2025-09-30	1,346	523	823	27	6
2025-10-31	1,733	666	1,067	22	10
2025-11-30	1,990	569	1,421	13	13
2025-12-31	2,575	35	2,540	2	10
Percent of total terminated for failure to manually renew prior to certification end					
2024-10-31*	100%	63%	37%	N/A	N/A
2024-11-30*	100%	61%	39%	N/A	N/A
2024-12-31*	100%	51%	49%	N/A	N/A
2025-01-31*	100%	54%	46%	N/A	N/A
2025-02-28*	100%	48%	52%	N/A	N/A
2025-03-31*	100%	53%	47%	N/A	N/A
2025-04-30	100%	48%	52%	N/A	N/A
2025-05-31	100%	39%	61%	N/A	N/A
2025-06-30	100%	46%	54%	N/A	N/A
2025-07-31	100%	45%	55%	N/A	N/A
2025-08-31	100%	50%	50%	N/A	N/A
2025-09-30	100%	39%	61%	N/A	N/A
2025-10-31	100%	38%	62%	N/A	N/A
2025-11-30	100%	29%	71%	N/A	N/A
2025-12-31	100%	1%	99%	N/A	N/A

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal. 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 (which allows future renewals to be initiated), 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 (through the 3/2025 cohort).
- 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 October 2025 and later 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 existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

55. **Regarding renewal notices:**
    a. **Of Medicaid enrollees who have been required to renew manually in FY 2025 and FY 2026, 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 DHCF has encountered in sending notices to Medicaid recipients in FY 2025 and FY 2026, to date, and any steps DHCF is taking to address these issues**

Response:

a. See table below. It reflects Medicaid enrollees required to renew manually (i.e., non-passively) in FY 2025 and FY 2026 YTD.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form by Pre-Populated Status, FY 2025 and FY 2026 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
2024-10-31	5,350	4,951	3,782	1,169
2024-11-30	4,479	4,270	3,599	671
2024-12-31	3,703	3,652	3,387	265
2025-01-31	2,713	2,700	2,446	254
2025-02-28	2,653	2,536	2,154	382
2025-03-31	3,136	3,009	2,584	425
2025-04-30	6,243	6,138	5,713	425
2025-05-31	4,601	4,495	4,019	476
2025-06-30	5,804	5,780	5,178	602
2025-07-31	6,906	6,864	6,257	607
2025-08-31	6,166	6,102	5,512	590
2025-09-30	2,905	2,860	2,262	598
2025-10-31	3,810	3,616	3,290	326
2025-11-30	4,078	3,945	2,770	1,175
2025-12-31	4,614	4,547	4,065	482

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: The number of beneficiaries required to submit the conversion form declined substantially since 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).

b. Medicaid beneficiaries receive renewals 60 to 90 days in advance of their renewal end date.

There were no issues with generating the 60- or 90-day advance renewal notices in FY 2025 or FY 2026 to date. These notices are generated in advance with validation controls in place to ensure timely and accurate delivery.

56. **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 2025 and FY 2026, to date? For each form, please include the following info for FY 2025 and FY 2026, to date:**
    a. **How many people (as a raw number and percentage) returned the form before the date of termination of their Medical Assistance?**
    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?**
    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?**
    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?**

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 2025 and FY 2026 YTD.

Medicaid Beneficiaries Due for Renewal by Non-Passive Renewal Form Type, FY 2025 and FY 2026 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					
2024-10-31	34,574	5,350	399	1,169	3,782
2024-11-30	23,589	4,479	209	671	3,599
2024-12-31	32,477	3,703	51	265	3,387
2025-01-31	19,122	2,713	15	254	2,446
2025-02-28	18,671	2,653	118	382	2,154
2025-03-31	18,956	3,136	128	425	2,584
2025-04-30	18,885	6,243	106	425	5,713
2025-05-31	15,136	4,601	106	476	4,019
2025-06-30	18,056	5,804	25	602	5,178
2025-07-31	21,901	6,906	44	607	6,257
2025-08-31	20,659	6,166	64	590	5,512
2025-09-30	18,748	2,905	46	598	2,262
2025-10-31	32,658	3,810	194	326	3,290
2025-11-30	24,478	4,078	133	1,175	2,770
2025-12-31	33,404	4,614	67	482	4,065

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**
Percent of total due for renewal					
2024-10-31	100%	15%	1%	3%	11%
2024-11-30	100%	19%	1%	3%	15%
2024-12-31	100%	11%	0%	1%	10%
2025-01-31	100%	14%	0%	1%	13%
2025-02-28	100%	14%	1%	2%	12%
2025-03-31	100%	17%	1%	2%	14%
2025-04-30	100%	33%	1%	2%	30%
2025-05-31	100%	30%	1%	3%	27%
2025-06-30	100%	32%	0%	3%	29%
2025-07-31	100%	32%	0%	3%	29%
2025-08-31	100%	30%	0%	3%	27%
2025-09-30	100%	15%	0%	3%	12%
2025-10-31	100%	12%	1%	1%	10%
2025-11-30	100%	17%	1%	5%	11%
2025-12-31	100%	14%	0%	1%	12%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

For each form, please include the following info for FY 2025 and FY 2026, to date:

a. 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 included 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

b. 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. 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

d. 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Medicaid Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**Total receiving conversion 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 reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**	
Number of beneficiaries						
2024-10-31*	399	210	92	8	24	89
2024-11-30*	209	112	51	23	14	23
2024-12-31*	51	20	20	2	1	9
2025-01-31*	15	5	4	1	0	5
2025-02-28*	118	50	42	13	12	13
2025-03-31*	128	64	28	9	20	27
2025-04-30	106	54	52		23	0
2025-05-31	106	62	44		15	0
2025-06-30	25	13	12		6	0
2025-07-31	44	20	24		11	0
2025-08-31	64	23	40		7	1
2025-09-30	46	29	17		6	0
2025-10-31	194	92	102		20	0
2025-11-30	133	98	35		17	0
2025-12-31	67	48	19		1	0
Percent of total receiving conversion renewal form						
2024-10-31*	100%	53%	23%	2%	6%	22%
2024-11-30*	100%	54%	24%	11%	7%	11%
2024-12-31*	100%	39%	39%	4%	2%	18%
2025-01-31*	100%	33%	27%	7%	0%	33%
2025-02-28*	100%	42%	36%	11%	10%	11%
2025-03-31*	100%	50%	22%	7%	16%	21%
2025-04-30	100%	51%	49%		22%	0%
2025-05-31	100%	58%	42%		14%	0%
2025-06-30	100%	52%	48%		24%	0%
2025-07-31	100%	45%	55%		25%	0%

1	2	3	4	5	6	7
Recertification Date	**Total receiving conversion 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 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)**	
2025-08-31	100%	36%	63%		11%	2%
2025-09-30	100%	63%	37%		13%	0%
2025-10-31	100%	47%	53%		10%	0%
2025-11-30	100%	74%	26%		13%	0%
2025-12-31	100%	45%	18%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**Total receiving 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 reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**	
Number of beneficiaries						
2024-10-31*	1,169	827	198	48	56	96
2024-11-30*	671	422	144	40	36	65
2024-12-31*	265	173	58	13	17	21
2025-01-31*	254	147	66	20	26	21
2025-02-28*	382	237	99	27	35	19
2025-03-31*	425	271	93	27	24	34
2025-04-30	425	295	130		51	0
2025-05-31	476	318	158		57	0
2025-06-30	602	389	213		75	0
2025-07-31	607	400	207		75	0

1	2	3	4	5	6	7
Recertification Date	**Total receiving 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 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)**	
2025-08-31	590	416	174		78	0
2025-09-30	598	436	161		68	1
2025-10-31	326	224	102		38	0
2025-11-30	1,175	719	456		139	0
2025-12-31	482	275	204		5	3
Percent of total receiving non-MAGI renewal form						
2024-10-31*	100%	71%	17%	4%	5%	8%
2024-11-30*	100%	63%	21%	6%	5%	10%
2024-12-31*	100%	65%	22%	5%	6%	8%
2025-01-31*	100%	58%	26%	8%	10%	8%
2025-02-28*	100%	62%	26%	7%	9%	5%
2025-03-31*	100%	64%	22%	6%	6%	8%
2025-04-30	100%	69%	31%		12%	0%
2025-05-31	100%	67%	33%		12%	0%
2025-06-30	100%	65%	35%		12%	0%
2025-07-31	100%	66%	34%		12%	0%
2025-08-31	100%	71%	29%		13%	0%
2025-09-30	100%	73%	27%		11%	0%
2025-10-31	100%	69%	31%		12%	0%
2025-11-30	100%	61%	39%		12%	0%
2025-12-31	100%	57%	42%		1%	1%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

Medicaid Beneficiaries Receiving D2 (MAGI) Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertificatio	**Total**	**Date of renewal received is known**				**Renewal**

Date	receiving non-passive D2 (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)	received with an unknown date
Number of beneficiaries						
2024-10-31*	3,782	2,076	1,287		910	419
2024-11-30*	3,599	1,891	1,298		857	410
2024-12-31*	3,387	1,686	1,362		711	339
2025-01-31*	2,446	1,255	920		510	271
2025-02-28*	2,154	1,131	785		397	238
2025-03-31*	2,584	1,510	1,070		596	4
2025-04-30	5,713	2,769	2,915		1,421	29
2025-05-31	4,019	1,928	2,078		823	13
2025-06-30	5,178	2,566	2,567		1,212	45
2025-07-31	6,257	3,336	2,887		1,307	34
2025-08-31	5,512	2,953	2,514		1,289	45
2025-09-30	2,262	1,088	1,169		449	5
2025-10-31	3,290	1,751	1,529		608	10
2025-11-30	2,770	1,258	1,499		413	13
2025-12-31	4,065	1,706	2,352		29	7
Percent of total receiving D2 (MAGI) renewal form						
2024-10-31*	100%	55%	34%		24%	11%
2024-11-30*	100%	53%	36%		24%	11%
2024-12-31*	100%	50%	40%		21%	10%
2025-01-31*	100%	51%	38%		21%	11%
2025-02-28*	100%	53%	36%		18%	11%
2025-03-31*	100%	58%	41%		23%	0%
2025-04-30	100%	48%	51%		25%	1%
2025-05-31	100%	48%	52%		20%	0%
2025-06-30	100%	50%	50%		23%	1%
2025-07-31	100%	53%	46%		21%	1%
2025-08-31	100%	54%	46%		23%	1%
2025-09-30	100%	48%	52%		20%	0%
2025-10-31	100%	53%	46%		18%	0%
2025-11-30	100%	45%	54%		15%	0%
2025-12-31	100%	42%	58%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2025.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to tables with data on conversion renewal forms: The number of beneficiaries required to submit the conversion form declined substantially since 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:

Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), 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 (through the 3/2025 cohort).
- Column 4 reflects MAGI beneficiaries terminated at their certification date and/or non- MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 includes non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- 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 (through the 3/2025 cohort). 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 2025 and later 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 existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 through March 2025 and led to an increase in renewals in these months with dates that are no longer readily available.

57. 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 2025 and in FY 2026, 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 2025 and in FY 2026, 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 2025 and in FY 2026, 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 2025 and in FY 2026, to date?

d. How many ABD enrollees lost coverage in FY 2025 and FY 2026 due to increased income?

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 2025 and FY 2026 YTD.

a. See columns 5 and 6 below.

Medicaid ABD Beneficiaries Due for Renewal by Passively Renewed and Non-Passive Renewal Form Type, FY 2025 and FY 2026 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					
2024-10-31	14,401	14,065	336	82	254
2024-11-30	2,416	2,030	386	113	273
2024-12-31	1,555	1,476	79	20	59
2025-01-31	664	615	49	3	46
2025-02-28	1,118	960	158	50	108
2025-03-31	1,014	824	190	66	124
2025-04-30	1,436	1,282	154	47	107
2025-05-31	1,389	1,223	166	52	114
2025-06-30	848	718	130	10	120

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**
2025-07-31	870	754	116	13	103
2025-08-31	1,549	1,377	172	14	158
2025-09-30	1,376	1,193	183	18	165
2025-10-31	11,906	11,810	96	12	84
2025-11-30	2,235	1,930	305	14	291
2025-12-31	1,707	1,529	178	6	172
Percent of total due for renewal					
2024-10-31	100%	98%	2%	1%	2%
2024-11-30	100%	84%	16%	5%	11%
2024-12-31	100%	95%	5%	1%	4%
2025-01-31	100%	93%	7%	0%	7%
2025-02-28	100%	86%	14%	4%	10%
2025-03-31	100%	81%	19%	7%	12%
2025-04-30	100%	89%	11%	3%	7%
2025-05-31	100%	88%	12%	4%	8%
2025-06-30	100%	85%	15%	1%	14%
2025-07-31	100%	87%	13%	1%	12%
2025-08-31	100%	89%	11%	1%	10%
2025-09-30	100%	87%	13%	1%	12%
2025-10-31	100%	99%	1%	0%	1%
2025-11-30	100%	86%	14%	1%	13%
2025-12-31	100%	90%	10%	0%	10%

Source: DHCF eligibility system data extracted January 5, 2026.
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 included 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**ABD beneficiaries required to complete the conversion 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)**	
Number of beneficiaries						
2024-10-31*	82	54	21	1	5	6
2024-11-30*	113	52	34	15	7	12
2024-12-31*	20	6	9	1	1	4
2025-01-31*	3	2	0	1	0	0
2025-02-28*	50	24	19	5	5	2
2025-03-31*	66	30	19	5	9	12
2025-04-30	47	25	22		13	0
2025-05-31	52	32	20		11	0
2025-06-30	10	4	6		4	0
2025-07-31	13	8	5		4	0
2025-08-31	14	7	7		3	0
2025-09-30	18	12	6		2	0
2025-10-31	12	7	5		4	0
2025-11-30	14	8	6		2	0
2025-12-31	6	4	2		0	0
Percent of total receiving conversion renewal form						
2024-10-31*	100%	66%	26%	1%	6%	7%
2024-11-30*	100%	46%	30%	13%	6%	11%
2024-12-31*	100%	30%	45%	5%	5%	20%
2025-01-31*	100%	67%	0%	33%	0%	0%
2025-02-28*	100%	48%	38%	10%	10%	4%
2025-03-31*	100%	45%	29%	8%	14%	18%
2025-04-30	100%	53%	47%		28%	0%
2025-05-31	100%	62%	38%		21%	0%
2025-06-30	100%	40%	60%		40%	0%
2025-07-31	100%	62%	38%		31%	0%

2025-08-31	100%	50%	50%		21%	0%
2025-09-30	100%	67%	33%		11%	0%
2025-10-31	100%	58%	42%		33%	0%
2025-11-30	100%	57%	43%		14%	0%
2025-12-31	100%	67%	33%		0%	0%

Source: DHCF eligibility system data extracted January 5, 2026.
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 included 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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 2025 and FY 2026 to Date

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)**	
Number of beneficiaries						
2024-10-31*	254	159	45	13	15	37
2024-11-30*	273	163	61	20	17	29
2024-12-31*	59	36	11	4	6	8
2025-01-31*	46	24	11	5	6	6

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)**	
2025-02-28*	108	76	21	6	15	5
2025-03-31*	124	79	29	7	9	9
2025-04-30	107	73	34		20	0
2025-05-31	114	71	43		24	0
2025-06-30	120	67	53		24	0
2025-07-31	103	58	45		17	0
2025-08-31	158	105	53		26	0
2025-09-30	165	118	46		26	1
2025-10-31	84	56	28		8	0
2025-11-30	291	171	120		37	0
2025-12-31	172	89	81		0	2
Percent of total receiving non-MAGI renewal form						
2024-10-31*	100%	63%	18%	5%	6%	15%
2024-11-30*	100%	60%	22%	7%	6%	11%
2024-12-31*	100%	61%	19%	7%	10%	14%
2025-01-31*	100%	52%	24%	11%	13%	13%
2025-02-28*	100%	70%	19%	6%	14%	5%
2025-03-31*	100%	64%	23%	6%	7%	7%
2025-04-30	100%	68%	32%		19%	0%
2025-05-31	100%	62%	38%		21%	0%
2025-06-30	100%	56%	44%		20%	0%
2025-07-31	100%	56%	44%		17%	0%
2025-08-31	100%	66%	34%		16%	0%
2025-09-30	100%	72%	28%		16%	1%
2025-10-31	100%	67%	33%		10%	0%
2025-11-30	100%	59%	41%		13%	0%
2025-12-31	100%	52%	47%		0%	1%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to tables that appear under responses to items b and c:
Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

*Due to a system process implemented to ensure that existing renewals are fully recognized in

DCAS (which allows future renewals to be initiated), 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 (through the 3/2025 cohort).
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- 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 (through the 3/2025 cohort). 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 October 2025 and later 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 existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

d. DHCF does not have readily available data on coverage losses due to increased income. However, DHCF can estimate that this figure would be very low. Columns 2 and 3 in Question 57a show that 94% of ABD beneficiaries were passively renewed in FY 2025 and FY 2026 to date. Column 4 in Question 57a shows that only 6% received a non-passive renewal form (an average of 180 beneficiaries per month). The number of beneficiaries that lost coverage due to an increase in income would be a subset of column 4.

58. 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 2025 and in FY 2026, to date?

a. How many QMB enrollees were sent the Conversion Renewal Form as a raw number and percentage of the overall QMB population in FY 2025 and in FY 2026, to date?

i. 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 2025 and in FY 2026, to date?

ii. 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 2025 and in FY 2026 to date?

Response:

For Qualified Medicare Beneficiary (QMB) only individuals (i.e., those with Medicaid coverage limited to payment of Medicare premiums and cost sharing) are required to submit the non-MAGI renewal form type, see column 6 of the table below. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

a. For Qualified Medicare Beneficiary (QMB) only individuals (i.e., those with Medicaid coverage limited to payment of Medicare premiums and cost sharing) are required to submit the conversion renewal form type, see column 5 of the table below. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

Medicaid QMB Only Beneficiaries Passively Renewed and Receiving Non-Passive Renewal Form by Form Type, FY 2025 and FY 2026 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					
2024-10-31	1,048	512	536	72	464
2024-11-30	1,750	1,279	471	93	378
2024-12-31	361	245	116	20	96

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**
2025-01-31	309	228	81	6	75
2025-02-28	902	687	215	50	165
2025-03-31	887	684	203	44	159
2025-04-30	929	683	246	41	205
2025-05-31	950	673	277	42	235
2025-06-30	728	366	362	10	352
2025-07-31	784	376	408	20	388
2025-08-31	1,170	823	347	33	314
2025-09-30	1,167	827	340	22	318
2025-10-31	1,263	972	291	64	227
2025-11-30	1,823	944	879	15	864
2025-12-31	579	282	297	11	286
Percent of total receiving non-passive renewal form					
2024-10-31	100%	49%	51%	7%	44%
2024-11-30	100%	73%	27%	5%	22%
2024-12-31	100%	68%	32%	6%	27%
2025-01-31	100%	74%	26%	2%	24%
2025-02-28	100%	76%	24%	6%	18%
2025-03-31	100%	77%	23%	5%	18%
2025-04-30	100%	74%	26%	4%	22%
2025-05-31	100%	71%	29%	4%	25%
2025-06-30	100%	50%	50%	1%	48%
2025-07-31	100%	48%	52%	3%	49%
2025-08-31	100%	70%	30%	3%	27%
2025-09-30	100%	71%	29%	2%	27%
2025-10-31	100%	77%	23%	5%	18%
2025-11-30	100%	52%	48%	1%	47%
2025-12-31	100%	49%	51%	2%	49%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

i. 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 included 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**QMB-only beneficiaries required to complete the conversion 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)**	
Number of beneficiaries						
2024-10-31*	72	49	10	1	0	12
2024-11-30*	93	57	17	8	7	11
2024-12-31*	20	11	5	1	0	3
2025-01-31*	6	1	3	0	0	2
2025-02-28*	50	23	14	7	3	6
2025-03-31*	44	26	8	3	1	7
2025-04-30	41	23	18		6	0
2025-05-31	42	23	19		2	0
2025-06-30	10	5	5		1	0
2025-07-31	20	9	11		4	0
2025-08-31	33	12	20		2	1
2025-09-30	22	13	9		4	0
2025-10-31	64	23	41		5	0
2025-11-30	15	12	3		1	0
2025-12-31	11	8	3		0	0
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	68%	14%	1%	0%	17%
2024-11-30*	100%	61%	18%	9%	8%	12%
2024-12-31*	100%	55%	25%	5%	0%	15%

1	2	3	4	5	6	7
Recertification Date	**QMB-only beneficiaries required to complete the conversion 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)**	
2025-01-31*	100%	17%	50%	0%	0%	33%
2025-02-28*	100%	46%	28%	14%	6%	12%
2025-03-31*	100%	59%	18%	7%	2%	16%
2025-04-30	100%	56%	44%		15%	0%
2025-05-31	100%	55%	45%		5%	0%
2025-06-30	100%	50%	50%		10%	0%
2025-07-31	100%	45%	55%		20%	0%
2025-08-31	100%	36%	61%		6%	3%
2025-09-30	100%	59%	41%		18%	0%
2025-10-31	100%	36%	64%		8%	0%
2025-11-30	100%	80%	20%		7%	0%
2025-12-31	100%	73%	27%		0%	0%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

ii. 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 included 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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

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. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.
Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 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 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	**QMB-only 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)**	
Number of beneficiaries						
2024-10-31*	464	328	92	9	26	35
2024-11-30*	378	241	82	19	18	36
2024-12-31*	96	66	20	2	5	8
2025-01-31*	75	43	21	5	7	6
2025-02-28*	165	101	48	8	12	8
2025-03-31*	159	95	37	9	9	18
2025-04-30	205	141	64		18	0
2025-05-31	235	152	83		19	0
2025-06-30	352	229	123		41	0
2025-07-31	388	255	133		50	0
2025-08-31	314	225	89		39	0
2025-09-30	318	234	84		27	0
2025-10-31	227	156	71		29	0
2025-11-30	864	529	335		101	0
2025-12-31	286	168	118		4	0
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	71%	20%	2%	6%	8%
2024-11-30*	100%	64%	22%	5%	5%	10%
2024-12-31*	100%	69%	21%	2%	5%	8%
2025-01-31*	100%	57%	28%	7%	9%	8%
2025-02-28*	100%	61%	29%	5%	7%	5%
2025-03-31*	100%	60%	23%	6%	6%	11%
2025-04-30	100%	69%	31%		9%	0%
2025-05-31	100%	65%	35%		8%	0%
2025-06-30	100%	65%	35%		12%	0%
2025-07-31	100%	66%	34%		13%	0%
2025-08-31	100%	72%	28%		12%	0%
2025-09-30	100%	74%	26%		8%	0%
2025-10-31	100%	69%	31%		13%	0%
2025-11-30	100%	61%	39%		12%	0%
2025-12-31	100%	59%	41%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2026.
Notes: See notes applicable to all tables at the end of this document.

Notes applicable to tables that appear under responses to items a and b:

Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to the 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 (through the 3/2025 cohort).
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- 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 (through the 3/2025 cohort). 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 2025 and later 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 existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available

59. Of the people who had their Medical Assistance terminated in FY 2025 and FY 2026, 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 2025 and in FY 2026, 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 2025 and in FY 2026 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 2025 and FY 2026 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 2025 and FY 2026 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									
2024-10-31	589	23	6	253	176	97	2	29	3
2024-11-30	489	25	0	220	137	85	0	21	1
2024-12-31	461	12	3	182	121	132	1	7	3
2025-01-31	362	4	6	173	101	72	0	5	1
2025-02-28	190	5	5	43	101	26	1	9	0
2025-03-31	202	3	2	48	111	36	0	2	0
2025-04-30	508	0	0	101	221	185	0	1	0
2025-05-31	288	2	0	59	155	69	1	2	0
2025-06-30	363	0	1	96	147	116	3	0	0
2025-07-31	365	1	1	89	175	97	1	0	1
2025-08-31	217	1	0	60	106	49	0	1	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**
2025-09-30	81	1	2	21	43	13	0	1	0
2025-10-31	112	0	3	38	51	17	0	3	0
2025-11-30	72	0	1	23	30	16	0	1	1
2025-12-31	104	0	0	19	45	38	0	2	0
Percent of total determined ineligible									
2024-10-31	100%	4%	1%	43%	30%	16%	0%	5%	1%
2024-11-30	100%	5%	0%	45%	28%	17%	0%	4%	0%
2024-12-31	100%	3%	1%	39%	26%	29%	0%	2%	1%
2025-01-31	100%	1%	2%	48%	28%	20%	0%	1%	0%
2025-02-28	100%	3%	3%	23%	53%	14%	1%	5%	0%
2025-03-31	100%	1%	1%	24%	55%	18%	0%	1%	0%
2025-04-30	100%	0%	0%	20%	44%	36%	0%	0%	0%
2025-05-31	100%	1%	0%	20%	54%	24%	0%	1%	0%
2025-06-30	100%	0%	0%	26%	40%	32%	1%	0%	0%
2025-07-31	100%	0%	0%	24%	48%	27%	0%	0%	0%
2025-08-31	100%	0%	0%	28%	49%	23%	0%	0%	0%
2025-09-30	100%	1%	2%	26%	53%	16%	0%	1%	0%
2025-10-31	100%	0%	3%	34%	46%	15%	0%	3%	0%
2025-11-30	100%	0%	1%	32%	42%	22%	0%	1%	1%
2025-12-31	100%	0%	0%	18%	43%	37%	0%	2%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: ABD is Aged, Blind, or Disabled; QMB is Qualified Medicare Beneficiary; "Other adults" reflects adults excluded from other groups, such as incarcerated.

60. Regarding new applications for Medicaid in FY 2025 and in FY 2026, 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;**
- **b. The number of applications submitted in person at ESA Service Centers;**
- **c. For applications not based on disability, please provide:**
  - **i. The number of these applications that were processed within 45 days of submission;**
- **d. For applications based on disability, please provide:**
  - **i. The number of these applications that were processed within 90 days of submission; and**
  - **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.**

Response:

a. The table below presents the total number of applications received each month of FY25 and FY26 YTD, along with the numbers that were submitted online.

Month	Total applications	Online applications
Oct-24	1,500	1,129
Nov-24	1,359	965
Dec-24	1,528	1,117
Jan-25	1,737	1,243
Feb-25	1,416	991
Mar-25	1,718	1,175
Apr-25	1,462	1,027
May-25	1,364	945
Jun-25	1,172	813
Jul-25	1,359	986
Aug-25	1,213	833
Sep-25	1,263	839
Oct-25	1,173	824
Nov-25	929	645
Dec-25	1,009	706

Source: DHCF eligibility system data compiled as of January 5, 2026.
Notes: Online reflects the District Direct website and mobile app.

b. The table below presents the total number of applications received each month of FY25 and FY26 YTD, along with the number that were submitted in-person.

Month	Total applications	Applications submitted in person
Oct-24	1,500	346
Nov-24	1,359	343
Dec-24	1,528	379
Jan-25	1,737	449
Feb-25	1,416	386
Mar-25	1,718	489
Apr-25	1,462	394
May-25	1,364	388
Jun-25	1,172	328
Jul-25	1,359	345
Aug-25	1,213	353
Sep-25	1,263	397
Oct-25	1,173	315
Nov-25	929	263
Dec-25	1,009	281

Source: DHCF eligibility system data compiled as of January 5, 2026.

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

    i. See response to Question 61.

Percent of Applications Processed Timely, FY 25 - FY 26 YTD

Month	Percent of MAGI Applications Processed Within 45 Days	Percent of Non-MAGI Applications Processed Within 90 Days
Oct-24	86%	93%
Nov-24	88%	94%
Dec-24	88%	98%
Jan-25	88%	88%
Feb-25	92%	99%
Mar-25	92%	99%
Apr-25	88%	97%
May-25	90%	86%
Jun-25	88%	95%
Jul-25	86%	96%
Aug-25	80%	92%
Sep-25	75%	91%
Oct-25	72%	95%
Nov-25	70%	100%

Dec-25	71%	93%

Source: DHCF eligibility system data compiled as of January 5, 2026.
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.

61. Please describe DHCF's efforts to reduce any backlog in processing applications including:

a. The metrics used to indicate backlog(s) have been reduced, and by how much; and
b. Steps DHCF has taken in FY 2025 or will take over the remainder of FY 2026 to investigate whether such backlogs exist, both for applications submitted online and for applications submitted at ESA Service Centers.

Response:

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

Ex Parte Process for Non-Magi Programs.

Ex Parte or Passive renewals are federally required. 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, as well as the 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.

Caseworkers are cross trained to ensure they can process all social services programs (SNAP, TANF, Medicaid, Alliance). DHCF has regular scheduled meetings with DHS's policy and training team to ensure alignment on policies and Medicaid changes. DHCF funded a contract from April 2023 through April 2025 that provided additional staff members to log applications and renewals that were handwritten or faxed into the system; staff members from that contract entered in 27,422 cases in FY23, 24,099 cases in FY24, and 10,056 in FY25.

a. The metrics used to indicate backlog(s) have been reduced, and by how much; and

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 case worker in order to receive an eligibility determination; it excludes applications not yet registered in DCAS. DHCF monitors the timeliness of application processing in part through a review of the percentage of Medicaid MAGI applications taking more than 45 days to process and the percentage of non-MAGI taking more than 90 days. In FY 2025 and FY 2026 Q1, the MAGI percentage ranged from 8% to 30% and the non-MAGI percentage ranged from 0% to 14%.

b. Steps DHCF has taken in FY 2025 or will take over the remainder of FY 2026 to investigate whether such backlogs exist, both for applications submitted online and for applications submitted at ESA Service Centers.

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

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, has lowered the number of cumulative outstanding renewal cases.

62. At any point in FY 2025 or in FY 2026, to date, has DHCF encountered "stuck" or "malformed" Medicaid applications?

c. **If so, how many applications have been affected in FY 2025 and in FY 2026, to date?**

d. **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.

63. How many adults enrolled in Emergency Medicaid in FY 2025 and FY 2026, to date?

a. **Please provide the average length of coverage for beneficiaries and cost per enrollee.**

Response:

The number of adults age 21 and older with emergency Medicaid claims for dates of service in FY 2025 is 3,849; it is 670 in FY 2026 to date.

a. The District provides emergency Medicaid coverage for most individuals by claiming federal match for certain emergency services paid by DHCF for beneficiaries who are enrolled in Alliance coverage. Only a small number of individuals are currently enrolled in Medicaid (rather than Alliance) under an emergency Medicaid program code.

Among the 3,849 adults with emergency Medicaid claims in FY 2025, the average number of months with emergency Medicaid service use was 1.3 and the average payment per user for these services was $11,377.

64. How many beneficiaries enrolled in the Program for All-Inclusive Care for the Elderly (PACE) program in FY 2025 and FY 2026, to date?

a. **What are the District's plans for expanding and/or improving the PACE program in FY 2026 and FY 2027?**

Response:

As of 12/31/25, the PACE program has a total enrollment of 48 participants.

a. The District is focused on improving the current performance of the PACE provider organization and DHCF is not currently planning any expansion to the PACE program. On 10/28/24, the PACE program was placed under a Corrective Action Plan (CAP) to address deficiencies identified by the District and the Centers for Medicare & Medicaid Services (CMS), in accordance with federal regulations (42 C.F.R. Part 460) and Contract CW94623. The program remains under this CAP.

   DHCF continues to work with the PACE provider to address the deficiencies outlined in the CAP. Efforts include implementing corrective actions, proposed modification to the current contract requirements to strengthen oversight deliverables, and providing technical, clinical, and operational support to the program.

65. Please provide the total number of people enrolled in the elderly and persons with disabilities (EPD) waiver in FY 2025 and FY 2026, to date.

Response:

For FY25 and FY26 (As of 12/31/25), the EPD Waiver Program enrollment was 6530.

66. How many Dual Choice enrollees were also enrolled in the EPD waiver in FY 2025 and FY 2026, to date?

Response:

For FY25, there were 3058 unique Dual Choice enrollees in the EPD Waiver Program. Currently for FY26, (10/1/25 through 12/31/25), there are 2833 Dual Choice enrollees in the EPD Waiver Program.

67. Please confirm if DHCF assesses medical eligibility for the EPD waiver through the InterRAI assessment administered by Telligen.

a. If not, what assessment tool does DHCF use to determine medical eligibility?
b. Are Dual Choice enrollees who receive coverage through the EPD waiver assessed by Telligen?

Response:

DHCF uses the InterRAI Home Care (HC) assessment as the standardized, comprehensive tool to evaluate the needs, strengths, and preferences of individuals receiving care at home. The tool captures detailed information on physical health, cognitive status, daily functioning, mental well-being, and social support, enabling care providers to develop personalized care plans and allocate resources effectively. Telligen conducts all LTSS assessments for DHCF's Long Term Care programs, including Fee for Service, and Dual eligible enrollees in both PACE and DSNP (Dual Choice) Program. Telligen does not conduct non-LTSS initial assessments for beneficiaries enrolled in other Medicaid programs such as DC Healthy Families Program Managed Care Plans, which include AmeriHealth, MedStar, Amerigroup, and HSCSN. These non-LTSS assessments remain the responsibility of MCPs as outlined in their respective contracts.

68. Please confirm whether case managers for Dual Choice enrollees in the EPD waiver are provided directly by the Dual Choice Plan or by the private case management agencies that contract directly with DHCF.

a. If by the Dual Choice plan, how many case managers for the EPD waiver program did the Dual Choice plan employ in FY 2025 and FY 2026, to date?

i. If not, how many case managers are assigned to EPD waiver beneficiaries who are enrolled in the Dual Choice Plan, and who employs them?

b. What was the ratio of case managers to EPD waiver beneficiaries for Dual Choice enrollees in FY 2025 and FY 2026, to date?

Response:

In the Dual Choice Plan, a total of 55 case managers are employed to support the EPD Waiver program as of 12/31/25. United Health Care's hiring activity for FY25 and FY26 to date shows that 25 case managers were onboarded between 10/1/24 and 9/30/25, with an additional 10 hired between 10/1/25 and 12/31/25.

In addition to directly employed staff, several Contracted Management Agencies (CMAs) also provide case management (CM) support for EPD waiver beneficiaries enrolled in the Dual Choice Plan. As of 12/31/25, these contacted CMAs collectively supplied 10 case managers across six agencies. Only one CMA case manager was hired during the period of 10/1/24 through 9/30/25, and no CMA case managers were hired between 10/1/25 and 12/31/25.

Per 29 DCMR Chapter 42, a case manager's caseload may not exceed forty-five individuals at any time, inclusive of both Medicaid and non-Medicaid beneficiaries served across all case management agencies. In addition, each case manager's caseload must be proportionate to the number of hours the case manager works per week, ensuring that workload aligns with available staffing capacity. This requirement is applicable to both Fee-For-Service and Dual Choice case managers.

Dual Choice (DSNP) Case Management Staffing Summary Table

Total # CMs as of 12/31/25	**55**
Timeline	**EPD CMs Hired**
10/1/2024 – 9/1/2025	25
10/1/2025 – 12/31/2025	10
Current # of contracted CMA CMs as of 12/31/25	• Autumn Leaf: 2 CMs • Family Healthcare Solutions: 2 CMs • KCC: 1 CM • Absolute Healthcare Resources: 2 CMs • Ultimate: 1 CM

	• Progressive: 2 CMs
Timeline	**EPD CMA CMs Hired**
10/1/2024 – 9/1/2025	• Absolute Healthcare Resources: 1 CM
10/1/2025 – 12/31/2025	• No CMA CMs hired during this timeframe

69. In FY 2025 and FY 2026, 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 2025 and FY 2026, to date, for how many Personal Care Aides are employed by each Home Health Agency.

Response:

8,377 unduplicated PCAs were employed by Home Health Agencies (HHAs) in 2025. The aggregate number of PCAs reported by individual providers is higher than the overall total because some PCAs work for more than one provider. DHCF does not have data for FY2026 so we estimate the number of PCAs working in FY2026 will be the same as FY2025.

a. See Q69-Attachment 1.

70. 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 2025 and in FY 2026, to date;**

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

24.

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 2025 and FY 2026, to date.

Response:

a. The first 8 hours of Plan Personal Care Aide (PCA) are billed by Medicaid Providers as a state plan service. As of December 31, 2025, DHCF and its managed care plans provided PCA services exclusively through the Medicaid State Plan to 2,470 individuals assessed for 0–8 hours of PCA services during FY25, and to 2,349 individuals to date in FY26.

The LTSS assessment methodology for determining minimum, midpoint, and maximum clinically recommended PCA service hours remains unchanged, with DHCF continuing to default to the maximum recommendation. Beneficiaries may access these hours through their assigned home health agency and retain the right to request a fair hearing or reconsideration under both Fee-for-Service and Dual Choice if dissatisfied with recommended or reimbursed services. Reconciling authorized PCA hours with billed or reimbursed hours for specific dates is challenging due to several factors: assessments provide hour ranges within which final authorizations may be tailored based on beneficiary preferences; plans of care may be adjusted for staffing needs, causing fluctuations in delivered hours; and issues such as staffing availability, incomplete EVV data, and pending appeals further complicate analysis. These constraints prevent DHCF from producing the requested analysis in the specified format.

b. FY25 (10/01/24–09/30/25):4,282 unique enrollees accessed PCA services through agency-based home health providers. 2,426 unique enrollees accessed personal care services through participant-directed services.

FY26 (10/01/25–12/31/25):
4,282 unique enrollees accessed PCA services through agency-based home health providers. 3,642 unique enrollees have accessed personal care services through participant-directed services so far this fiscal year.

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

a. The number receiving 16-17 hours of PCA services per day, 7 days per week;
b. The number receiving 18-19 hours of PCA services per day, 7 days per week;
c. The number receiving 20-23 hours of PCA services per day, 7 days per week; and
d. The number receiving 24 hours of PCA services per day, 7 days per week.

Response:

Based on 9,517 Medicaid-enrolled beneficiaries' and Medicaid applicants' LTSS assessments completed during FY25:

a. 601 beneficiaries (6%) were assessed for 16 to 17 hours of PCA services per day, including 347 beneficiaries (4%) who were specifically recommended 16 hours per day.

b. 90 beneficiaries (1%) were assessed for 18 or 19 hours of PCA services per day.

c. Less than 1% (0.042%), representing 4 assessments, were assessed for 20 to 23 hours of PCA services per day.

d. 365 beneficiaries (3.8%) were assessed as needing 24 hours of Personal Care Aide (PCA) services per day, seven days a week.

72. 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 2025 and in FY 2026, 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 2025 and in FY 2026, 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 2025 and in FY 2026, to date?**

Response:

During FY 2025, DHCF implemented a passive renewal process for EPD waiver participants that assumed a beneficiary's level of care remained the same and resulted in almost 100% of beneficiaries being renewed passively.

On average, 478 beneficiaries were included per recertification period. During FY 2026, DHCF made additional changes to the EPD renewal process to include level of care data, which resulted in the passive renewal rate declining to about 90% in the first quarter of the fiscal year, causing 21 beneficiaries to remain terminated after the grace period as of 1/6/25 (this is not the final termination count as it is currently the grace period for these cohorts). DHCF will continue to monitor the impact of renewal changes for EPD beneficiaries.

73. 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 2025 and FY 2026, 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. DHCF uses InterQual criteria, as does Amerihealth, HSCSN, Medstar, and United Health. Amerigroup uses the Milliman Care Guidelines.

For long-term care, Private Duty Nursing (PDN) services are governed by DCMR Section 947.5, which defines these services as medically necessary for technology-dependent beneficiaries who rely on life-sustaining technology, such as ventilators, to maintain essential bodily functions and who require continuous nursing supervision to ensure 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, along with supporting documentation including the 719A form, the plan of care, medical necessity letters, and clinical records.

74. Of the Medicaid recipients who received PDN hours in FY 2025 and FY 2026, 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:

During the CY25 (10/1/24–9/30/25) and CY26 (10/1/25–12/31/25), there were 91 recipients with paid claims for Private Duty Nursing (PDN) services. Of these, 69 recipients (approximately 76%) had EPD Waiver enrollment and also had overlapping Personal Care Aide (PCA) services based on provider claims. The distribution of overlapping PCA services was highly concentrated, with the top three billing providers accounting for 36 recipients (52.2%).

75. How many Medicaid recipients (both State Plan and EPD waiver enrollees) received 24 hours of PDN care at any point during FY 2025 and FY 2026, to date?

a. **Of the recipients who received 24 hours of PDN care during FY 2025 and FY 2026 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 FY25 and FY26, 44 recipients received the maximum level of Private Duty Nursing (PDN) care, which is 24 hours per day. Of these, three recipients experienced a reduction in their PDN hours, representing 6.82% of those receiving full-time care. The reductions varied significantly: one recipient's hours were reduced to 2,880 units, which is a 50% decrease from the maximum of 5,760 units; another recipient's hours were reduced to 1,824 units, a 68.33% decrease; and the third recipient's hours were reduced to 4,032 units, a 30% decrease. Among the three recipients who experienced a reduction, one appealed the recommended change, accounting for 33% of those affected. Overall, the percentage of recipients who received any reduction in care during the reporting period was 6.82%. See summary table:

Description	Total Count	Percentages
Recipients who received 24 hours of PDN Care	44	
Recipients who received a reduction in PDN hours from 24 hours	3	6.82%
Of the 3 Recipients who received a reduction in PDN hours from 24 hours	Amount Reduced to (from the maximum 5760 units:	
Recipient 1	2880 units	50%
Recipient 2	1824 units	68.33%
Recipient 3	4032 units	30%
Recipients who appealed the recommended reduction in PDN service	1	33%
Percentage of recipients who received reduction in care.		6.82%

76. Of the Medicaid recipients who both: 1) received 24 hours of PDN hours and 2) experienced a reduction of those hours during FY 2025 and FY 2026, 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:

Description	**Total Count**	Percentages
Medicaid_Recipient_Count_FY2025 for PDN	440	
Medicaid_Recipient_Count_FY2026 for PDN	99	
Recipients who received 24 hours of PDN Care	44	8%
Recipients who received a reduction in PDN hours from 24 hours	3	6.82%
Of the 3 Recipients who received a reduction in PDN hours from 24 hours	Amount Reduced to (from the maximum 5760 units:	
Recipient 1	2880 units	50%
Recipient 2	1824 units	68.33%
Recipient 3	4032 units	30%
Recipients who appealed the recommended reduction in PDN service	1	33%
Percentage of recipients who received reduction in care.		6.82%

77. Please provide us with the total number of EPD waiver participants who are receiving their PCA hours through participant-directed services (i.e. "Services My Way") rather than through a Home Health Agency in FY 2025 and in FY 2026 to date. Please also provide the following information of the EPD waiver participants who receive their PCA hours through Service My Way:

a. **How many is DHCF reimbursing for the full number of approved PCA hours in FY 2025 and in FY 2026 to date?**
b. **How many are DHCF reimbursing for only some of the approved PCA hours in FY 2026 and in FY 2026 to date?**
c. **For cases where DHCF/an MCO is not reimbursing for the full number of approved PCA hours, how many EPD waiver participants are not being reimbursed for the following number of approved PCA hours in FY 2025 and in FY25 to date:**
    i. **Number of people for whom DHCF/an MCO is not reimbursing for 1 approved PCA hour.**
    ii. **Number of people for whom DHCF/an MCO is not reimbursing for 2 approved PCA hours.**
    iii. **Number of people for whom DHCF/an MCO is not reimbursing for 3 approved PCA hours.**
    iv. **Number of people for whom DHCF/an MCO is not reimbursing for 4 approved PCA hours.**
    v. **Number of people for whom DHCF/an MCO is not reimbursing for 5 or more approved PCA hours.**

Response:

The LTSS assessment methodology for determining minimum, midpoint, and maximum clinically recommended PCA service hours remain unchanged, with DHCF continuing to default to the maximum recommendation. Beneficiaries who choose to self-direct retain access to the default maximum PCA hours and maintain the right to request a fair hearing or reconsideration under both Fee-for-Service and Dual Choice models if dissatisfied with recommended or reimbursed services.

Reconciling authorized PCA hours with billed or reimbursed hours for specific dates remains challenging due to analytical constraints. Between October 1, 2024, and December 31, 2025, a total of 2,524 beneficiaries elected to self-direct and accessed Participant Directed Services (PDS) in lieu of PCA. Of these, 43 beneficiaries (1.7%) filed fair hearings disputing reductions in PCA/PDS services.

78. Please provide an update on the implementation of the Direct Support Professional Payment Rate Amendment Act of 2024, including:
a. **Number of direct support professionals (DSP) who have been reimbursed in FY 2025 and FY 2026, to date;**
b. **Number of DSPs who saw a rate increase in FY 2025;**
c. **Timeline for implementing the Direct Care Professional Payment Rate Amendment Act of 2025; any**
d. **Any anticipated challenges around implementing these subtitles, including strategies to address these challenges.**

Response:

a. For FY 2025, providers reported in their DSP Wage Enhancement submissions that a total of 8,377 Personal Care Aides (PCAs) worked in Home Health Agencies and approximately 4,853 DSPs worked for IDD Waiver Service Providers. DHCF has not yet received any reports for FY 2026. The report covering 10/1/25 – 12/31/25 (Q1 of FY26) is due in January.

b. In FY25, approximately 8,210 PCAs working in Home Health Agencies and 4,644 DSPs working for DD Waiver Service Providers received wage increases.

c. The American Rescue Plan Act (ARPA) funded supplemental payments for implementing the DSP Wage Enhancement ended on 12/31/25. Providers are expected to submit their final reports in January 2026, after which DHCF will reconcile the reports to address any underpayments or overpayments. Effective 1/1/26, through 9/30/26, funding for DSP Wage Enhancement has been incorporated into the regular provider rates. There is no funding available to continue wage enhancements beyond 9/30/26.

d. During the implementation of the DSP Wage Enhancement, DHCF faced several challenges, including delays in the submission of required reports and instances where providers did not use the allocated funds as intended, either failing to meet the expected 17.6% average wage increase or exceeding it. Some providers also included non-DSP staff or contracted employees in their reports, complicating the review process. Additionally, audits revealed that certain providers lacked adequate documentation to support the rates or hours they reported. In response, DHCF has maintained ongoing engagement with providers and conducted targeted audits to strengthen oversight and ensure compliance.

79. Please provide the following information regarding DC's Money Follows the Person (MFP) grant program:

a. **DHCF's efforts in FY 2025 and FY 2026, to date, to utilize the MFP grant to transition District residents from nursing facilities to the community;**
b. **Number of unique individuals who enrolled in MFP during FY 2025 and FY 2026, to date; and**
c. **MFP benchmarks for transitioning individuals from nursing facilities back into the community.**

Response:

a. Money Follows the Person (MFP) funds were used in FY25 and FY26 to accelerate transitions from nursing facilities and strengthen the direct care workforce. In FY25, the agency completed 84 transitions, well above the benchmark of 60 and the highest annual total in the program's history. To reduce administrative delays, DHCF implemented a 15-day eligibility processing window for MFP participants and began holding biweekly Community Transition Rounds with DACL to coordinate cases more efficiently. The agency also introduced the Community Transition Fact Sheet as a formal service authorization, allowing providers to begin billing immediately upon discharge and preventing gaps in care.

Through the MFP Capacity Building award, DHCF partnered with DC Health to expand the CNA and PCA workforce by covering full tuition and certification costs through the High-Need Healthcare Career Scholarship Program. In FY25, four District schools received support to increase training capacity, helping build a more reliable pipeline of direct care workers needed to sustain community placements. Additional investments are planned for FY26 to continue addressing workforce shortages.

As of January 2026, these combined efforts, faster eligibility processing, streamlined service authorization, and targeted workforce development, are strengthening the District's ability to transition residents safely and maintain high-quality community-based care.

b.

Fiscal Year	Date Range	Unique Individuals Enrolled in MFP
FY 2025	10/1/24 – 9/30/25	84
FY 2026	10/1/25 – 12/31/25	23

c. In FY 2025, the Department of Health Care Finance (DHCF) implemented a series of targeted operational improvements to strengthen the Money Follows the Person (MFP) program. These efforts are centered on streamlining eligibility processes and enhancing

coordination across agencies to support timely and effective transitions of nursing facility residents back into community settings.

FY 2025 Operational Enhancements and Care Coordination:

i. **Biweekly Transition Rounds:** DHCF launched biweekly Community Transition Rounds in partnership with the Department of Aging and Community Living (DACL). These sessions enabled MFP Community Transition Specialists to triage cases, resolve eligibility issues, and ensure timely completion of Form 1346 and related application materials prior to discharge.
ii. **Community Transition Fact Sheet:** In collaboration with DACL, DHCF introduced a standardized Transition Fact Sheet to serve as a formal service authorization. This tool improved communication and coordination among community-based providers serving MFP participants.
iii. **Accelerated Eligibility Processing:** DHCF established a dedicated 15-day eligibility processing window for MFP beneficiaries, significantly reducing administrative delays that previously slowed transitions. This improvement allowed DHCF to complete application reviews and submit Form 1346 to the Medicaid Branch for EPD Waiver eligibility determinations before individuals returned to the community.

80. **How many births did DHCF pay for in FY 2025 and FY 2026, to date, for Medicaid and Alliance patients?**
    a. **What share of the total District resident births did Medicaid/Alliance-covered births represent in FY 2025?**
    b. **Of the Medicaid enrollees who gave birth in FY 2025, how many will be shifted to a Healthy DC Plan when their 12-months postpartum coverage expires?**
    c. **How many will be eligible for a QHP on the DC Health Exchange? What notifications and resources will these patients receive?**

Response:

The number of DHCF-funded births was 3,256 in FY 2025 and is 519 in FY 2026 to date.

a. Based on provisional data available for January 1, 2025, through October 31, 2025 (the period currently available for both Districtwide and DHCF-funded births), the share of total District resident births funded by DHCF, including Medicaid/Alliance, was 43.4%.
   This figure reflects 6,076 births Districtwide from CDC WONDER data for January through October 2025 and 2,640 DHCF-funded births for the same time frame. The CDC WONDER data is provisional as of November 30, 2025 (available at https://www.cdc.gov/nchs/data_access/vitalstatsonline.htm). DHCF data is as of January 2026 and will be higher when run at a future date due to lagged submission and payment of claims from providers.

b. Based on a beneficiary's current income as of January 2026, there are 117 Medicaid enrollees who gave birth in FY 2025 who will potentially be shifted to a Healthy DC Plan when their 12-months postpartum coverage expires. Beneficiary circumstances (family size, income level, etc.) can change over time and would be reassessed at the end of the postpartum period to determine the appropriate coverage.

c. Based on a beneficiary's current income as of January 2026, there are 51 Medicaid enrollees who gave birth in FY 2025 who will potentially be eligible for a QHP on the DC Health Exchange. Beneficiary circumstances (family size, income level, etc.) can change over time and would be reassessed at the end of the postpartum period to determine the appropriate coverage. Please refer to the Question 97 response for additional information on pregnancy and postpartum coverage.

81. How many women received prenatal care in their first trimester in FY 2024, FY 2025, and FY 2026 to-date? Please provide this data as a raw number and percentage, stratified by age and divided by MCO.

Response:

Please see the following five tables for each Managed Care Plan and Final Totals, organized by Fiscal Year and Age Group.

AmeriHealth	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	41	92	44.57%
	20-29	421	631	66.72%
	30-39	419	639	65.57%
	40-49	41	76	53.95%
	Total	922	1438	64.12%
FY2025	10-19	48	82	58.24%
	20-29	351	545	64.40%
	30-39	395	599	65.94%
	40-49	34	54	62.96%
	Total	828	1280	64.69%
FY2026	10-19	7	16	43.75%
	20-29	93	141	65.96%
	30-39	100	160	62.50%
	40-49	10	19	52.63%
	Total	210	336	62.50%

HSCSN	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	10	15	66.7%
	20-29	29	43	67.4%
	Total	39	58	67.2%
FY2025	10-19	5	8	62.5%
	20-29	11	18	61.1&
	Total	16	26	61.5%
FY2026	10-19	0	1	0%
	20-29	3	3	100%
	Total	3	4	75%

MedStar Family Choice	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	26	36	72.22%

	20-29	185	239	77.41%
	30-39	172	251	68.53%
	40-49	12	16	75%
	Total	395	542	72.88%
FY2025	10-19	23	33	69.70%
	20-29	210	291	72.16%
	30-39	197	290	67.93%
	40-49	11	18	61.11%
	Total	441	632	69.78%
FY2026	10-19	7	13	53.85%
	20-29	52	65	80%
	30-39	43	51	84.31%
	40-49	1	1	100%
	Total	103	130	79.23%

Wellpoint	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	19	50	38%
	20-29	163	350	47%
	30-39	182	378	48%
	40-49	9	32	28%
	Total	373	811	46%
FY2025	10-19	27	56	48%
	20-29	191	372	51%
	30-39	182	334	54%
	40-49	17	33	52%
	Total	417	795	52%
FY2026	10-19	3	8	38%
	20-29	40	68	59%
	30-39	34	54	63%
	40-49	4	6	67%
	Total	81	136	60%

Total		Total 1st Trimester	Total Deliveries	Percentage
FY2024		1729	2849	60.68%
FY2025		1702	2733	62.28%
FY2026		397	606	65.5%

82. Provide an update on the implementation of the State Plan Amendment to cover doula services, including:

a. The number of doulas currently receiving reimbursement, broken down by FFS and each MCO.

b. The expected number of doulas to receive reimbursements in the remainder of FY 2026, broken down by FFS and each MCO.

c. Total reimbursements distributed to doulas in FY 2025 and FY 2026, to date, broken down by FFS and each MCO.

d. A narrative explanation on how DHCF continues to make doulas as well as DC residents aware of their eligibility for reimbursement.

e. Each MCO's protocols for doula reimbursement including step-by-step instructions on how to bill the MCO including applicable codes and modifiers.

Response:

In 2022, DHCF established the Doula benefit for the Medicaid, Alliance, and Immigrant Children's Program(s), including a comprehensive service list, enrollment and certification standards, reimbursement rates, and billing protocols.

Utilization of doula services in both FFS and Managed Care has been lower than anticipated, with specific data provided below. The highest consumption of doulas services to-date has been for doulas participating in health centers and practice groups where revenue cycle management support exists and sources of referral are internal. DHCF is leveraging our Transforming Maternal Health (TMaH) grant, from the Centers for Medicare and Medicaid Innovation (CMMI), to enhance recruitment, provide technical assistance, for public education, and to increase the rate of referral. These efforts include collaboration with the MCPs, Doula Learning Action Collaborative, FQHCs, DC Health, and other District stakeholders.

a. (See Table)

b. (See Table)

Plan	# Doulas	# Doula Grps	FY26 Anticipated
FFS	27	10	35
Amerihealth	4	0	7
HSCSN	1	0	5
MedStar Family Choice	4	1	7
Wellpoint	4	0	25% Increase each QTR

c. See Table

Plan	Total FY25	Total FY26
FFS	$420.20	$125.000
Amerihealth	$11,609.89	$420.20
HSCSN	$0	$0
MedStar Family Ch	$1,005.05	$0
Wellpoint	$1,260.58	$0

d. DHCF is leveraging the Transforming Maternal Health Model Grant (TMaH) to partner with the Doula Learning Action Collaborative and establish a State Doula Advisory Council. TMaH resources also support a Provider Incentive Program that enhances doulas' ability to deliver whole-person care. The provider incentive program offers financial incentives for quality improvement activities, strengthening doula revenue and reimbursement capacity. Additionally, the District is conducting beneficiary focus groups to gather insights on the doula benefit, which will inform strategies to increase awareness and utilization. DHCF's Managed Care Plan partners are also active collaborators for TMaH and our doula recruitment initiatives.

e. See Attachment 1-4 to Q82

83. Please provide updates on DHCF's administration of the $325,000 grant funds to support the implementation of the Nurse Family Partnership (NFP) Home Visiting Program, including grant funds spent and funds remaining.

a. **What quality metrics is DHCF using to measure NFP's performance?**
b. How is DHCF planning to incorporate home visiting into the Transforming Maternal Health model?

Response:

In FY25, DHCF awarded one home visiting grant in the amount of $325,000. The purpose of the grant was to provide evidence-based home visiting services to eligible first-time mothers and birthing parents in the District according to the Nurse Family Partnership (NFP) model. The grantee, Mary's Center, expended $162,500 of the FY25 grant.

DHCF intends to award an FY25 grant in the amount of $625,000 by February 2026. DHCF is reviewing a project proposal and budget for the FY26 Grant, which was received in late December, and is preparing a Notice of Grant Award.

a. The FY25 grantee's performance is evaluated on process and performance measures.
    - On process, the grantee demonstrated the following:
        i. 26 new program recipients
        ii. 388 home visits to 65 families
        iii. 21 families graduated from the program
    - On performance, the grantee demonstrated the following outcomes related to its goals:

Measure	Target	Actual
Goal 1: Improve pregnancy outcomes by helping women improve prenatal health.		
Proportion of NFP pregnant women with a birth plan by 37 weeks gestation	80%	84%
Proportion of NFP pregnant women who attend all recommended prenatal visits since enrolling in the program.	80%	88%
Proportion of NFP participants who receive perinatal depression screening and referrals as appropriate.	80%	85%
Goal 2: Improve child health and development by helping parents provide sensitive and competent caregiving.		
Proportion of NFP infants reported to have initiated breastfeeding	80%	97%
Proportion of NFP infants reported to be breastfeeding at 6 months	60%	52%
Proportion of NFP participants' children between ages 0-18 months who receive well-child visits	90%	94%

Proportion of NFP infant participants who receive developmental screening and referral as necessary.	80%	
ASQ 3 screening at 4 months	*80%*	*91%*
ASQ 3 screening at 10 months	*80%*	*93%*
ASQ 3 screening at 18 months	*80%*	*94%*
Proportion of NFP participants who report having a medical home for their infant	90%	100%
Proportion of NFP participants who report engaging in safe sleep behaviors	60%	58%
Proportion of NFP participants who received all recommended immunization for age at 12 months	90%	87%
Goal 3: Improve parental life-course by helping parents develop a vision for their future, plan subsequent pregnancies and reduce parental stress.		
Proportion of NFP pregnant women who report using a contraceptive method at 6 months postpartum	50%	69%
Proportion of NFP participants who receive a postpartum visit.	80%	98%
Proportion of NFP participants who conceived within 18 months of their previous birth	<30%	9%
Proportion of NFP participants who receive intimate partner violence screening and referrals as necessary.	80%	73%

b. In TMaH, coverage of home visitation is an optional element of the model. We are awaiting additional information from CMS on what may be required as part of this optional element and how it may be integrated into the value-based payment model currently being designed by CMS. In the interim, DHCF has leveraged the Maternal Health Advisory Group to solicit policy and implementation feedback on maternal health innovation. We anticipate that we will have a future meeting focused on home visitation.

85. Please share all MCO performance measures data that are related to maternal health, including perinatal mental health, in FY 2025 and FY 2026, to date.

a. For each measure, please provide data on how each MCO, including HSCSN, performed in FY 2025 and FY 2026, to date.

Response:

DHCF continues efforts to improve the health of pregnant people and babies. DHCF tracks MCP performance in the HEDIS Prenatal and Postpartum Care measures via the Maternal Health and Birth Outcome Focus Study conducted by DHCF's independent External Quality Review Organization (EQRO), Qlarant. Measurement Years must be evaluated after complete submission and processing of claims. Providers are allowed a full year from the date of service to submit a claim. Our most current study managed care enrollees who were continuously enrolled for at least 120 days and had a live birth during fiscal year (FY) 2024, which spanned from October 1, 2023, through September 30, 2024. FY 2023 serves as a baseline; this report includes the second year of analysis and compares FY 2024's performance to the FY 2023 baseline. These measures and the associated MCP performance are described below.

Prenatal and Postpartum Care (PPC)
The percentage of live births on or between October 8 of the prior year and October 7 of the measurement year.

For these enrollees, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of Prenatal Care.** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

- **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 7 to 84 days after delivery.

Table A.1 includes annual rates for the Prenatal and Postpartum Care measures. The DC Average is compared to national average benchmarks.

Table A.1. Prenatal and Postpartum Care Measures

Measure	Measurement Year (MY)	ACDC [AmeriHealth]	HSCSN	MFC [MedStar]	WPDC [Wellpoint/ formerly Amerigroup]	DC AVG	Comparison to Benchmark
Prenatal and Postpartum Care (PPC)							
Timeliness of Prenatal Care	2022	82.55%	66.67%	77.12%	NA	75.45%	♦
	2023	82.70%	70.00%	75.80%	NA	76.17%	♦
	2024	83.24%	61.54%	77.50%	75.18%	74.37%	♦

Postpartum Care	2022	76.01%	78.57%	65.54%	NA	73.64%	♦
	2023	76.76%	53.33%	68.62%	NA	66.24%	♦
	2024	78.38%	76.92%	73.33%	70.32%	74.74%	♦

* NA = MCP did not report due to contract start date of April 1, 2023.
♦ The DC MCP Average is below the National Average.
♦ ♦ The DC MCP Average is equal to or exceeds the National Average but does not meet the 75th Percentile.
♦ ♦ ♦ The DC MCP Average is equal to or exceeds the 75th Percentile.

Although the DC Average is below the national average, Table A.1 showed performance improvement;

- FY24: Timeliness of Prenatal Care
  - AmeriHealth and MedStar show improvements in Timeliness of Prenatal Care.
  - HSCSN's Timeliness of Prenatal Care performance declined.
  - Wellpoint established baseline performance data.

- FY24: Postpartum Care
  - AmeriHealth, HSCSN, and MedStar performance improved.
  - Wellpoint established baseline performance data.

In addition to prenatal and postpartum care, DHCF is tracking MCP performance in the *new* HEDIS Prenatal and Postpartum Depression Screening and Follow-Up measures. These measures and MCP performance are described below. For these *new* measures, it is important to note that not all MCPs are consistently reporting but are expected to moving forward.

Performance Measures:

Prenatal Depression Screening and Follow-Up (PND-E)
The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Postpartum Depression Screening and Follow-Up (PDS-E)
The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Table A.2 below includes annual rates for the Prenatal and Postpartum Depression Screening and Follow-Up measures. In FY 24, AmeriHealth is the only MCP that reported performance for all measures.

- The DC average and a comparison to benchmark was not calculated due to limited data.
- Comparison to benchmarks was not completed due to limited data.

Table A.2. Prenatal and Postpartum Depression Screening and Follow-Up Measures

Measure	Measurement Year (MY)	ACDC [AmeriHealth]	HSCSN	MFC [MedStar]	WPDC [Wellpoint/ formerly Amerigroup]	DC AVG	Comparison to Benchmark
Prenatal Depression Screening and Follow-Up (PND-E)							
Depression Screening	2022	51.32%	DNR	DNR	*	NC	-
	2023	54.34%	0.00%	DNR	*	NC	-
	2024	53.12%	0.00%	DNR	0.99%	NC	-
Follow-Up on Positive Screen	2022	45.63%	DNR	DNR	*	NC	-
	2023	40.40%	NA	DNR	*	NC	-
	2024	44.16%	NA	DNR	0.00%	NC	-
Postpartum Depression Screening and Follow-Up (PDS-E)							
Depression Screening	2022	32.72%	DNR	DNR	*	NC	-
	2023	46.09%	0.00%	DNR	*	NC	-
	2024	40.91%	0.00%	DNR	3.69%	NC	-
Follow-Up on Positive Screen	2022	40.98%	DNR	DNR	*	NC	-
	2023	46.00%	NA	DNR	*	NC	-
	2024	56.25%	NA	DNR	100%	NC	-

* MCP did not report due to contract start date of April 1, 2023.
NA – Not applicable. Screening not completed (0.00%); therefore, follow-up was not completed.
DNR – Did not report.
NC – Not calculated due to lack of MCP reporting.

86. Please 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 2025 and FY 2026, to date, broken down by type of service and total expenditures for each type of service.

a. Please send a link to where the DHCF report as required by A25-173 is posted.

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 for FY 2025 and FY 2026 to date.

DHCF Beneficiaries with Infertility Diagnosis and Use of Fertility Enhancing Drugs

Fiscal year	Type of service	Number of beneficiaries	Expenditures
FY 2025*	Drug services	31	$1,964
FY 2026 to date	Drug services	9	$440

Source: DHCF's Medicaid Management Information System data extracted January 12, 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.
* Includes 5 beneficiaries enrolled in the Alliance, totaling $101. All remaining data for FY 2025 and FY 2026 to date reflects Medicaid.

a. Please see below:

Currently, the District covers a number of diagnostic and treatment-related services for infertility through Medicaid, including:

• **Fertility-enhancing medications** (e.g., Clomid/clomiphene citrate) – effective January 1, 2024, via State Plan Amendment (SPA) 23-0016
• **Laboratory tests** (e.g., progesterone levels, ovarian reserve testing, thyroid function, prolactin)
• **Semen analysis**
• **Imaging** (e.g., pelvic ultrasound, hysterosalpingogram [HSG])
• **Diagnostic procedures and surgeries** (e.g., laparoscopy, hysteroscopy)

States may submit approval to cover in-vitro fertilization (IVF). No state currently offers this to beneficiaries as a covered benefit.

87. In FY 2024, DHCF announced that it will pause its plans to fully integrate behavioral health services into managed care. Does DHCF have an updated timeline to move forward the integration and whole-person care strategy for Medicaid beneficiaries?

Response:

DHCF and the Department of Behavioral Health (DBH) are reassessing carving in mental health rehabilitative and substance use disorder services into the managed care program. Currently, DHCF is analyzing the financial feasibility of the carve-in. Once preliminary information is received, DHCF and DBH will review and then make a recommendation to the Deputy Mayor for Health and Human Services.

88. 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 2025 and FY 2026, to date, and projected for the remainder of FY 2026.

Response:

DBH's Medicaid budget includes Medicaid utilization for Medicaid beneficiaries who are not Childless Adults. The Childless Adults were part of Medicaid expansion under the Affordable Care Act (ACA) and spending for this group is included in DCHF's budget because of enhanced federal match percentage. Budget expenditures for these services which occurred in FY 2025 were $73,010,461.60, including $4,770,887 funded from the non-lapsing local Medicaid HCBS Enhancement Fund at DHCF, and the total number of unique beneficiaries receiving these services was 18,210. Through the end of December 2025, spending for services which occurred in FY 2026 was $12,304,409.96 (note that this figure is incomplete due to lagged submission and payment of claims and will be higher when run at a future date). The local budget for these services under DBH for FY2026 is $44,502,648.

89. **How many unique consumers were authorized for Mental Health Rehabilitation Services Community Support Services (CSS) in FY 2024, FY 2025, and FY 2026, to date?**
    a. **Given that the District reduced the number of CSS units that each consumer can be authorized for during a 180-day period, how is DHCF ensuring consumers are directly notified of an impending reduction to their Medicaid services?**

Response:

The number of Medicaid beneficiaries with paid claims for Community Support Services billed by a Mental Health Rehabilitation Services provider are as follows: 35,282 in FY 2024; 37,174 in FY 2025; and 24,789 in the first quarter of FY 2026.

a. Community Support Services providers are required to maintain treatment plans that document an individual's behavioral health needs and are expected to regularly communicate with beneficiaries on their service planning. In addition, the District communicates changes in program services to beneficiaries, providers, and other stakeholders through channels that include, for example: DHCF and DBH rulemakings that provide an opportunity for public notice and input; transmittals that summarize program changes for the public; billing manuals and trainings targeted to providers; and stakeholder meetings that seek to engage providers and others in the behavioral health services community.

90. **How many children enrolled in Medicaid diagnosed with a "serious emotional disturbance" were receiving services from a behavioral health service provider other than a core service provider, including services provided by Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), Department of Human Services (DHS), and Free-Standing Clinic Providers, in FY 2025 and FY 2026, to date?**
    a. Please list these behavioral health service providers and indicate for each what service they provide.

Response:

The number of Medicaid children under age 21 with a diagnosis of serious emotional disturbance who had a paid claim for a behavioral health service other than Mental Health Rehabilitation Services (MHRS), Adult Substance Abuse Rehabilitative Services (ASARS), Adolescent Substance Abuse Treatment Expansion Project (ASTEP), Recovery Support Services (RSS), or Behavioral Health Stabilization delivered by a DBH-certified provider (i.e., core service agency) was 3,730 in FY 2025 and 1,551 in the first quarter of FY 2026.

These figures reflect billing under Freestanding Mental Health Clinic, Federally Qualified Health Center (FQHC) with a behavioral health specialty, and other licensed behavioral health practitioners (e.g., psychologist and social worker) provider types.

a. See Attachment 90.

91. Please provide details regarding all Psychiatric Residential Treatment Facility (PRTF) placements paid for with Medicaid funds in FY 2025 and FY 2026, 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.

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

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 30 Medicaid beneficiaries placed at a PRTF in FY25**.**

Table 1. PRTF Beneficiaries Served FY25

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	11	36.66
AmeriHealth Caritas DC	8	26.66
Wellpoint (formerly Amerigroup)	2	6.67
HSCSN	5	16.66
OSSE	2	6.67
Local Dollars (CFSA)	1	3.34
Local Dollars (DYRS)	1	3.34
Total	**30**	**100**

Length of Time from Determination to Placement

The letter of medical necessity issued by the Department of Behavioral Health (DBH) is valid for 60 days from the date of determination; therefore, the youth must be placed within that 60-day timeframe. Although most of the 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 is 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 FY25
Florida	6
Pennsylvania	2
Virginia	7
Maryland	14
Georgia	1
Total	**30**

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 FY25 was 5.1 months (approximately 156 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 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 25**	**Other Agency Involvement**
Child and Family Services (CFSA)	11	DBH, HSCSN, DYRS
District of Columbia Public School (DCPS)	0	DBH, HSCSN
Department of Youth Rehabilitation Services (DYRS)	17	DBH, HSCSN, CFSA
DC Superior Court (Court Social Services)	0	N/A
Office of the State Superintendent of Education (OSSE)	1	DBH, HSCSN
HSCSN	1	DBH
Total	30	

a. Please see Q91-Attachment.

Please note that the fee schedule for New Hope Carolinas, Inc., lists two rates. The second rate includes an enhancement for youth diagnosed with Autism Spectrum Disorder.

92. Please describe, if any, updated discussions that took place in FY 2025 or FY 2026 to-date regarding the Department's involvement in the District's pursuit of alocal PRTF for psychiatric care for children.

Response:

None.

93. **Please provide Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program from FY 2023, FY 2024, FY 2025, and FY 2026 to date. Include a breakdown for (1) DBH-employed clinicians and (2) Community-based Organization (CBO) clinicians, stratified by CBO group. For each group please provide:**
    a. **Total Medicaid reimbursement amounts;**
    b. **Number of students served;**
    c. **Types of services billed (ex. individual therapy, group therapy, assessments).**

Response:

See Question 93 Attachment.

94. How many childless adults or parents/caretakers who were previously enrolled in DC Medicaid have been transitioned to a Healthy DC Plan as of 12/19/25?

a. What is that percentage in terms of total potential eligible adults to be enrolled in a Healthy DC Plan?

Response:

Based on DCAS data as of 11/29/2025, a total of 18,182 Medicaid childless adults and parent/caretaker relatives with incomes above 138% FPL were expected to transition to HBX eligibility effective 1/1/2026. Based on data in DHCF's MMIS as of December 21:

- 15,588 (86% of the November 29 total) had incomes in the Healthy DC Plan range (from 139%-200% FPL).
- 1,823 (10% of the November total) had incomes in the Qualified Health Plan (QHP) range (above 200% FPL).
- 771 (4% of the November total) had incomes below 139% FPL. This could occur, for example, if an individual reported a change in circumstance (e.g., job loss) after DCAS ran its list on November 29.

Based on HBX data as of January 8, there were 14,738 enrollees transitioned from Medicaid to the Healthy DC Plan.

95. How many childless adults or parents/caretaker who were enrolled in DC Medicaid between September 1, 2025, and December 2025, with income between 138% and 200% of FPL, have not yet enrolled in Healthy DC?

Response:

Please see response to question 94 for a breakout of the Medicaid childless adult and parent/caretaker relative population from 139%-200% FPL expected to transition to Healthy DC Plan eligibility effective 1/1/2026 and the number enrolled in the Healthy DC Plan.

96. How many people whose DC Medicaid was terminated on January 1, 2026, due to the new income eligibility rules were not transitioned to Healthy DC because their countable income was determined to be above 200% of FPL.

Response:

Please see response to question 94 for a breakout of the Medicaid childless adult and parent/caretaker relative population above 200% FPL expected to transition to Qualified Health Plan (QHP) eligibility.

97. Please describe the process for a BHP enrollee who become pregnant and qualifies for Medicaid coverage. Please include:

a. Who the enrollee would need to inform;

b. What forms they may need to complete, and within what specified time frame;

c. Income requirements;

d. Services an enrollee can expect during the pregnancy and post-partum period including length of coverage;

e. How DHCF will notify the enrollee that their coverage is ending; and

f. What coverage is available to both the parent and their child after pregnancy-related Medicaid coverage ends.

Response

BHP enrollees who become pregnant will qualify for Medicaid. Residents can report this change to their health plan or DCHBX. Residents can report their pregnancy to DCHBX through all available methods, such as the DC Health Link resident portal, phone, e-mail, or mail. Residents only need to report that they are pregnant, the expected due date (or date of conception), and expected number of babies. No additional verification of pregnancy or completion of forms is needed for updating BHP eligibility.

After reporting a change, BHP enrollees will receive outreach from a DCHBX case worker to answer any questions and ensure that next steps in the transition process to Medicaid are clear. DCHBX will process the change in eligibility and work with DHS/DHCF staff to establish Medicaid eligibility. Residents will be eligible for Medicaid if they meet the following requirements:

Medicaid Program

- Pregnant
- DC Resident
- US Citizen or eligible immigration status
- Meet income requirements (319% FPL)

Residents are entitled to all services covered under the Medicaid State Plan, including care related to the pregnancy, labor, and delivery and any complications that may occur during pregnancy, as well as post-partum care which begins on the date the pregnancy ends. Medicaid offers an additional twelve (12) months of post-partum care.

Once the birth is reported, the child will automatically enroll in Medicaid until their first birthday, at which time they will need to be redetermined for Medicaid eligibility.

Once coverage ends for the birthing parent, the resident will be redetermined for alternative coverage under Medicaid, BHP, or QHP. If the resident qualifies for additional Medicaid coverage, they will receive notice alerting them to a change in Medicaid eligibility. If the resident does not qualify for further Medicaid coverage, they will receive a notice of adverse action for Medicaid, and the case will be transferred to DCHBX for enrollment in BHP/QHP.

98. What transportation programs administered by the Department for Hire Vehicles (DFHV), Department of Aging and Community Living (DACL), Department of Behavioral Health (DBH), or any other District agencies are currently reimbursed in whole or in part through Medicaid?

a. Please describe how DHCF coordinates with each agency to ensure transportation services are billed appropriately to Medicaid.

b. For each agency, please provide a breakdown of Medicaid transportation by service type, including non-emergency medical transportation, paratransit services, and specialized transportation programs.

Response:

Medicaid reimbursed transportation services are covered for emergency ambulance transportation and non-emergency medical transportation (NEMT). Currently, emergency transportation services are provided by the District Fire and Emergency Medical Services (FEMS) and reimbursed directly by Medicaid. DHCF contracts with a transportation broker to provider NEMT services for the Medicaid fee for service (FFS) program; the managed care plans have similar arrangements for NEMT services.

DFHV, DACL, and DBH are not current Medicaid providers for the purpose of providing Medicaid covered transportation services.

99. Please provide the following data for each Medicaid-reimbursed transportation program:

a. How many unique Medicaid beneficiaries received transportation services in FY 2023, FY 2024, FY 2025, and FY 2026, to date?

b. How many total one-way trips and round trips were reimbursed by Medicaid in FY 2023, FY 2024, FY 2025, and FY 2026, to date? And, what was the average cost per trip?

c. Total Medicaid spend on transportation services in FY 2023, FY 2024, FY 2025, and FY 2026, to date?

Response:

See chart below- This is data from the NEMT Transportation Broker for Question 99 A & B. This information reflects the average reimbursed cost per trip paid to transportation providers from our vendor, MTM.

WASHINGTON DC MEDICAID	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires	4,386	3,781	4,134	2,821
One Way - To Leg	102,549	76,532	73,761	45,895
One Way - From Leg	81,592	66,477	66,236	42,511
Total Number of One Way Trip Legs	184,141	143,009	139,997	88,406
Average Reimbursed Cost Per Trip	$ 35.42	$ 39.23	$ 41.63	$ 44.90
WASHINGTON DC MEDICAID IDD	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires	496	514	459	428
One Way - To Leg	43,584	48,631	46,999	36,296
One Way - From Leg	40,839	46,031	45,675	35,537
Total Number of One Way Trip Legs	84,423	94,662	92,674	71,833
Average Reimbursed Cost Per Trip	$ 25.98	$ 29.72	$ 32.15	$ 35.25
WASHINGTON DC MEDICAID MY HEALTH GPS	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires	153	167	188	116
One Way - To Leg	273	214	248	163
One Way - From Leg	180	131	160	133
Total Number of One Way Trip Legs	453	345	408	296
Average Reimbursed Cost Per Trip	$ 23.32	$ 17.60	$ 17.74	$ 20.05
WASHINGTON DC MEDICAID NURSE TRIAGE	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires	295	313	252	156
One Way - To Leg	72	70	151	28
One Way - From Leg	5	19	129	4
Total Number of One Way Trip Legs	77	89	280	32
Average Reimbursed Cost Per Trip	$ 12.97	$ 15.88	$ 21.41	$ 18.48

See chart below for Medicaid and Non-Medicaid expenditures for FY 2023 through FY 2026 year-to-date:

Cost Center Description	FY 2023	FY 2024	FY 2025	FY 2026
Non-Emergency Medical Transportation	19,631,470.26	23,945,426.75	15,059,371.83	3,998,277.38
Non-Emergency Medical Transportation - CHIP	87,570.36	272,630.82	112,005.99	23,009.52

Fire & EMS Services (Ambulance)	74,645,416.80	85,507,840.88	90,126,350.87	8,759,850.58
Fire & EMS Services (Ambulance) - CHIP	489,714.41	683,748.57	859,654.02	141,097.43
OSSE-Children W/Special Needs Transportation	22,950,359.24	28,619,221.99	9,824,652.50	1,450,384.70
OSSE- Children W/Special Needs Transportation - CHIP	2,146,320.54	2,206,336.84	717,664.68	311,475.78
Alliance Emergency Medical Transportation	1,316,093.12	2,303,073.95	2,118,263.84	0.00

Other transportation spending not included above are transportation services that are within managed care capitation rates.

100. What performance metrics does DHCF use to monitor Medicaid-reimbursed transportation services (ex. on-time trips, trip completion rates, beneficiary complaints, etc.)?

Response:

DHCF's non-emergency medical transportation (NEMT) program uses a comprehensive set of performance metrics to monitor Medicaid-reimbursed transportation services and ensure beneficiaries have reliable, timely, and appropriate access to care. Our monitoring framework includes the following categories:

Access and Availability Metrics

- Denial rate of requested trips, which captures the percentage of trip requests that were not fulfilled.
- Trip fulfillment rate, measuring the percentage of requested trips that were successfully completed.
- Vehicle type availability, ensuring the fleet includes the appropriate vehicle types needed to meet beneficiary needs across all wards.

Timeliness and Reliability Metrics

- On-time pickup and drop-off performance, monitored through daily and monthly reporting.
- Late arrivals and driver no-show rates, supported by a dedicated report that tracks both beneficiary and driver no-show details, which DHCF reviews closely.

Quality of Service Metrics

- Complaint and grievance monitoring, reviewed monthly with the vendor. When repeated complaints emerge, DHCF intervenes immediately to require corrective action and prevent escalation.
- Surveys and audits, including desk audits conducted by the DPI team and on-site, pop-up audits conducted by the Contract Administrator.
- Annual vehicle inspections, attended by DHCF to ensure compliance with state and federal safety and regulatory requirements.

Compliance and Regulatory Metrics

- Monthly status and bi-monthly compliance meetings with the vendor, during which eligibility, prior authorizations, credentialing, and vehicle inspection results are reviewed in detail.
- Utilization and Efficiency Metrics
- Cost-effectiveness and operational efficiency monitoring, ensuring the program is delivering value while meeting beneficiary needs.

Network Adequacy Metrics

- Provider-to-beneficiary ratios,
- Backup provider coverage, and
- Peak-time capacity assessments,

All of which are evaluated by the broker to ensure the network can meet demand across all wards.

Health Outcome Metrics

- Missed appointment rates attributable to transportation,
- Hospital readmission correlations, and
- Dialysis attendance rates,

101. Please describe how DHCF assesses whether existing transportation is sufficient to meet beneficiary demand across wards.

Response:

DHCF's Non-Emergency Medical Transportation (NEMT) program assesses whether existing transportation services are sufficient to meet beneficiary demand across all wards through a comprehensive, data-driven approach. This includes analyzing the number of active beneficiaries by ward and by transportation mode, as well as reviewing key performance metrics and KPIs. DHCF uses transportation provider trip reports to evaluate capacity, fleet utilization, on time performance, and overall service delivery. In addition, DHCF's program integrity team conducts independent utilization analyses to further validate demand and service levels.

Once the program integrity team retrieves the data, they immediately provide it to the Contract Administrator (CA). The CA reviews the information and makes decisions on how to move forward to ensure the service is being fully utilized by the beneficiary population. This review helps determine whether adjustments, additional oversight, or targeted outreach are needed to meet demand across all wards.

Most recently, DHCFs vendor increased their marketing and outreach efforts, including collaboration with the Department of Human Services – Economic Security Administration (ESA) and participation in community events across the District. These efforts are designed to identify and engage eligible beneficiaries particularly those in wards with lower utilization to ensure they are aware of and able to access NEMT services.

DHCF also performs ongoing compliance monitoring through bi-monthly meetings with the transportation vendor. During these meetings, DHCF reviews trip activity, ride assignments across all wards, and any operational issues or barriers. These discussions help identify compliance concerns and opportunities to strengthen outreach and marketing efforts to ensure utilization rates align with District expectations.

To supplement the data review, the CA conducts in-person audits at adult day care facilities during both pick-up and drop-off times. These site visits allow DHCF to verify that the beneficiary population using the service aligns with reported data and to ensure that transportation services are adequately meeting the needs of beneficiaries in real time.

102. Please provide an update on 1115 waiver planning, including what the timeline is for implementation, and what funding considerations exist for implementing the waiver.

a. What housing support and services will be included in the District's 1115 waiver and how will it be implemented?

Response:

In June 2024, DHCF submitted a five-year renewal request of the Behavioral Health Transformation 1115 Waiver to the Centers for Medicare & Medicaid Services (CMS). In this submission, DHCF proposed: (1) extending current waiver authorities (i.e., residential substance use disorder (SUD) and serious mental illness (SMI) treatment, and elimination of the $1 copay for medication assisted treatment); and (2) implementing new justice-involved reentry and health-related social needs (HRSN) services. Since the 2024 submission, CMS provided temporary extensions of the current waiver authorities, allowing DHCF to continue reimbursing for these services while CMS considers our 1115 waiver renewal request. The current temporary extension expires on December 31, 2026.

Upon approval of the waiver, DHCF anticipates approximately a one-year planning period to ensure completion of required post-approval deliverables to CMS and allow for implementation readiness. Given the current budget environment, DHCF would prioritize locally funded programs. While the 1115 renewal application remains pending with CMS, DHCF has continued to move forward with planning and community engagement activities to support implementation, including:

- **Implementation and Policy Planning:** Since July 2024, DHCF leveraged the Medical Care Advisory Committee Health System Redesign (HSR) Subcommittee to support 1115 renewal policy and planning. These monthly meetings are well attended, with over 100 individuals regularly participating. The HSR group developed implementation-related recommendations across housing, reentry, and nutrition services. These recommendations and other feedback can be found on the DHCF 1115 waiver webpage.

- **Enhanced Community Engagement:** In January 2025, DHCF launched an effort to get targeted feedback from beneficiaries, front-line staff; individuals who often are unable to attend the monthly HSR meetings. Feedback was received from over 130 Medicaid beneficiaries and frontline staff via surveys, listening sessions, and community meetings.

- **Provider Readiness Trainings:** In July 2025, DHCF launched a seven-month learning collaborative to help providers and organizations that deliver or partner with housing, nutrition, and reentry services prepare for Medicaid payment and operations. Thirty-nine (39) organizations participated in learning collaborative activities including interactive webinars, individual and group coaching sessions, and an in-person half-day meeting.

a. Housing Supports in the Pending 1115 Waiver Application: DHCF included the following housing supports in the 1115 waiver application, consistent with November 2023 CMS guidance:

- Rent/temporary housing for up to six (6) months and related utility assistance;
- Short-term pre-procedure and/or post-hospitalization housing for up to six (6) months;
- Transition, navigation, pre-tenancy, and tenancy-sustaining services;
- One-time transition and moving costs;
- Medically necessary home remediations; and
- Home/environmental accessibility modifications.

Also consistent with the November 2023 CMS guidance, DHCF's proposal targeted beneficiaries transitioning out of or experiencing the following situations:

- Institutional care or congregate settings such as nursing facilities, IMDs, intermediate care facilities, acute care hospitals, group homes, and correctional facilities
- Homelessness, risk of homelessness, or transitioning out of an Emergency Shelter
- Individuals transitioning out of the child welfare system including foster care

Of note, CMS has since rescinded the November 2023 guidance and is considering HRSN waivers on a case-by-case basis.

103. How many unique individuals received the Housing Supportive Services (HSS) Medicaid 1915(i) State Plan benefit in FY 2025 and FY 2026 to date, broken down by housing related activity provided?

Response:

In FY25, 6,497 beneficiaries received Medicaid Housing Supportive Services (HSS) under the 1915(i) benefit. In FY26, 5,201 beneficiaries received HSS services. The chart below breaks out the housing related activity by the two services authorized under the 1915(i) benefit: housing navigation and housing stabilization.

	FY2025*	FY2026*
Total	**6,497****	**5,201****
Housing Navigation***	1,884	753
Housing Stabilization****	5,377	4,514

Source: DHCF MMIS data extracted 12/30/2025.

Notes:

*Reflects final status paid claims with a date of service in the fiscal years shown.

**Sum of rows can exceed unduplicated total due to individuals receiving both service types during the year.

****Housing Navigation*: Services that help a participant plan for, find, and move to housing of their own in the community. Identified in MMIS as the H2044 procedure code with U1 modifier.

*****Housing Stabilization*: Services that help a participant sustain living in their own housing in the community. Identified in MMIS as the H2044 procedure code with U2 modifier.

104. In FY 2024 Performance Oversight responses, DHCF stated they would not move forward with Community Health Workers (CHWs) without certification/license. What was DHCF's rationale for that decision?

a. How is DHCF considering the integration of CHWs in either its Transforming Maternal Health or 1115 waiver?

Response:

DHCF typically relies on DC Health certification/licensure and training requirements to establish provider qualification in Medicaid. This alignment between the agencies helps ensure Medicaid beneficiaries receive services from highly qualified providers while also adding an extra layer of provider oversight from DC Health.

a. As we await DC Health's certification/licensure work, DHCF continues to review opportunities to integrate CHWs throughout its service array. Two specific initiatives that present opportunities for CHW integration are TMaH and the 1115 waiver.

In TMaH, coverage of perinatal CHWs is an optional element of the model. DHCF is awaiting additional information from CMS on what may be required as part of this optional element and how it may be integrated into the value-based payment model currently being designed by CMS. In the interim, DHCF has leveraged the Maternal Health Advisory Group to solicit policy and implementation feedback on maternal health innovation. Over the last year, providers, beneficiaries, and trade associations have met monthly at Maternal Health Advisory Group meeting to inform DHCF, including a meeting in December 2025 focused solely on doulas and perinatal CHWs. The notes from these meetings can be found here: https://dhcf.dc.gov/page/transforming-maternal-health

Similarly, under the 1115 waiver, DHCF is awaiting CMS approval as outlined in the response to Question 102. In the interim, DHCF has leveraged the Health System Redesign (HSR) Subcommittee of the Medical Care Advisory Committee (MCAC) to solicit policy and implementation feedback on the 1115 waiver. Over the last 18 months, providers, beneficiaries, and trade associations have met monthly at the HSR meeting to inform DHCF, culminating in a set of recommendations. One recommendation received from the HSR was to: "Advance the policy changes required to allow community health workers (CHWs) to be a fully integrated workforce to support the provision of HRSN service delivery, within their appropriate scope and training. This will require implementation of certification standards by DC Health, recognition of CHWs as a qualified provider type by DHCF, and identification of covered services. If a systemic approach cannot occur due to funding or other constraints, the Subcommittee recommends DHCF and community stakeholders collaboratively determine if other avenues exist for enhanced integration of this workforce." The notes from these meetings can be found here: https://dhcf.dc.gov/1115-waiver-initiative

105. Please provide the following information on access to care coordination in the District:

a. How does DHCF currently pay for care coordination?

b. Does DHCF set standards, targets, or ratios for how many case managers per member each MCO employs?

If so, please provide the standards and whether each MCO is meeting the requirements.

Response:

a. DHCF's contracted Actuary includes administrative costs as part of capitation rate development, which anticipates the expected cost to operate a Medicaid managed care program. The model includes personnel costs for program management and general administrative operations, as well as non-personnel costs necessary to administer the program, including Case Management as defined by DHCF's contractual requirements.

The care management model includes both care management and care coordination to ensure efficient, coordinated, and quality care. Care coordination is mostly an administrative support, available to all beneficiaries, and often performed by a non-licensed staff member. Case management is a team-based, person-centered approach, that seeks to effectively manage patients' medical, social, and behavioral conditions.

DC Healthy Families Program (DCHFP)

The rate modeling assumes 100% of beneficiaries will have access to care coordination, whereas case management will be focused on low- to high-needs beneficiaries, anticipated to be approximately 10% of the total program population. This projection assumes 100% of SSI Adults 21+ and 5% of other populations receive case management services. The care management modeling includes consideration for case management FTEs based on a beneficiary-to-staff ratio (see next response).

Year (DCHFP)	General Administration Expense	Care Management	Total
FY2025	$31.59	$20.15	$51.74
FY2026	$32.41	$18.70	$51.11

Child and Adolescent Supplemental Security Income Program (CASSIP)

The care management modeling assumes 100% of beneficiaries will have access to care management. Mercer stratified the CASSIP population as low- to specialized high-need members based on the tiers of care management described in the CASSIP contract. The modeling includes consideration for care management FTEs based on a beneficiary to staff Ratio.

Year (CASSIP)	General Administration Expense	Care Management	Total
FY2025	$330.69	$291.25	$621.93
FY2026	$392.02	$310.35	$702.38

b. DHCF does not set staff-to-enrollee ratios for the DC Healthy Families Program (DCHFP). DHCF contractually requires the MCP to assign specified licensed healthcare professionals to enrollees depending on complexity.

For the Child and Adolescent Supplemental Security Income Program (CASSIP), the MCP is meeting the Case Manager-to-Enrollee acuity level ratio requirements, and are as follows:

I. Acuity Level I (Low): 1:100
II. Acuity Level II (Intermediate): 1: 75
III. Acuity Level III (High): 1: 60.

106. How has DHCF stayed involved since Cedar Hill's opening to ensure the full array of services that were promised are being offered?

Response:
DHCF is responsible for effectuating the Operating Agreement between the District and UHS. Those responsibilities are limited to areas such as a request for reserve funding, receipt of annual reporting, and changes to service lines. DHCF communicates and oversees issues related to Medicaid reimbursement for all participating hospitals in the District including Cedar Hill.

107. Who has DHCF recommended for the agency's two vacant positions for Cedar Hill's Board of Directors?

Response:

The Mayor's Office of Appointments reviews and submits candidates for appointment.

108. How many former United Medical Center employees were hired to work at Cedar Hill as part of the employee transfer program? In what capacity?

a. How many are still employed at Cedar Hill today?

Response:

This Operating Agreement does not require this information be provided to the District. UHS, as the private operator, is the appropriate source for this data.

109. Since opening on April 15, 2025, by month, what percentage of Cedar Hill's total net patient revenue has come solely from the emergency department? How does this compare to the hospital's inpatient and outpatient revenue?

Response:

UHS, as the private operator, is the appropriate source for this data.

110. How many ambulance diversions has Cedar Hill facilitated since opening? How long did each diversion last?

Response:

DHCF does not track this data.

110. What is Cedar Hill's payer mix for ED services broken down by month and type of service? For inpatient services?

Response:

UHS, as the private operator, is the appropriate source for this data.

111. What is the new target date for specialty services that were intended to open in July but have not yet opened? Please list out the specialty services and intended launch date.

Response:

UHS, as the private operator, is the appropriate source for this data.

112. Please provide an update on the status of construction and operations for the freestanding emergency department to be opened at the Fletcher Johnson campus in Ward

a. What is the anticipated open date?

Response:

DGS began demolition of the former school and site infrastructure in the fall of 2025 and the site will be turned over to UHS in late 2026. UHS estimates the facility would open in late 2027 or early 2028.

- DGS completed hazmat remediation of the school building in summer 2025
- Partial demolition of the former school was completed in the winter of 2025
- Sealing and weather proofing the partially demolished school building expected to be completed by Feb 2026
- Infrastructure design and permit underway
- Site grading and infrastructure construction expected to be completed in late 2026
- UHS currently estimates construction of the FED will take 12-14 months, followed by a month for regulatory review and approval.
- The facility would then open to patients in late 2027 or early 2028.

113. Since opening until the hospital received its Medicare certifications, how many Medicare beneficiaries sought care and were either deferred, redirected, or offered a payment plan, broken down by service type and month?

Response:
UHS, as the private operator, is the appropriate source for this data.

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

Response:

Please see Q115 attachment.

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

Response:

Please see the attached evaluation. UDC completed this review in FY22, covering fiscal years 2010–2020. They are currently finalizing the evaluation for fiscal years 2021–2023, and we will continue working with them to ensure the subsequent evaluation for FY2024–FY2025 is completed so our office remains current.

117. How many grievances were filed against DHCF providers and DHCF during FY 2025? Please briefly describe the grievances filed and DHCF's response. How many of these grievances did DHCF find in favor of the beneficiary?

a. Please provide a narrative text around the grievances submitted to the Health Care Ombudsman in FY 2025 and FY 2026, to date, that DHCF had a role in reviewing and steps taken to resolve those issues.

Response:

In FY25, a total of 97 administrative hearing requests were filed on behalf of consumers by the Office of Health Care and Public Benefits Ombudsman Bill of Rights (OHCPBOBR). Of the 97 administrative hearing requests that were filed, 53 (55%) were against the Department of Human Services (DHS). Of those 53 hearing requests, 45 (85%) were for inaction or delay in processing an application/recertification for medical benefits; 4 (7%) were for denial of application/recertification for medical benefits; 2 (4%) were for the denial of retro-active Medicaid benefits; and 2 (4%) were regarding the Supplemental Nutrition Assistance Program (SNAP) benefits (reduction and termination).

Of the 97 administrative hearing requests filed, 1 (1%) was filed against the Department on Disability Services (DDS) for the reduction of in-home support services.

Of the 97 administrative hearing requests filed, 43 (44%) were filed against the Department of Health Care Finance (DHCF). Of those 43 hearing requests, 20 (47%) were for inaction or delay in processing an application/recertification for Elderly and Persons with Disabilities (EPD) Waiver benefits; 5 (12%) were for denial or termination of PCA/Private Duty Nursing service hours (unmet or no LOC); 4 (9%) were termination/denial of benefits through the Katie Beckett Waiver (unmet or no LOC); 3 (7%) for denial of increase in PCA hours; 2 (5%) involved case management services (delay in assignment and termination-inability to meet client's needs); 2 (5%) for the denial of medical or dental services; 2 (5%) were for the reduction of PCA services; 1 (2%) denial of payment for nursing home stay; 1 (2%) was for the denial of EPD Waiver application (excess income); 1 (2%) was for non-payment of PCA services (Services My Way Program); 1(2%) was for failure to provide PCA Services; and 1 (2%) was for termination of benefits (program policy change).

Of the 43 DHCF administrative hearing requests filed, 13 (30%) were against United Health Care (UHC) Dual Eligible Special Needs Program (D-SNP). Of those 13 hearing requests, 13 (100%) were for inaction or delay in processing an application/recertification for medical benefits.

Of the 43 DHCF administrative hearing requests filed, 5 (12%) were against Telligen. Of those 5 hearing requests, 3 (60%) were for the denial of an increase in PCA service hours; 1 (20%) was for the reduction of PCA services based on an assessment; and 1 (20%) was for the denial of PCA service based on assessment.

OHCPBOBR was able to determine that 87 (90%) of these hearing requests were resolved successfully in favor of the beneficiary, 7 (7%) were resolved in favor of the provider, 1 (1%) is still pending, and 2 (2%) could not be determined (DDS and DHS).

a. Although hearing requests were not submitted for many issues, as they were promptly addressed, OHCPBOBR still continues to receive 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.

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

118. 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 2025.

Response:

The Office of Health Care and Public Benefits Ombudsman and Bill of Rights (OHCPBOBR) partnered with the Department of Aging and Community Living (DACL), Ward 8 Clergy and Faith Leaders, District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), the Mayor's Office of Latino Affairs, the Mayor's Office of African Affairs, and organizers of various health fairs throughout the District, both in-person and virtually.

In FY 2025, the team participated in 70 community events.

To meet growing demand, OHCPBOBR assigned additional staff to outreach activities due to an increase in requests from organizations across the District. Outreach efforts were tailored based on questions received, discussion topics, and the types of assistance provided during events.

While in the community, the team provides information about OHCPBOBR and assists District residents in verifying their Medicaid eligibility. This year, our office also produced two new brochures:

· Sickle Cell Disease Treatment Brochure

https://healthcareombudsman.dc.gov/sites/default/files/dc/sites/Office%20of%20Health%20Care%20Ombudsman%20and%20Bill%20of%20Rights/page_content/attachments/Sickle%20Cell%20Disease%20Brochure.pdf

· Crisis and Urgent Behavioral Health Services for Children and Youth Brochure

https://healthcareombudsman.dc.gov/sites/default/files/dc/sites/Office%20of%20Health%20Care%20Ombudsman%20and%20Bill%20of%20Rights/page_content/attachments/DHCF_Behavioral_Health_Brochure_2025.pdf

OHCPBOBR continued working directly with managed care organizations' outreach departments to provide education and information about its programs and the role OHCPBOBR plays in ensuring District residents have access to health care services and resources. Additionally, OHCPBOBR provided information at District Government Open Enrollment Fairs.

119. Please provide a status update on Health Care and Public Benefits Ombudsman Program Amendment Act of 2025, including a staffing update, and what new trainings may have been provided to staff to implement this subtitle.

a. How many public benefit cases has the office received in FY 2025 and FY 2026 to-date?

b. How many were resolved?

Response:

In alignment with the implementation requirements of the Health Care and Public Benefits Ombudsman Program Amendment Act of 2025, the Ombudsman staff began accepting public benefits related inquiries in October 2025.

Training for the Health Care and Public Benefits Ombudsman Program staff was conducted in October and November of FY25. All staff completed two days of instruction and more comprehensive training sessions are being planned and will be scheduled as needed bases as the program changes are implemented.

To operationalize the grievance-handling provisions of the subtitle, a process was developed in consultation with DHS to ensure timely routing, review, and resolution of issues as they arise.

a. Of the 15,191 total cases opened in FY25, 5*4* cases were related to SNAP (53) and/or TANF (1). Of the 4785 total cases in FY26, *15* related to SNAP (12) and/or TANF (3).

Of the *15,192* public benefits cases opened in FY25, a total of *14,533* have been resolved to date.

Of the 4,758 public benefits cases opened to-date in FY26 (October 1 – December 31, 2025), a total of 4,271 have been resolved as of January 8, 2026.