From:	Carter, Carla (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=USER71EF86DF <Carla.Carter@HHS.GOV>
To:	Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; Randolph, Jammie (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=431122649a00448ea41f2e1c81c4c4b5-Randolph, J <Jammie.Randolph@hhs.gov>
CC:	Pittman, Ivey R. (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dba36c813f2e4cbfb3d515d544896bf0-Belton, Ive <Ivey.Pittman@hhs.gov>
Subject:	FW: TN litigation involving unwinding & disability discrimination
Date:	2023/08/18 12:53:11
Priority:	Normal
Type:	Note

For your awareness and consideration when OCR receives a complaint concerning Medicaid unwinding issues in Tennessee.

From: Perez, Luis (HHS/OCR) <Luis.Perez@hhs.gov>
Sent: Wednesday, August 16, 2023 9:56 AM
To: Carter, Carla (HHS/OCR) <Carla.Carter@HHS.GOV>
Subject: FW: TN litigation involving unwinding &disability discrimination

---

From: Mara Youdelman <youdelman@healthlaw.org>
Sent: Tuesday, August 1, 2023 3:01 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Cc: Elizabeth Edwards <edwards@healthlaw.org>
Subject: TN litigation involving unwinding &disability discrimination

Hi Melanie and Lauren,

I wanted to share an update on a case we are co-counseling. While the case preceded unwinding, more recent developments involve and unwinding and significant disability access issues are involved.

We've also shared with Karen Baratta who reached out recently about unwinding issues related to LEP &people with disabilities.

If you have any questions, we're happy to help. I've cc'd Elizabeth Edwards who is on our litigation team for this case.

Thanks,
Mara

From: Elizabeth Edwards [mailto:edwards@healthlaw.org]
Sent: Tuesday, August 1, 2023 11:50 AM
To: Stephens, Jessica O. (CMS/CMCS) <Jessica.Stephens@cms.hhs.gov>; MS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>; akg72@georgetown.edu; Allison Orris <aorris@cbpp.org>; Barry, Meg (CMS/CMCS) <meg.barry@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@cms.hhs.gov>; Harris, Monica (CMS/CMCS) <Monica.Harris@cms.hhs.gov>; Idil Samantar <isamantar@cbpp.org>; jca25@georgetown.edu; Jennifer Wagner <jwagner@cbpp.org>; Kim Lewis <lewis@healthlaw.org>; Lovejoy, Shannon (CMS/CMCS) <Shannon.Lovejoy@cms.hhs.gov>; Gravens (she/her), Colleen (CMS/CCIIO) <Colleen.Gravens@cms.hhs.gov>; Mara Youdelman <youdelman@healthlaw.org>; O'Connor, Sarah (CMS/CMCS) <Sarah.OConnor@cms.hhs.gov>; perkins@healthlaw.org; Seng, Suzette (CMS/CMCS) <Suzette.Seng@cms.hhs.gov>; Spector, Sarah (CMS/CMCS) <Sarah.Spector@cms.hhs.gov>; Steinberg, Marc (CMS/CMCS) <Marc.Steinberg@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Tricia Brooks <pab62@georgetown.edu>; Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>; Weiss, Alice (CMS/CMCS) <Alice.Weiss@cms.hhs.gov>; Unwinding Support <UnwindingSupport@mathematica-mpr.com>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; Ginnis (she/her), Kate (CMS/CMCS) <katherine.ginnis@cms.hhs.gov>; Kuhn, Juliet (CMS/CMCS) <Juliet.Kuhn@cms.hhs.gov>; Alicia Emanuel <emanuel@healthlaw.org>
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Sarah Grusin <grusin@healthlaw.org>
Subject: TN Issues: Recent filings in AMC case show ongoing problems

CMS Team,

I mentioned in earlier meetings that we know of ongoing problems in TN due to our litigation, AMC v. Smith, regarding issues with due process (notices and access to hearings), TennCare's ability to evaluate for all categories of eligibility, and ADA violations. Recently, the State filed for summary judgment and yesterday plaintiffs, for which NHeLP is co-counsel, filed their response. I'm not attaching everything that was filed yesterday, but thought you may be most interested in a few things:

- • Plaintiffs' response in opposition to summary judgment: describes issues with inadequate notices, systematic denial of fair hearings, failure to provide access under the ADA and other issues. Also the Plaintiffs' response to the summary of undisputed material fact (SUMF) and the Plaintiffs Additional Disputed Facts (PADF) that are cited in the brief.
- • New declarations from Guyton, Holland, and Riley describing past and recent experiences of individuals having trouble with TennCare coverage and notices/appeals.
- • Redacted version of the expert report that was filed as an exhibit 57 that describes the plaintiffs' expert's opinions regarding ADA issues, including that TennCare does not have a reliable system for providing reasonable accommodations.
- • Defendant's motion for summary judgment. Notably for CMS, TennCare makes a lot of arguments about deference to CMS and CMS having approved or certified what they are doing, including making a point of them not having a mitigation plan. These arguments are primarily towards the end of the brief, p. 28 on, but are not exclusively there.

- Outside of TN, we've heard from advocates that the CMS mitigation plans document is being used as a shield by states that are not identified as having a mitigation plan to say they have no issues. Adding language to that document about it not indicating all compliance issues states may have would be extremely helpful.

I recognize this is a lot of information. If you have limited time, I'd say focus on the response to summary judgment and the new declarations. As always, happy to answer questions or provide more information.

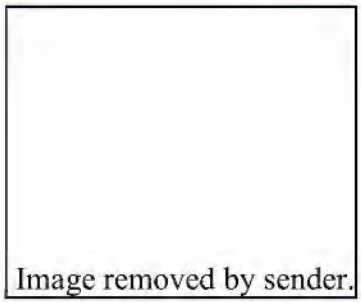
Elizabeth

--

Elizabeth Edwards (she/her/hers)
Senior Attorney
National Health Law Program
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27514
(b)(6)
edwards@healthlaw.org

healthlaw.org

Image removed by sender. Facebook Image removed by sender. Twitter Image removed by sender. LinkedIn



"Securing Health Rights for Those in Need"

NOTICE: The information contained in this e-mail message and any attachments are confidential and may be legally privileged. This message is intended only for the individual(s) named herein or other contacts of the National Health Law Program specifically authorized to receive this communication. If you are not the intended recipient, please notify the sender and delete the message immediately. Please do not store, copy or otherwise disseminate or distribute this e-mail or any part of it.

Sender:	Carter, Carla (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=USER71EF86DF <Carla.Carter@HHS.GOV>
Recipient:	Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; Randolph, Jammie (OS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=431122649a00448ea41f2e1c81c4c4b5-Randolph, J <Jammie.Randolph@hhs.gov>;

	Pittman, Ivey R. (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dba36c813f2e4cbfb3d515d544896bf0-Belton, Ive <Ivey.Pittman@hhs.gov>
Sent Date:	2023/08/18 12:50:44
Delivered Date:	2023/08/18 12:53:11

From:	Albrecht, Sarah B. (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=USERA956839A <Sarah.Albrecht@hhs.gov>
To:	Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>
CC:	Perez, Luis (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=eb4f62687d764a40a5c4e52f94b8354a-Perez, Luis <Luis.Perez@hhs.gov>; Carter, Carla (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user71ef86df <Carla.Carter@HHS.GOV>; Rhodes, Susan (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=486f3fac513b44318992b6a79e96c28a-Rhodes, Sus <Susan.Rhodes@HHS.GOV>; Baratta, Karen (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=usercc9b40cf <Karen.Baratta@HHS.GOV>
Subject:	Aware?: TN litigation involving unwinding & disability discrimination
Date:	2023/08/03 11:06:11
Priority:	Normal
Type:	Note

Barbara,

(b)(5); (b)(7)(E)

Thanks,
Sarah

From: Perez, Luis (HHS/OCR) <Luis.Perez@hhs.gov>
Sent: Tuesday, August 1, 2023 3:50:10 PM
To: Albrecht, Sarah B. (HHS/OCR) <Sarah.Albrecht@hhs.gov>
Subject: FW: TN litigation involving unwinding &disability discrimination

For discussion later this week. Thanks.

From: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>
Sent: Tuesday, August 1, 2023 3:16 PM
To: Perez, Luis (HHS/OCR) <Luis.Perez@hhs.gov>
Cc: Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Subject: FW: TN litigation involving unwinding &disability discrimination

(b)(5); (b)(7)(E)

From: Mara Youdelman <youdelman@healthlaw.org>
Sent: Tuesday, August 1, 2023 3:01 PM
To: Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>
Cc: Elizabeth Edwards <edwards@healthlaw.org>
Subject: TN litigation involving unwinding &disability discrimination

Hi Melanie and Lauren,

I wanted to share an update on a case we are co-counseling. While the case preceded unwinding, more recent developments involve and unwinding and significant disability access issues are involved.

We've also shared with Karen Baratta who reached out recently about unwinding issues related to LEP &people with disabilities.

If you have any questions, we're happy to help. I've cc'd Elizabeth Edwards who is on our litigation team for this case.

Thanks,
Mara

From: Elizabeth Edwards [mailto:edwards@healthlaw.org]
Sent: Tuesday, August 1, 2023 11:50 AM
To: Stephens, Jessica O. (CMS/CMCS) <Jessica.Stephens@cms.hhs.gov>; MS CMCS_Unwinding <CMCSUnwinding@cms.hhs.gov>; akg72@georgetown.edu; Allison Orris <aorris@cbpp.org>; Barry, Meg (CMS/CMCS) <meg.barry@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Delone, Sarah (CMS/CMCS) <Sarah.Delone2@cms.hhs.gov>; Harris, Monica (CMS/CMCS) <Monica.Harris@cms.hhs.gov>; Idil Samantar <isamantar@cbpp.org>; jca25@georgetown.edu; Jennifer Wagner <jwagner@cbpp.org>; Kim Lewis <lewis@healthlaw.org>; Lovejoy, Shannon (CMS/CMCS) <Shannon.Lovejoy@cms.hhs.gov>; Gravens (she/her), Colleen (CMS/CCIIO) <Colleen.Gravens@cms.hhs.gov>; Mara Youdelman <youdelman@healthlaw.org>; O'Connor, Sarah (CMS/CMCS) <Sarah.OConnor@cms.hhs.gov>; perkins@healthlaw.org; Seng, Suzette (CMS/CMCS) <Suzette.Seng@cms.hhs.gov>; Spector, Sarah (CMS/CMCS) <Sarah.Spector@cms.hhs.gov>; Steinberg, Marc (CMS/CMCS) <Marc.Steinberg@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Tricia Brooks <pab62@georgetown.edu>; Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>; Weiss, Alice (CMS/CMCS) <Alice.Weiss@cms.hhs.gov>; Unwinding Support <UnwindingSupport@mathematica-mpr.com>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; Ginnis (she/her), Kate (CMS/CMCS) <katherine.ginnis@cms.hhs.gov>; Kuhn, Juliet (CMS/CMCS) <Juliet.Kuhn@cms.hhs.gov>; Alicia Emanuel <emanuel@healthlaw.org>
Cc: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Sarah Grusin <grusin@healthlaw.org>
Subject: TN Issues: Recent filings in AMC case show ongoing problems

CMS Team,

I mentioned in earlier meetings that we know of ongoing problems in TN due to our litigation, AMC v. Smith, regarding issues with due process (notices and access to hearings), TennCare's ability to evaluate for all categories of eligibility, and ADA violations. Recently, the State filed for summary judgment and yesterday plaintiffs, for which NHeLP is co-counsel, filed their response. I'm not attaching everything that was filed yesterday, but thought you may be most interested in a few things:

- • Plaintiffs' response in opposition to summary judgment: describes issues with inadequate notices, systematic denial of fair hearings, failure to provide access under the ADA and other issues. Also the Plaintiffs' response to the summary of undisputed material fact (SUMF) and the Plaintiffs Additional Disputed Facts (PADF) that are cited in the brief.
- • New declarations from Guyton, Holland, and Riley describing past and recent experiences of individuals having trouble with TennCare coverage and notices/appeals.
- • Redacted version of the expert report that was filed as an exhibit 57 that describes the plaintiffs' expert's opinions regarding ADA issues, including that TennCare does not have a reliable system for providing reasonable accommodations.
- • Defendant's motion for summary judgment. Notably for CMS, TennCare makes a lot of arguments about deference to CMS and CMS having approved or certified what they are doing, including making a point of them not having a mitigation plan. These arguments are primarily towards the end of the brief, p. 28 on, but are not exclusively there.
    - • Outside of TN, we've heard from advocates that the CMS mitigation plans document is being used as a shield by states that are not identified as having a mitigation plan to say they have no issues. Adding language to that document about it not indicating all compliance issues states may have would be extremely helpful.

I recognize this is a lot of information. If you have limited time, I'd say focus on the response to summary judgment and the new declarations. As always, happy to answer questions or provide more information.

Elizabeth

--

Elizabeth Edwards (she/her/hers)
Senior Attorney
National Health Law Program
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27514
(b)(6)
edwards@healthlaw.org

healthlaw.org
Facebook Twitter LinkedIn

NATIONAL HEALTH LAW PROGRAM

"Securing Health Rights for Those in Need"

NOTICE: The information contained in this e-mail message and any attachments are confidential and may be legally privileged. This message is intended only for the individual(s) named herein or other contacts of the National Health Law Program specifically authorized to receive this communication. If you are not the intended recipient, please notify the sender and delete the message immediately. Please do not store, copy or otherwise disseminate or distribute this e-mail or any part of it.

Sender:	Albrecht, Sarah B. (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=USERA956839A <Sarah.Albrecht@hhs.gov>
Recipient:	Stampul, Barbara (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=aba3e5fc28844f3399581d12fbec4fcb-Stampul, Ba <Barbara.Stampul@hhs.gov>; Perez, Luis (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=eb4f62687d764a40a5c4e52f94b8354a-Perez, Luis <Luis.Perez@hhs.gov>; Carter, Carla (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user71ef86df <Carla.Carter@HHS.GOV>; Rhodes, Susan (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=486f3fac513b44318992b6a79e96c28a-Rhodes, Sus <Susan.Rhodes@HHS.GOV>; Baratta, Karen (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=usercc9b40cf <Karen.Baratta@HHS.GOV>
Sent Date:	2023/08/03 11:05:27
Delivered Date:	2023/08/03 11:06:11

Administrative Complaint

Office for Civil Rights
U.S. Department of Health and Human
Services 200 Independence Avenue, S.W.,
Room 509F Washington, DC 20201

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Discriminatory Medicaid Renewal Processes in the District of Columbia

The National Health Law Program (NHeLP) and Disability Rights DC at University Legal Services (DRDC) file this complaint on behalf of the people with disabilities who are discriminated against by the policies and processes of, and failure to act by the Department of Health Care Finance (DHCF), the Medicaid agency for the District of Columbia (DC). NHeLP protects and advocates for the health rights of low-income and underserved individuals, including people with disabilities, through advocacy, education, and litigation at the federal and state levels. DRDC is the federally mandated protection and advocacy program (P&A) for DC and represents people with disabilities and older adults who rely on long-term care (LTC) services, among other activities. NHeLP and DRDC have been advocating to address Medicaid renewal issues causing coverage losses in DC throughout the unwinding of the Medicaid continuous coverage period.

DHCF operates Medicaid renewal systems and processes that fail to provide equal access to Medicaid coverage, and DC residents with disabilities have been harmed by the methods of administration that have caused Medicaid-eligible disabled individuals to lose their coverage. Specifically, DHCF:

5th Interim Response 9

- Operates Medicaid eligibility computer systems that limit the ability of individuals receiving LTC to renew their Medicaid coverage independently, forcing them to rely on the unreliable assistance of Medicaid providers or case managers and not assistants of their own choosing;
- Screens out individuals with disabilities by failing to use available information to complete *ex parte* renewals and requiring individuals to submit information that is already available to the agency; and
- Fails to halt procedural terminations for this population and protect eligible individuals from improper loss of coverage or otherwise intervene to ensure ongoing coverage and services when responsible entities fail to perform their assigned duties.

Legal Background[1]

DHCF has an affirmative obligation to people with disabilities to ensure equal access to services and nondiscrimination under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.[2] States and DC must not simply avoid disability discrimination, but actively ensure access to its programs and services, including through program design and policy choices as well as evaluations of access.[3] A Title II entity must also make reasonable accommodations to its policies and procedures when necessary to ensure program access to people with disabilities and make program choices such that the program does not discriminate by design or policy.[4] A program that responds *ad hoc* to access issues, fails to adequately plan, requires individuals to hope assistance occurs, or otherwise deters access does not meet the affirmative obligations of disability discrimination protections.[5] DHCF's failure

---

[1] "DOJ and HHS both enforce the Americans with Disabilities Act (ADA) with respect to state Medicaid programs. . . . This includes providing individuals with disabilities equal opportunity to participate in and benefit from a state's Medicaid program." U.S. Dep't of Justice Civil Rts. Div. & Ctrs. for Medicare & Medicaid Services, Dear State Medicaid Admin. & Other Interested Parties (Jan. 24, 2024).

[2] 42 U.S.C. § 12132; 29 U.S.C. § 794; *see also Pierce v. Dist. of Columbia*, 128 F. Supp. 3d 250, 269 (D.D.C. 2015) (discussing the affirmative obligations under the ADA and obligation to evaluate programs and services to ensure they are providing access).

[3] 42 U.S.C. § 12132; 28 C.F.R. § 35.130(b); *Tennessee v. Lane*, 541 U.S. 509, 524-26 (2004) (the ADA is prophylactic measure needed to counter systematic deprivations of rights); *Ability Ctr. of Greater Toledo v. Sandusky*, 385 F.3d 901, 907 (6th Cir. 2004); *see also Pierce* 128 F. Supp. 3d at 269.

[4] 42 U.S.C. § 12101(a)(5) (ADA purpose includes discriminatory policies and criteria); 385 F.3d at 901; *Disabled in Action v. Bd. of Elections*, 752 F.3d 189, 200-02 (2d Cir. 2014).

[5] *Disabled in Action*, 752 F.3d at 200-02.

to provide access to Medicaid coverage and reasonable accommodations to the existing renewal procedures amounts to deliberate indifference to Medicaid beneficiaries with disabilities' rights.[6] The relevant inquiry is "whether those with disabilities are as a practical matter able to access benefits to which they are legally entitled."[7] DC residents enrolled in LTC do not have such access to Medicaid coverage.

Statement of Problems

As a result of DHCF's choices, individuals with disabilities who need LTC are being improperly terminated from Medicaid coverage, including due to case managers failing to submit renewals timely.[8] This includes those who use home and community-based waiver services, such as DC's Waiver Program for People who are Elderly and/or have Physical Disabilities ("EPD Waiver"). For EPD Waiver participants, losing Medicaid coverage means losing needed waiver services, causing segregation from the community and increased risk of institutionalization.[9] In addition, the LTC population does not have the ability to submit information or have their choice of assistance as required by the Medicaid Act while other DC Medicaid enrollees may submit their information and have choice of assistance. This barrier is due to the design of the LTC eligibility system that limits access to certain providers and related policy choices that discriminatorily limit independence of the LTC population.[10]

I. DHCF's Renewal Process for the LTC Population Limits Access to Coverage.

DHCF operates different renewal systems for different Medicaid populations, and these systems do not provide equal access to coverage. The design of the system and policy

---

[6] *Pierce*, 128 F. Supp. 3d at 278-79.
[7] *Henrietta D. v. Bloomberg*, 331 F.3d 261, 273 (2d Cir. 2003).
[8] 42 C.F.R. 435.930(a). The District must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures" and must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible."
[9] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).
[10] 29 U.S.C. § 701(b)(1) (stating the purpose of the Rehabilitation Act is "to empower individuals with disabilities to maximize . . . independence, and inclusion and integration into society"); *Disabled in Action*, 752 F.3d at 200-02 (discussing the importance of access to voting that is independent and deterrence from access is an injury). The Medicaid Act requires an application and renewal process by a system that allows residents to file forms online, in person by mail, or by telephone. 42 U.S.C. § 18083. It also requires that an individual be allowed their choice of assistance in the application and renewal process. 42 C.F.R. § 435.908(b).

choices, including failures by DHCF to remediate known problems, screen out people with disabilities in the LTC population, impose additional eligibility criteria on them, and use methods of administration that discriminate against the LTC population—all substantially impairing their access to Medicaid coverage.[11]

A. Continuing Reliance on Non-Performing Case Management Screens Out EPD Waiver and other LTC Participants.

In DHCF's current DC Access System (DCAS) a renewal for an individual receiving LTC must occur through the DC Direct Partner Portal. DHCF made the design choice to limit access to the Partner Portal to LTC providers, including ICF/IDs, nursing facilities, PACE providers and EPD Waiver case managers. Individuals cannot access their own information or file through the Partner Portal. Only designated agencies can submit information through the Partner Portal. These designated agencies are all providers and therefore limit choice of assistance for beneficiaries.[12] LTC enrollees cannot submit their renewal forms through the DHCF portal available to non-LTC enrollees.[13]

For EPD Waiver participants, their case managers are the Partner Portal providers and are explicitly responsible for "ensuring a beneficiary timely completes Medicaid reassessment(s) as part of the annual recertification requirements."[14] Case management for EPD Waiver participants is performed by private providers contracted with DHCF.[15] Many of these EPD Waiver case management agencies have a history of non-performance including failures to: complete the minimum required contacts, create person centered service plans, request prior authorizations, and complete renewal

---

[11] 28 C.F.R. §§ 35.130(b)(1)(ii), (iv), (2), (3), (8); *see also Ability Ctr. of Greater Toledo*, 385 F.3d at 907; *Henrietta D.*, 331 F.3d 261, 273 (2d Cir. 2003). The LTC population cannot submit the required renewal information through the portal available to non-LTC Medicaid enrollees.

[12] Not all EPD waiver providers have access to the Partner Portal. Direct care agencies do not have such access and can only "collaborate and support case managers." Ex. 1, Letter from Melissa Byrd, Sen. Deputy Dir. & Medicaid Dir., DHCF, to Lyndsay Niles, Managing Attorney, DRDC et al. 2 (July 28, 2023) [hereinafter "DHCF Response to Advocates"].

[13] See DHCF, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement, Bi-weekly Meeting #7, at 15 (June 21, 2023), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20062123.pdf.

[14] 29 D.C. Mun. Regs. Tit. §§ 4203, 4224.14.

[15] For the minority of the EPD waiver population of individuals enrolled in the D-SNP program with United Healthcare, renewal assistance is provided by those case managers.

forms.[16] As of June 1, 2023, DHCF identified at least six fee-for-service case management agencies, or one-third of case management providers, as having been issued formal requests for remediation related to redeterminations.[17] DHCF did not take action to ask individuals if they wanted to move from these case management entities or otherwise meaningfully ameliorate the harm to the affected individuals; it vaguely promised to "leverage any options within its authority to obtain and process the information required."[18] DHCF also extended the time period to submit the renewal by 30 days for those who did not submit the renewal timely, but this did little to address the issues as the response rate with that extension remained low. DHCF has not taken steps to prevent EPD waiver and other LTC enrollees from being disenrolled due to program design and dysfunction.

EPD case management renewal problems only got worse. In October 2023, DHCF reported that at least 16 of the EPD waiver case management agencies, which serve 96% of the fee-for-service population, have failed to timely submit and process

---

[16] Ex. 2, Letter from Claudia Schlosberg, Interim Convener, DC Coalition on Long-Term Care to Melisa Byrd, Senior Deputy & State Medicaid Dir., DHCF 3-4 (July 25, 2023) [hereinafter "DC Coalition Ltr. to DHCF"]; Ex. 3, Letter from Lyndsay Niles, Managing Attorney, DRDC et al., to Melisa Byrd, Sen. Deputy Dir./Medicaid Dir., D.C. Dept. of Health Care & Fin.; Katherine Rogers, Dir., Long-Term Care Admin., D.C. Dept. of Health Care & Fin. 3-4 (July 18, 2023) [hereinafter "DC Advocates Ltr."]; Ex. 4, Letter from Lyndsay Niles, Managing Attorney, DRDC, to Deputy Mayor Wayne Turnage, DC Office of the Deputy Mayor for Health & Human Servs. et al. 3-4 (Oct. 25, 2023) [hereinafter "DRDC Oct. Ltr."].

[17] DHCF Response to Advocates, *supra* note 12, at 2. According to the last updated list of approved EPD Waiver providers available on DHCF's website, there are only 18 case management agencies, meaning one-third of case management agencies were under remediation. DHCF, Medicaid LTSS Provider Information Update, Medicaid LTSS Provider Listing (Approved Providers for EPD Waiver and State Plan Services, *available at* https://dhcf.dc.gov/node/1418101; DHCF Response to DRDC, *supra* note 18, at 2.

[18] DHCF Response to Advocates, *supra* note 12, at 2. DHCF promised to review the case files for the EPD waiver beneficiaries due for renewal in June that did not renew by the July 31, 2023 deadline in order to "better understand and hopefully determine any underlying causes [sic] non-responsiveness. The results of this review will inform whether additional agency action is needed related to the affected individuals and inform changes to our outreach and engagement activities. *Id.* at 3. Despite DRDC raising similar concerns regarding case management performance in its October 10, 2023 letter to DHCF, the agency did not report on this "review" or any findings. *Compare* DRDC Oct. Ltr., *supra* note 16 *with* Ex. 5, Letter from Melissa Byrd, Sen. Deputy Dir. & Medicaid Dir., DHCF, to Lyndsay Niles, Managing Attorney, DRDC (Dec. 12, 2023) [hereinafter "DHCF Response to DRDC"].

renewals.[19] Providers with repeat compliance notices are attending mandatory retraining and technical assistance, with future threat of sanctions for ongoing noncompliance.[20] Despite the ongoing noncompliance and more recent nearly complete non-compliance by case management agencies and procedural termination of EPD waiver members, DHCF has not described taking action steps to actually assist affected individuals. DHCF's policy of requiring case managers to assist individuals with disabilities in completing the Medicaid renewal is itself a policy that should help ensure access as people with disabilities commonly need assistance with the complex documentation and eligibility requirements of disability-related categories.[21] However, this policy choice fails to meet that goal when the case managers are the only ones who can complete the process, and they fail to perform their required function. DHCF's choice to focus on provider retraining is more of a long-term solution and does not address the immediate need to ensure access to the renewal process and ongoing coverage for the affected EPD waiver population and other LTC enrollees.

B. DHCF System Choices Limit LTC Passive Renewals and Create Unnecessary Administrative Burdens.

The need for assistance is exacerbated by DHCF's choices to move to an updated eligibility system. DHCF moved to the new DCAS systems for the LTC population

---

[19] DHCF, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement, Bi-weekly Meeting #16, at 13 (Oct. 25, 2023), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20102523%20%281%29.pdf. Subsequent presentations have simply reminded that "Beneficiaries with LTC and Waiver Coverage SHOULD have their renewal completed by a case worker" and that case workers are expected to complete the beneficiary's renewal through the case worker's version of District Direct, the Partner Portal. *See, e.g.*, DHCF, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement, Bi-weekly *Meeting* #22, at 6 (Feb. 28, 2024), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Community%20Meeting%20022824.pdf. *See also* DHCF, Meeting Recordings and Slides, https://dhcf.dc.gov/page/meeting-recordings-and-slides [last visited Mar. 6, 2024]. The same slide from the Feb. 28, 2024 meeting is also in other slide decks, including Feb. 14, 2024, Jan. 17, 2024; Dec. 20, 2023; and Dec. 6, 2023 but no additional information about actions taken by DHCF to assist this population is included. *Id.*

[20] DHCF Response to Advocates, *supra* note 12, at 2; DHCF Response to DRDC, *supra* note 18, at 2; DHCF, Bi-weekly Meeting #16, *supra* note 19, at 13.

[21] 29 D.C. Mun. Regs. Tit. §§ 4203, 4224.14.

without information needed for the new system from the legacy system, ACEDS.[22] This choice limited the number of EPD Waiver and other LTC participants who could be renewed passively and placed unnecessary documentation burdens on those individuals in the form of longer renewal forms.[23]

The forms a LTC eligible individual must return through their case manager or facility vary depending on when they were found eligible, but regardless of which form they are sent, they are facing requests to provide information to which DHCF should already have access.[24] If found eligible before November 15, 2021, which is many of the EPD waiver enrollees, an individual must work through their case manager or facility to return the 46-page conversion form and the LTC supplement.[25] The conversion form essentially asks all the same questions as a DHCF Medicaid application.[26] A LTC

---

[22] DHCF Response to DRDC, *supra* note 18, at 3. DHCF says that DCAS needs information that ACEDS does not have and that the information is collected through the one-time conversion renewal forms. *Id.* However, DHCF does not indicate that all of the information requested is not otherwise available to it or not required. For example, the forms request information about current facility, which is not even relevant for waiver participants, but is also available to the agency through billing records. It also requests information on disability, which should be available based on enrollment in the waiver and other data as well.

[23] EPD Waiver enrollees need their LOC assessment to remain eligible for the waiver. 29 D.C. Mun. Regs. Tit. §§ 4201.2(a), 4201.6; DC Coalition Ltr. to DHCF, *supra* note 16, at 3.

[24] *Id.* Information should be available through data sources, including information available due to enrollment in the EPD waiver. Agencies are supposed to first try to renew non-MAGI eligible members through information available to the agency. 42 C.F.R. § 435.916(b).

[25] DHCF, Medicaid Restart Renewal Notices, https://dhcf.dc.gov/page/medicaid-restart-renewal-notices [last visited Feb. 23, 2024] [hereinafter DHCF Renewal Notices List]. DHCF, *Sample Notice: Conversion Renewal Form*, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/documents/%23%202%20Conversion%20Renewal%20Form%20Notice%20.pdf; DHCF, Sample Notice: Long Term Care Renewal Form, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/documents/%23%205%20LTC%20Renewal%20Form%20Notice.pdf. DHCF indicated in a meeting that those found eligible after November 15, 2021 would submit the LTC supplement and a pre-populated form that is shorter than the conversion form, but it is not clear what form they meant.

[26] The conversion form appears to be the general and non-MAGI Medicaid questions from the DHS Integrated Application, which is the application the DHCF website directs people to for non-MAGI categories. *See* DHCF, How to Apply for DC Medicaid?, https://dhcf.dc.gov/service/how-apply-dc-medicaid; DHS, DHS Integrated Application, https://dhs.dc.gov/sites/default/files/dc/sites/dhs/page_content/attachments/Integrated%20Application%2009092021a%20Final%20_0.pdf. Most non-MAGI beneficiaries were

supplement asks many of the same questions regarding household members, income, and assets. Those found eligible after November 15, 2021 must return the LTC supplement.[27] Federal law requires the Medicaid agency to redetermine eligibility by using reliable information available in the individual's account or available to the agency, only contacting the individual to supplement.[28] DHCF has information available to it that it did not use during the ex parte process and is not pulling before sending documentation requests to non-MAGI eligible individuals.

Although DHCF cites CMS-approved mitigation plans for its failure to transfer non-MAGI information to DCAS in its responses to DRDC's letters, these mitigations only limit some income and asset requests, and they rely on providers to engage and assist beneficiaries with their Medicaid renewals.[29] This mitigation plan is reliant on the case management providers actually providing the expected services, which they have not. In addition, although DHCF touts that they are "encouraging and facilitating" providers' opportunities to provide enrollment supports but most of these providers do not have access to DCAS and must also rely on the non-performing case managers to submit any information.[30] DHCF's choices screen out people with disabilities, including the EPD Waiver participants, and inhibit access to ongoing coverage.[31]

II. DHCF's Provider Portal and Policy Framework Interfere with the Right to Independence and Choice.

Independence, autonomy, and choice are key elements of disability rights and the protections of nondiscrimination statutes.[32] As recognized in other areas of accessibility, independent access is the goal with program features and policies to ensure access included, including modifications as needed and reasonable. For example, physical accessibility requirements are structured so that access is addressed for most types of

---

required to submit a conversion renewal form. Ex. 6, Dept. of Health Care Fin., Fiscal Year 2023 Performance Oversight Pre-Hearing Responses 50 (2024).

[27] DHCF Renewal Notices List, *supra* note 25.

[28] 42 C.F.R. § 435.916(b).

[29] DHCF Response to DRDC, *supra* note 18, at 3; *see also* CMS, Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023 at 5, https://www.medicaid.gov/sites/default/files/2023-07/sum-st-mit-strat-comply-medi-renew-req.pdf.

[30] DHCF Response to DRDC, *supra* note 18, at 2-3.

[31] 28 C.F.R. § 35.130(b)(1)(ii), (2), (3), (8).

[32] *See, e.g.*, 29 U.S.C. § 701(b)(1); *see also Pashby v. Delia*, 708 F.3d 307 (4th Cir. 2013) (discussing a key feature of community integration versus institutionalization is autonomy and personal choice).

disabilities, including those with limited mobility, visual impairments, and limited hearing. A building cannot simply put a ramp in place when someone needs it; change must be part of the design and permanent so that an individual who needs to use a ramp instead of stairs can do so without asking.[33]

The Medicaid Act recognizes the importance of individual choice and autonomy in eligibility processes. Individuals must be allowed to have assistance from the person of their choice during application and renewal.[34] They must also be allowed to designate an individual or organization to act as an authorized representative.[35] The authorized representative must be allowed to complete and submit a renewal form, receive copies of the individual's notices and other agency communications, and act on behalf of the individual in all matters with the agency.[36] Non-LTC enrollees may use the assistance of their choice, complete the renewal process independently, and use a separate portal and processes generally. DHCF's requirement that a LTC must work through their case manager or facility to complete their Medicaid renewal limits access, provides an ineffective alternative program, denies access to the program that is not different, and limits choice and autonomy.[37]

III. DHCF's Choices Harm Individuals with Disabilities.

DHCF's renewal processes are harming LTC enrollees, particularly those in the EPD waiver. Although these individuals are likely eligible for ongoing waiver services and other LTC services, the District is subjecting them to serious risk of harm, institutionalization, and potentially death. The most recent data from DHCF shows that an average of 25 percent of EPD Waiver participants, or over 100 individuals, have been procedurally terminated each month.[38] Eight percent complete renewals during the current one month extension period, and four percent complete a renewal later, with three percent within the 90-day recertification period and one percent after that time.[39] DHCF reports that approximately 21 percent of EPD Waiver participants due to recertify on or before September 30, 2023 remain disenrolled as of January 2, 2024.[40] Although DHCF offered vague assumptions that many of those disenrolled may have passed

---

[33] *Tennessee v. Lane*, 541 U.S. 509 (2004); *Dopico v. Goldschmidt,* 687 F.2d 644, 652 (2d Cir. 1982); *see also Disabled in Action,* 752 F.3d at 200-01 (recognizing the importance of independence and privacy).
[34] 42 C.F.R. § 435.908(b).
[35] 42 C.F.R. § 435.923.
[36] *Id.*
[37] 28 C.F.R. §§ 35.130(b)(1)(iii)-(v); (2)-(4); (8).
[38] Ex. 6, *supra* note 26, at 78-79.
[39] *Id.* at 79.
[40] *Id.*

away or moved, more detailed information has not been made available to understand the impact of DHCF's actions.[41]

The District is aware its choices are harming people with disabilities because this is not the first time that DHCF's processes have had a detrimental impact on coverage for EPD waiver participants. In 2012, bureaucratic problems leading to procedural terminations left many EPD waiver participants without services, struggling for care and overall survival.[42] In 2012, DHCF similarly cited problems with contract case managers submitting incomplete or late paperwork.[43] In contrast to EPD Waiver participants, those receiving ID/DD waiver services have not experienced the same extent of problems and have had more timely renewals, with a primary difference being that case managers for that program are agency employees under the Developmental Disabilities Administration.[44]

In the face of questioning and requests from multiple parties, DHCF has not reported on any evaluation of the ongoing accessibility of its program.[45] It has not released numbers that indicate the current situation of those who have been disenrolled from the EPD Waiver and other LTC services. In response to advocacy letters, DHCF declined to halt procedural terminations for this population and does not claim to be doing any follow up or checking on whether individuals are actually receiving promised assistance to retain coverage.[46] Nor is DHCF doing anything to stop procedural terminations caused by case management failures.

---

[41] DHCF Response to DRDC, *supra* note 18, at 3 ("Some of these beneficiaries do not appear to be actively using their Medicaid coverage, may be living outside of the District, or are deceased.")

[42] Alexia Campbell, *D.C. Dropped Hundreds of People from Medicaid Rolls without Cause, Attorneys Say*, WASH. POST (Aug. 11, 2013), https://www.washingtonpost.com/local/dc-dropped-hundreds-of-people-from-medicaid-rolls-without-cause-attorneys-say/2013/08/11/63d9ec54-002e-11e3-9711-3708310f6f4d_story.html.

[43] *Id.*

[44] DC Coalition Ltr. to DHCF, *supra* note 16, at 3, n. 2; *see also* DRDC Oct. Ltr., *supra* note 16, at 4, n. 13-15; DHCF, Bi-weekly Meeting #16, *supra* note 19, at 18 (out of 300 EPD waiver individuals that may have been improperly terminated for procedural reasons, 133 had died and 37 had entered nursing facilities; 95 were receiving Medicaid state plan services and 69 people were re-enrolled into waiver services).

[45] *Compare id.*; DRDC Oct. Ltr., *supra* note 1616; DC Advocates Ltr, *supra* note 16 *with* DHCF Response to Advocates, *supra* note 12; DHCF Ltr. to DRDC, *supra* note 18; *see also Pierce v. Dist. of Columbia,* 128 F. Supp. 3d at 269 (responsibility for ongoing evaluation).

[46] DHCF Response to DRDC, *supra* note 18, at 2-3. Although DHCF maintains lists of EPD Waiver enrollees up for renewal, it does not use these lists to prevent wrongful

Conclusion

DHCF created the barriers to access for the LTC population and knows that effective case management is important based on other populations, yet continues to simply sanction by issuing remediation requests, provide training to providers, and promote mechanisms for others to provide assistance. DHCF is not pausing procedural terminations for this group or otherwise using the information it claims to be collecting from providers to evaluate the reason for failure to respond before allowing a procedural termination to move forward. Nor has DHCF notified individuals approaching a procedural termination that they may change case managers and receive an extension if necessary. While providing more time can be helpful, more time does not address the barriers to access that the DHCF has built into its system. DHCF is allowed to use a different system for LTC participants, but such a system must functionally provide equal or greater access to Medicaid coverage through the renewal process, while recognizing the rights of individuals to use their choice of assister and independently submit information.[47] DHCF's LTC renewal processes do no such thing.

DHCF is not taking necessary actions to meet its affirmative obligations to the EPD Waiver population or others affected by the separate LTC eligibility system. We ask that DHCF be required to:

- Halt procedural terminations for the affected populations;
- Evaluate those terminated since renewals began anew in 2023 and reinstate Medicaid and EPD Waiver services where case management did not submit information timely;

---

terminations or follow up to remediate procedural terminations occurring from failures by case management agencies. In comparison, DHCF recently touted that it identified "an issue affecting children with special needs" regarding children with SSI program codes and that its "response was to reinstate coverage for the impacted children while we work to solve the root cause of the problem." Wayne Turnage, Deputy Mayor for Health & Human Servs. & Dir., Dept. of Health Care Fin., Testimony at the Fiscal Year 2023-24 *Performance Oversight Hearing* 8 (Feb. 8, 2024), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/FY2023-24%20DHCF%20Performance%20Oversight%20Testimony%20-%202.7.2024.pdf; DHCF, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement, Bi-weekly Meeting #22, at 10 (Feb. 28, 2024), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Community%20Meeting%20022824.pdf (DHCF paused terminations and reinstated eligibility for some children with SSI who were improperly terminated.).

[47] 28 C.F.R. § 35.130(b)(1)(iv), (vii), (2).

- Allow alternatively pathways for LTC enrollees to complete the renewal process, including other providers and assisters to help complete the renewal process and DHCF staff to provide direct, one-on-one assistance to renew every LTC impacted by case manager neglect; and
- Implement policy changes to ensure equal access with all appropriate monitoring necessary to ensuring ongoing access.

Dated: March 12, 2024

Respectfully submitted,

Elizabeth Edwards
Jane Perkins
National Health Law Program
1512 E. Franklin St., Ste. 110
Chapel Hill, NC 27514
edwards@healthlaw.org
perkins@healthlaw.org

Lyndsay Niles
Disability Rights DC at University Legal Services
220 I Street NE, Ste. 130
Washington, D.C. 20002
lniles@uls-dc.org

DISABILITYRIGHTSDC

VIA EMAIL: melisa.byrd@dc.gov; katherine.rogers@dc.gov

July 18, 2023

Melisa Byrd, Senior Deputy Director/Medicaid Director
DC Department of Health Care Finance
441 Fourth St. NW, Suite 900S
Washington, DC 20001

Katherine Rogers, Director, Long-Term Care Administration
DC Department of Health Care Finance
441 Fourth St. NW, Suite 900S
Washington, DC 20001

Re: Medicaid Renewals for Long-Term Care Beneficiaries

Dear Ms. Byrd and Ms. Rogers:

As you know, Disability Rights DC at University Legal Services (DRDC) is the designated protection and advocacy program for the District of Columbia that represents DC residents with disabilities. We, together with the Office of the D.C. Long-Term Care Ombudsman and Legal Counsel for the Elderly, write regarding our serious concerns about the high rate of Medicaid beneficiaries that face procedural terminations, including long-term care beneficiaries who face termination because their case manager has failed to timely complete the renewal process. As of June 15, 2023, of the 71,087 Medicaid beneficiaries with Medicaid certification end dates on or before August 31, 2023, approximately 57.1% are at risk of termination due to non-response.[1] Although we applaud DHCF for agreeing to extend Medicaid coverage by 30 days[2] for 6/30 and 7/31 non-MAGI certification end dates to respond to this issue, DRDC is troubled that DHCF has declined to extend prior authorizations for long-term care services and other essential services for this non-MAGI group despite CMS allowing DHCF this flexibility.

Accordingly, we urge DHCF to immediately extend prior authorizations for these long-term care and other non-MAGI beneficiaries. As outlined in DRDC's February 14, 2023 letter, DHCF must modify its renewal policies and practices as necessary to accommodate people with disabilities and to prevent discrimination. Extending prior authorizations are necessary to

[1] DC Department of Health Care Finance Eligibility Monitoring Dashboard: Medicaid Unwinding Report and Related Data, last updated June 15, 2023, available at https://app.powerbigov.us/view?r=eyJrIjoiMjg0MzBmYmUtMzY1NS00Y2U5LWIxZTQtZjNlZTQwZmFmZWY2IiwidCI6IjhmZTQ0OWYxLThiOTQtNGZiNy05OTA2LTZmOTM5ZGE4MmQ3MyJ9.

[2] It is also our understanding that CMS will also permit DHCF to grant additional extensions as needed to allow for completion of the renewal process.

prevent unnecessary institutionalization and to maintain the health and safety of these Medicaid beneficiaries who have or will without prior authorization lose access to EPD waiver services and other critical services they need to remain in the community. Because these long-term care beneficiaries are not allowed to submit renewals on their own and must rely on a case manager to do so, DHCF should also extend prior authorizations in fairness to these beneficiaries because the lack of response is at no fault of their own.[3]

DRDC also raised concerns in its February 14, 2023 letter about DHCF's plans to rely on providers such as EPD waiver case managers to shepherd beneficiaries through the complicated redetermination process. These concerns have been realized, in part, by these providers' failure to timely complete the renewal process. DHCF must hold its providers accountable for failing to submit Medicaid renewals. Please answer the following questions regarding provider accountability:

1. When case managers are not being responsive and the result is that a beneficiary loses eligibility, how will DHCF hold these case managers accountable? What is the penalty to the case manager? Will DHCF accept this as grounds to have the beneficiary's Medicaid automatically reinstated because the termination was through no fault of their own?
2. Because DHCF has indicated it is not able to open the Partner Portal to other provider partners, have you considered a work around that would allow other assisters and authorized representatives to complete the renewal process for EPD waiver beneficiaries? If not, why not?

If DHCF maintains that it will not extend prior authorizations, please answer the following additional questions:

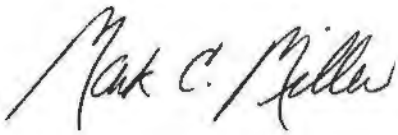
1. What is the reason(s) for not extending prior authorizations for on-going services that the beneficiary is receiving while DHCF is extending Medicaid eligibility?
2. What steps will DHCF take to ensure continuity of care and treatment for Medicaid beneficiaries who are receiving on-going care (e.g., PCA services, Waiver services, ADHP, Assisted Living, etc.), or who are undergoing a course of treatment?
3. Is it DHCF's position that claims submitted by the provider after the expiration of the prior authorization will not be paid?
4. What guidance is DHCF offering providers about their obligations to continue to provide services and treatment after a prior authorization has ended?
5. Other than the beneficiary filing a fair hearing request, will DHCF take any specific steps to ensure care is not interrupted?

Please provide a comprehensive response to this letter by July 28, 2023. Thank you for your attention to this urgent matter.

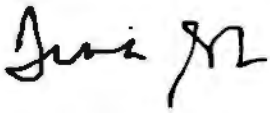
Sincerely,

Lyndsay Niles, Managing Attorney

[3] Of course, there are Medicaid beneficiaries who are required to submit their renewal forms that also may be unable to submit their renewal forms timely for reasons outside of their control and/or because they were not reasonably accommodated in the renewal process.



Mark Miller, D.C. Long-Term Care Ombudsman
Office of the D.C. Long-Term Care Ombudsman



Tina Smith Nelson
Managing Attorney, Economic & Healthcare Security Practice Group
Legal Counsel for the Elderly

cc: Alison Barkoff, U.S. Department of Health and Human Services, Administration on Community Living

DC Coalition on Long-Term Care

July 25, 2023

Melisa Byrd
Senior Deputy and State Medicaid Director
Department of Health Care Finance
441 4th Street, NW
Washington, DC. 20010

Dear Melisa:

On behalf of the DC Coalition on Long-Term Care, allow me to express our appreciation for all the information that DHCF is sharing about the Medicaid renewal process and progress made to date. The many public meetings, trainings and the renewal dashboard are extremely informative. We recognize the restart of renewals presents unprecedented challenges and that DHCF staff is committed to keeping DC residents connected to their Medicaid benefits.

Unfortunately, the information shared to date is showing that even with the ability to process a majority of renewals through the passive renewal pathway, a significant number of Medicaid beneficiaries are not responding to renewal notices or have not been able to complete the process timely. This is not unique to the District of Columbia, but it is nevertheless very concerning. According to DHCF's own data, as of June 15, 2023, of the 71,087 Medicaid beneficiaries with Medicaid certification end dates on or before August 31, 2023, over 50% were at risk of termination due to non-response.[1] More recent data shared at the July 19, 2023 Medicaid Renewal Community Meeting shows that of 2,200 people with disabilities and adults age 65+ due to recertify by the end of June, 1,200 (55%) failed to respond to the renewal

[1] DC Department of Health Care Finance Eligibility Monitoring Dashboard: Medicaid Unwinding Report and Related Data, last updated June 15, 2023, available at https://app.powerbigov.us/view?r=eyJrIjoiMjg0MzBmYmUtMzY1NS00Y2U5LWIxZTQtZjNlZTQwZmFmZWY2IiwidCI6IjhmZTQ0OWYxLThiOTQtNGZiNy05OTA2LTZmOTM5ZGE4MmQ3MyJ9.

notices and faced termination. For people with disabilities and adults age 65+ with renewals due July 31, 1,500 faced termination. This group of 1,500 includes ~300 beneficiaries in EPD waiver and ~200 nursing home residents.

To avoid a high rate of procedural terminations, DHCF responded by extending eligibility for 30 days for those facing termination on June 30 and July 31. While the extension of Medicaid eligibility for an additional 30 days is welcome and greatly appreciated, without additional changes to the process, it is unlikely to address the underlying reasons for the low response rate. Further, as Katherine Rogers explained at our last Long-term Care Coalition meeting, these extensions are designed only to give beneficiaries additional time to complete the renewal process. While Medicaid eligibility is technically extended, the extensions do not apply to prior authorizations. This means that claims submitted by EPD waiver providers who are providing needed, on-going services during the extension period will not be paid. This places additional financial stress on providers such as home health agencies, assisted living providers and adult day health programs and places affected beneficiaries at risk of being discharged for non-payment, which in many cases is due to no fault of their own. Case managers at our meeting reported that their clients already are receiving 30-day advance notices of discharge for non-payment. This sets up an even greater challenge as without the ability to reestablish Medicaid eligibility, the affected beneficiaries will be left with no services.

Accordingly, following discussion among members, the DC Coalition on Long-term Care is offering the following recommendations with the goal of increasing the renewal closure rate, particularly for the most vulnerable beneficiaries enrolled in the EPD Waiver:

1. To ensure beneficiaries continue to receive ongoing, needed services pending the processing of a renewal application, **DHCF should extend prior authorizations when Medicaid eligibility is extended.** This is necessary to ensure that beneficiaries are not subjected to involuntary discharge for non-payment due to no fault of their own and will ensure continuity of care.

2. **Address the issue of non-performing case managers –** While there are many hard working and conscientious case managers, we know some are not. The problems associated with non-performance are not new. Non-performing case managers who do not complete the minimum required contacts, fail to create PCSPs, fail to request PAs and do not complete renewal forms (without good cause) should be given notice and terminated from Medicaid for non-performance. We believe there are a variety of ways to connect beneficiaries to a new case manager without violating the beneficiary's right to freedom of choice. For example:

    a. Beneficiaries could be notified and asked to choose another case management agency, or

b. Beneficiaries could be notified, auto-assigned to another agency and then, given the opportunity to make an alternative choice within a specified period of time.
c. DHCF could use unused ARPA funds to establish a specialized back up team of case managers within DACL or within DHCF that can provide temporary case management services or, like the Department of Disability Services, provide on-going case management services for a portion of enrolled beneficiaries.[2] Again, beneficiaries assigned to this unit due to non-performance of their assigned case manager could be notified and given the opportunity to change case management agencies within a specified timeframe.

3. **Expand pathways for individuals on the waiver to complete needed paperwork and give other assisters and authorized representatives access to the DC Direct Partner Portal.** Currently, as the DCAS system is configured, the only pathway to completing the renewal process for someone receiving long-term care services and supports is by submitting the renewal forms through the DC Direct Partner Portal. By design, DHCF has limited access to the Partner Portal to hospitals, ICF/IDs, nursing homes, the Dual Choice MCO, our new PACE provider and EPD Waiver case managers. DHCF has insisted that for EPD waiver participants, completing the renewal form and uploading it into DC Direct is exclusively the case manager's role and that no other "assisters" can access the Partner Portal. This position not only limits who can help beneficiaries complete the process, but it is contrary to federal regulations which state that "the agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility." 42 CFR §435.908(b). Further, the agency must permit applicants and beneficiaries to designate an individual or organization to act as an authorized representative. An authorized representative, which may be a provider, must be able to act on behalf of the applicant or beneficiary in all matters with the agency including completing and submitting renewal forms. 42 CFR §435.923.[3]

4. **Redesign the eligibility forms.** The current renewal application is 44 pages. For those receiving long-term care services and supports, there is an additional 18-page supplemental long-term care form that requires the beneficiary to re-enter information that was already entered on the 44-page form. This creates additional work as well as opportunity for error. While we acknowledge that DHCF is required to collect a lot of information to make an eligibility determination, these forms are too long and too complicated.

---

[2] Katherine shared that renewals for the DD/IDD waiver beneficiaries all have been completed timely. All DDS case managers are employees of the agency.

[3] DHCF has stated that allowing providers to help beneficiaries complete and submit application and renewal forms would be a conflict of interest. We checked with the Centers for Medicare and Medicaid, and they did not see a conflict of interest. Providers are not conducting LOC assessments and have no authority to determine eligibility. When a provider is simply assisting a beneficiary to complete and submit forms needed to apply for or retain benefits, there is no conflict of interest.

5. To reduce delays in scheduling and obtaining LOC assessments, **allow assessments to be conducted virtually. DHCF could continue to offer face-to-face assessments for new applicants or when there is a special need or request for a face-to-face assessment,** but most assessments can be conducted virtually. A wide variety of stakeholders including advocacy organizations, providers and case managers support a return to virtual assessments, especially for renewals.

6. At least during this initial renewal period, consider **allowing ePOFs to be approved even if they have technical errors.**

Again, we wish to express our appreciation for the hard work of DHCF staff and particularly the work of Katherine Rogers and her team in the Long-Term Care Administration. We welcome the opportunity to discuss our recommendations with you and to working collaboratively to find creative solutions to improve the renewal process and keep eligible District residents connected to their Medicaid benefits.

Best regards,

Claudia Schlosberg
Interim Convenor
DC Coalition on Long-Term Care

CC: Katherine Rogers, Director
Long-Term Care Administration, DHCF

Honorable Christina Henderson
Chair, Committee on Health
Council of the District of Columbia

DISABILITYRIGHTSDC

VIA EMAIL: wayne.turnage@dc.gov; melisa.byrd@dc.gov; eugene.simms@dc.gov; katherine.rogers@dc.gov

October 25, 2023

Deputy Mayor Wayne Turnage
District of Columbia Office of the Deputy Mayor
for Health and Human Services
1350 Pennsylvania Avenue NW, Suite 223
Washington, DC 20004

Melisa Byrd, Interim Director
Eugene Simms, Interim Senior Deputy Director and Medicaid Director
Katherine Rogers, Director, Long-Term Care Administration
DC Department of Health Care Finance
441 Fourth St. NW, Suite 900S
Washington, DC 20001

RE: Improper Medicaid Termination of Long-Term Care and other Life-Sustaining Medicaid Services

Dear Deputy Mayor Turnage and Directors Byrd, Simms, and Rogers:

Disability Rights DC at University Legal Services (DRDC) represents people with disabilities and older adults who rely on long-term care services and other life-sustaining Medicaid services, including personal care aide (PCA) services under the DC Medicaid Home and Community-based Waiver Program for People who are Elderly and/or have Physical Disabilities (the "EPD Waiver Program").[1] We appreciate that DC Department of Health Care Finance (DHCF) leadership met with DRDC and other advocates on September 25, 2023 to discuss our concerns about the District's high rate of procedural terminations of Medicaid services for Non-MAGI beneficiaries, which includes seniors and people with disabilities who receive EPD Waiver services and other long-term care services and supports.

[1] DRDC, along with AARP Foundation Litigation and Terris, Pravlik, & Millian LLP, is plaintiffs' class counsel in *Brown v. District of Columbia*. *Brown* is a class action under Title II of the ADA on behalf of DC residents in nursing facilities who seek transition assistance from the DC government to move back to the community with the Medicaid long-term care services they need. DRDC is also plaintiffs' co-counsel and plaintiff in *LR v. District of Columbia*, a class action lawsuit under Title II of the ADA and the Medicaid statute on behalf of DC youth with significant mental and behavioral health challenges seeking intensive community-based services to prevent institutionalization.

We were disappointed that at this meeting DHCF declined to pause procedural terminations for all non-MAGI beneficiaries, including long-term care beneficiaries. We are writing to share our ongoing serious concerns regarding the District's policy and practices of improperly terminating Medicaid services for many eligible non-MAGI Medicaid beneficiaries. We also write to formally request that the District provide reasonable accommodations for these beneficiaries with disabilities to remedy discrimination, including by stopping these improper terminations and by allowing alternative pathways besides a case manager to submit renewals. Alternative pathways include direct assistance by DHCF staff to complete renewals for beneficiaries. DHCF knows case managers are not timely completing renewals and has an affirmative obligation to act to protect this vulnerable population from unlawful Medicaid terminations.

Although these individuals are likely eligible for ongoing waiver services and other long-term care services, the District is subjecting them to serious risk of harm, institutionalization, and potentially death. The District is aware of these risks because the District previously unlawfully ended the Medicaid benefits of EPD waiver beneficiaries who remained eligible for them. As reported by the Washington Post in August 2013, in 2012 approximately 300 EPD waiver beneficiaries were terminated from DC Medicaid for procedural reasons.[2] At DRDC and other advocacy groups' urging, DHCF identified those individuals and found that 133 had died and 37 had entered nursing facilities or other long-term care facilities.[3] We urge the District to intervene to stop this practice and remediate the harm to those who need EPD Waiver services and other long-term care services to maintain their health and safety and remain in their homes and the community, rather than in nursing facilities.

Medicaid Renewal Process and the Long-term Care Program– Background and Issues

After Congress passed the Consolidated Appropriations Act of 2023 ending the Medicaid continuous enrollment requirement,[4] DHCF restarted the process of renewing Medicaid eligibility on April 1, 2023. An accessible renewal process for people with disabilities is required by federal law and critical to help minimize the chance of wrongful Medicaid eligibility redetermination denials for individuals that remain eligible. Equal access to the renewal process is required by the Medicaid Act, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and Section 1557 of the Affordable Care Act. Unfortunately, DHCF has structured its Medicaid renewal process in a manner that results in discrimination against people with disabilities. Despite being aware of systemic problems with the Medicaid renewal process, the District has failed to reasonably modify it to avoid discrimination as required under federal law.

---

[2] Alexia Campbell. *D.C. dropped hundreds of people from Medicaid rolls without cause, attorneys say*, Washington Post (August 11, 2013), https://www.washingtonpost.com/local/dc-dropped-hundreds-of-people-from-medicaid-rolls-without-cause-attorneys-say/2013/08/11/63d9ec54-002e-11e3-9711-3708310f6f4d_story.html.

[3] *Id.*

[4] Pub. L. No. 117-328, Sec. 2, Division FF, Title V, Subtitle D, Sec. 5131, "Transitioning from Medicaid FMAP increase requirements" of the Consolidated Appropriations Act, 2023, available at: https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf#page=1491.

DHCF administers the EPD Waiver Program which, coupled with the State Plan PCA services program, provides up to 24 hours[5] of daily Personal Care Aide (PCA) services and case management for people who need assistance with activities of daily living (i.e., bathing, dressing, mobility transfers, toileting, and eating). People with incomes up to 300% of SSI (= $2,742 per month in 2023) and have $4,000 maximum assets ($6,000 for a couple) are eligible for the program. All of the waiver participants terminated by DHCF likely continue to meet the medical and financial eligibility requirements for the waiver program.

Long-term care and home and community-based waiver beneficiaries are not allowed to submit renewals on their own and must rely on a case manager to do so. This population includes individuals receiving long-term care services in the community and individuals receiving long-term care in assisted living facilities and nursing facilities. Pursuant to District regulations and directives,[6] EPD Waiver participants are neither responsible for, nor authorized by, DHCF to recertify their eligibility for waiver services. DHCF only accepts waiver recertification or applications from designated EPD waiver agencies that include case managers responsible for preparing applications, assessments, and recertification documents.[7] Accordingly, each waiver participant is assigned to a case manager who must complete the annual recertification paperwork necessary to maintain the waiver services and submit it to DHCF and its contract agency, Liberty, for prior authorization. DHCF also requires people with disabilities to submit longer renewal forms than people without disabilities because DHCF decided to transition to an updated District Direct eligibility system without manually transferring long-term care beneficiary information into the updated system, compounding the barriers for people with disabilities to complete the renewal process and contrary to a renewal requirement that the District conduct *ex parte* renewals for the non-MAGI population.[8]

The District is aware that DHCF and its waiver case management agencies have failed to timely submit and process the recertifications.[9] Specifically, DHCF has identified at least "six case management agencies that have been issued a formal request for remediation related to redeterminations. . ." as of June 1, 2023.[10] During our September 25 meeting, DHCF also reported that it has a master tracking document that identifies individual enrollees whose renewal has not been completed by the case manager and cases where the program code cannot be updated. According to DHCF, this master tracker is used to facilitate twice a week communication with case management agencies regarding compliance issues. We know that DHCF is focusing on more intensive training on the case manager's role in renewal process, but training will not address the neglect by DHCF providers. Lack of recertification due to case manager non-response is a longstanding issue that has been exacerbated by the District

---

[5] For individuals that need more than 8 hours a day under the Medicaid State Plan, the EPD Waiver provides up to 16 hours a day of additional PCA service hours, totaling up to 24 hours of PCA services per day.
[6] 29 D.C. Mun. Regs. Tit. 29, §§4203, 4224.14 ("The Case Manager shall ensure a beneficiary timely completes Medicaid reassessment(s) as part of the annual recertification requirements.").
[7] This requirement may run afoul of the federal requirement that beneficiaries are able to choose who helps them to complete the renewal process and submit renewal information in the variety of ways. *See* 42 C.F.R. § 435.908(b), 42 C.F.R. § 435.923.
[8] 42 C.F.R. § 435.916(b); Centers for Medicare & Medicaid Services, Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023, at 5, available at: https://www.medicaid.gov/sites/default/files/2023-07/sum-st-mit-strat-comply-medi-renew-req.pdf.
[9] DHCF Response Letter to DRDC, DC Long Term Care Ombudsman, and Legal Counsel for the Elderly regarding Medicaid Renewals for Long-Term Care Beneficiaries, July 28, 2023.
[10] *Id.* at 2.

undertaking a massive review of Medicaid eligibility after a 3-year pandemic-era pause on renewals. As a result, the District has terminated and continues to terminate Medicaid eligibility and services.

As a result of DHCF's administrative renewal procedures, there is a low renewal rate for people with disabilities. At a rate of 39%, people with disabilities and individuals 65 and older with renewals due May-August have had lower renewal rates than other Medicaid groups to date.[11] This means that 61% of non-MAGI Medicaid beneficiaries due to renew in May-August faced termination. DHCF reports that among District Medicaid beneficiaries due in May, June or July who have lost coverage to date (18,198 individuals), there is a 90% (16,454 individuals) procedural termination rate.[12] Of those due to renew in June and July 2023, DHCF reported that approximately 1,600 non-MAGI seniors and people with disabilities were procedurally terminated from Medicaid, including almost 200 EPD waiver beneficiaries, 30 ID/DD waiver beneficiaries, 230 nursing facility and other non-waiver long-term care enrollees. [13, 14] As of August 30, 2023, 2,100 individuals with disabilities and seniors due in August faced termination, including 170 EPD waiver beneficiaries, 50 ID/DD waiver beneficiaries, 190 nursing facility and other non-waiver long-term care enrollees.[15]

We request that consistent with CMS guidance[16] and to reasonably accommodate people with disabilities in the renewal process, DHCF should stop procedural terminations for this population that would otherwise occur due to a non-response to the renewal form until DHCF

---

[11] DC Department of Health Care Finance, Medicaid and Alliance Recertification Outcomes Report, September 2023, at 9, 23, available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Redetermination%20Report%20September%20-%202023.pdf.

[12] DC Department of Health Care Finance, Medicaid and Alliance Recertification Outcomes Report, August 2023, at 25, available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Redetermination_Report_August_2023_1.pdf.

[13] As of July 31, 2023, approximately 780 beneficiaries with a disability or seniors (i.e., non-MAGI) who were due to renew in June but extended through July lost coverage effective August 1. This includes approximately 250 full Medicaid beneficiaries, 110 Elderly and Persons with Physical Disabilities (EPD) waiver beneficiaries, 10 ID/DD waiver beneficiaries, and 100 nursing facility and other non-waiver long-term care enrollees. DC Department of Health Care Finance, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #10, August 2, 2023, at 8, available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Final%20Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20for%20Posting%20080223%20%281%29.pdf.

[14] As of August 29, 2023, approximately 820 Medicaid beneficiaries with a disability or seniors who were due to renew in July but had coverage extended through August had their Medicaid terminated as of September 1. This includes approximately 260 full Medicaid beneficiaries, 80 EPD waiver beneficiaries, 30 ID/DD waiver beneficiaries, and 130 nursing facility and other non-waiver long-term care enrollees. DC Department of Health Care Finance, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #12, August 30, 2023, at 12, available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20083023.pdf.

[15] DC Department of Health Care Finance, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #12, August 30, 2023, at 11, available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20083023.pdf.

[16] Centers for Medicare & Medicaid Services, Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023, at 2, available at: https://www.medicaid.gov/sites/default/files/2023-07/sum-st-mit-strat-comply-medi-renew-req.pdf.

can remediate the systems issues. Additionally, DHCF should also increase DHCF staffing to provide one-on-one help to people with disabilities and others who have been unable to complete timely renewals of Medicaid eligibility due to a lack of response by their case manager and provide the beneficiary the option to change case management agencies that are neglecting them in the redetermination process. At a minimum, DHCF must stop terminations for those beneficiaries DHCF is tracking and has knowledge that their renewal has not been completed at least in part because a case manager has failed to submit renewal information, or any other delay caused by DHCF's administrative procedures. DHCF must also: (1) monitor the list of long-term care beneficiaries pending procedural termination; (2) investigate if the case manager has completed their tasks; if the beneficiary understands the renewal process; and if the beneficiary needs assistance completing the renewal process; and (3) extend eligibility and authorizations for services as needed to prevent termination of beneficiaries eligible for Medicaid and/or long-term care services. There is good cause for pausing terminations for the long-term care population because the lack of renewal response is at no fault of the beneficiary.

We are also concerned about systems issues that result in automatic terminations when renewals are timely submitted. Despite the District's policy that timely submitted renewals will be placed in a pending status and Medicaid coverage will be extended to allow for ESA processing, DHCF acknowledges that there are still gaps in coverage.[17] Although DHCF reports that its taking steps to manually extend Medicaid coverage for pending renewals to help prevent gaps in coverage[18], we urge DHCF to modify its system to automatically identify that a renewal is pending and automatically stop that termination.

Medicaid Act Violations

Federal Medicaid law prohibits states from "terminat[ing] Medicaid benefits or allow[ing] them to lapse without either providing adequate notice or without specifically finding those recipients ineligible for Medicaid." *Salazar v. District of Columbia*, 954 F.Supp. 278, 327 (D.D.C. 1996). Specifically, the District must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures" and must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible." 42 C.F.R. 435.930(a), (b); 431.916(f)(1). Yet, in administering the Medicaid renewal process for long-term care beneficiaries, the District's policy and practice has been to act contrary to this requirement. By failing to timely initiate, process or act on Medicaid renewals, and thereby improperly terminating EPD Waiver services for eligible individuals and/or allowing their Medicaid benefits to lapse, the District illegally penalizes long-term care participants for its own administrative failures and at no fault of the beneficiary.[19] The District is also failing in its Medicaid obligations to streamline and simplify the process, and provide assistance during the

[17] DC Department of Health Care Finance, Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #15, October 11, 2023, at 12, available at: https://dhcf.dc.gov/sites/default/files/u23/Medicaid%20Renewal%20Biweekly%20Community%20Meeting%20101123.pdf.

[18] *Id.*

[19] The District's choices to not transfer data to facilitate ex parte renewal for this population fail to meet the obligations under the Medicaid Act to conduct ex parte renewals and not require Medicaid beneficiaries to provide unnecessary information. 42 U.S.C. § 18083; 42 C.F.R. §§ 435.916, .952(c). In addition, the choice to limit the renewal process to require individuals to go through their case manager improperly limits the person's choice in assistant and ability to submit information in person, over the phone, and online. 42 C.F.R. §§ 435.907, .908, .916.

renewal process in a manner that is accessible to people with disabilities. 42 U.S.C. § 1396w-3; 42 C.F.R. § 435.908, .916.

Such policies and practices unequivocally violate long-term care beneficiaries' constitutional and federal statutory rights, and therefore give rise to claims actionable under 42 U.S.C. § 1983.

ADA and Section 504 Violations

In addition to the Medicaid Act violations described above, the District's Medicaid terminations of long-term care beneficiaries run afoul of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a). As detailed above, the Medicaid and long-term care recertification process has been designed in a manner that discriminates against DC Medicaid beneficiaries with disabilities. 28 C.F.R. § 35.130(b)(3)(i). DHCF must, therefore, modify its renewal policies and practices to accommodate people with disabilities and to prevent discrimination. Halting Medicaid terminations for this population and extending prior authorizations are necessary to prevent unnecessary institutionalization and to maintain the health and safety of these Medicaid beneficiaries who have or will without prior authorization lose access to EPD waiver services and other critical services they need to remain in the community. Because these long-term care beneficiaries are not allowed to submit renewals on their own and must rely on a case manager to do so, DHCF should also extend prior authorizations in fairness to these beneficiaries because the lack of response is at no fault of their own.

Because the District is aware of these Medicaid beneficiaries' disabilities and is knowledgeable of and tracking the neglect by its case managers that is resulting in procedural terminations, the District's failure to provide access to Medicaid coverage and reasonable accommodations to the existing renewal procedures amounts to deliberate indifference to Medicaid beneficiaries with disabilities' rights. *See Pierce v. D.C.*, 128 F. Supp. 3d 250, 278-79 (D.D.C. 2015). "Section 504 and Title II mandate that entities act *affirmatively* to evaluate the programs and services they offer and to ensure that people with disabilities will have meaningful access to those services." *Id.* at 268 (citing 42 U.S.C. § 12131(2); 28 C.F.R. § 35.150(a); 28 C.F.R. § 35.150). Consistent with the duty to the Plaintiff in *Pierce*, the District has an affirmative responsibility to these Medicaid beneficiaries with disabilities to provide reasonable accommodations to afford them meaningful access to long-term care services and supports and cannot "sit idly by, taking no affirmative steps to accommodate" them. *Id.* at 270.

The District's improper terminations also violate the integration mandate of the ADA, as articulated in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). By terminating Medicaid and waiver services, the District places individuals at risk of unnecessary placement in nursing facilities and limiting their ability to participate in their communities, which constitutes "[u]njustified isolation of the disabled." The Court in *Olmstead* ruled that State and local governments must provide services and supports to people with disabilities in the most integrated settings appropriate to their needs and honor their choice of community-based alternatives to institutional placement.

5th Interim Response 33

Affordable Care Act Violations

The District's denial of equal access to the renewal process for this population similarly violates the Affordable Care Act (ACA). Section 1557 of the ACA provides that no health program or activity that receives federal funds may exclude from participation, deny the benefits of their programs, services, or activities, or otherwise discriminate against a person protected under Section 504 of the Rehabilitation Act, 42 U.S.C. § 18116. This includes an obligation to make reasonable modifications in policies, practices, and procedures necessary to avoid discrimination. 45 C.F.R. § 92.205.

Requested Relief

It is DHCF's responsibility to ensure that those individuals who are eligible for Medicaid, actually receive Medicaid-covered EPD Waiver services and other long-term care services. To accomplish this, DHCF must take the following steps as a reasonable accommodation:

(1) Rescind all Medicaid and EPD waiver terminations issued from June 2023 to the present for reasons other than a specific finding of financial or medical ineligibility. Provide notice to those individuals affected as well as information about retroactive coverage so that people may have outstanding bills covered.
(2) Restore Medicaid and EPD Waiver services to all those whose waiver services were terminated from June 2023 to the present due to any DHCF, provider agency or other contractor failure timely to initiate, submit, process or act upon requests for renewal and authorization. A beneficiary's failure to act alone is insufficient reason to fail to restore coverage. Notice of reinstatement and retroactive coverage must also be sent to affected individuals.
(3) Stop all Medicaid and EPD waiver terminations (by extending Medicaid renewal dates) for all long-term care beneficiaries until renewals are completed and processed with a specific finding regarding eligibility.
(4) Extend prior authorizations (PAs) to ensure that EPD Waiver and other long-term care beneficiaries can continue to receive care without interruption and that providers can be paid for on-going, needed care.
(5) Issue a written memorandum to providers that includes a blanket prior authorization for this subset of enrollees due for renewal to assure providers that they will be paid for services rendered while the renewal is pending. And if an individual is ultimately found ineligible, the memo should make clear that DHCF will honor the PA consistent with 42 C.F.R. 435.930.
(6) Allow alternative pathways for long-term care beneficiaries to complete the renewal process, including:
    a. DHCF staff will provide direct, one-on-one assistance to recertify every long-term care beneficiary who has not responded to complete renewals.
    b. DHCF will allow other providers and assisters to help beneficiaries with completing the renewal process.
    c. DHCF will affirmatively provide the beneficiary with the option to change case management agencies that are neglecting them in the redetermination process. DHCF will extend renewal deadlines as needed so that a new case manager has sufficient time to complete the renewal process.

(7) Establish and implement new procedures for the efficient, timely processing of Medicaid renewals and requests for EPD Waiver authorization to ensure that EPD Waiver participants and other long-term care beneficiaries are no longer terminated from the program due to DHCF, provider agency or other contractor failure timely to initiate, process or act upon renewals and requests for authorization.
    a. Monitor the list of long-term care beneficiaries pending procedural termination; investigate if the case manager has completed their tasks; if the beneficiary understands the renewal process; and if the beneficiary needs assistance completing the renewal process; and extend eligibility and authorizations for services as needed to prevent termination of beneficiaries eligible for Medicaid and/or long-term care services.
    b. Consistent with CMS guidance[20] DHCF should streamline renewal forms and requirements for this population, including manually entering information from its legacy system into District Direct, rather than requiring individuals to provide information that DHCF already has.
    c. For pending renewals, DHCF should modify its system to automatically identify that a renewal is pending and automatically stop that termination.
(8) Create a plan to change the systems and policies such that an individual may access their renewal and submit information on their own, such that they may complete the renewal process directly as much as possible, or have help from their case manager or other assistants of their choice.
(9) Publicly report monthly the name of each case management provider with deficiency findings concerning renewals and the number of impacted beneficiaries receiving services from that provider[21], including the six case management agencies identified in DHCF's July 28, 2023 letter.

We urge you to respond to Lyndsay Niles by email at lniles@uls-dc.org or by phone to 202-547-0198 ext. 128 no later than November 8, 2023 regarding the immediate steps the District will take to resolve these issues.

Sincerely,

Lyndsay Niles, Managing Attorney
Disability Rights DC at
University Legal Services

cc: Sheryl Johnson, General Counsel, DHCF, sheryl.johnson@dc.gov

[20] Centers for Medicare & Medicaid Services, Summary of State Mitigation Strategies for Complying with Medicaid Renewal Requirements Described in the Consolidated Appropriations Act, 2023, at 2-3, available at: https://www.medicaid.gov/sites/default/files/2023-07/sum-st-mit-strat-comply-medi-renew-req.pdf.

[21] DHCF reported during the Medicaid Renewal Biweekly Community meeting on October 11, 2023, that DHCF will start reporting during the October 25 meeting the number of providers with current deficiency findings and the number of impacted beneficiaries. To facilitate full transparency, DHCF should also share the names of the providers, the specific nature of the deficiencies, and the corrective action to be taken.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director

VIA E-MAIL: LNiles@uls-dc.org

December 12, 2023

Lyndsay Niles
Managing Attorney
Disability Rights DC at University Legal Services

Re: Improper Medicaid Termination of Long-Term Care and Other Life Sustaining Medicaid Services

Dear Ms. Niles:

Thank you for the input and recommendations related to the Medicaid renewal processes for Non-MAGI beneficiaries, specifically those with disabilities or receiving long-term services and supports (LTSS). Overall, the DRDC suggests that the District's renewal system is broken at a systemic level because the District has not achieved a 100 percent renewal rate for this population. You have highlighted a number of specific concerns with the District's recertification process, including assertions that the District has fallen short of meeting certain federal requirements, such as accessibility, and indicate that the District has not taken the appropriate steps to ensure eligible non-MAGI groups remain enrolled.

The purpose of this response is to clarify the District's renewal processes, explain how the District provides oversight of this process, reviews and assesses the need for change, and details the resources the District has allocated to the renewal effort to support the unique needs of this group, as well as of every resident we serve. Additionally, while we seek to provide as much guidance as possible to correct erroneous assumptions and prevent them moving forward, it is important to note that issues raised were previously addressed in our regular provider meetings and in the biweekly Medicaid Renewal Community Stakeholder meetings, so this response reiterates some of what was previously shared.

Lastly, DHCF established a specific renewal process for individuals receiving LTSS, and DRDC is working in the community with the same beneficiaries that DHCF serves. I invite the DRDC to share any specific cases where an LTSS enrollee's needs are potentially unmet, so that DHCF can work toward resolution.

1. *Your letter expresses concern that DHCF declined to pause procedural terminations for all non-MAGI beneficiaries, including long-term care beneficiaries.*

The District is interested in taking targeted actions to keep individuals who remain eligible for Medicaid enrolled in the program. At this moment, DHCF believes pausing procedural terminations for all Non-MAGI beneficiaries is overbroad.

DHCF has taken steps to increase the time beneficiaries can submit a renewal and maintain access to their coverage, including increasing the grace period for Non-MAGI Medicaid beneficiaries from thirty (30) days

to ninety (90) days. DHCF has also extended enrollment for every Non-MAGI cohort since the start of unwinding. DHCF continues to review data, work with District stakeholders, and collaborate with the Centers for Medicare and Medicaid Services (CMS) to identify initiatives and methods to effectively outreach to Non-MAGI individuals who do not renew.

2. *Your letter states that DHCF knows case managers are not timely completing renewals and has an affirmative obligation to act to protect this vulnerable population from unlawful Medicaid terminations. Your letter recommends DHCF stop procedural terminations for this group and request that DHCF provide one-to-one support for individuals.*

DHCF works with LTSS partners and providers to ensure compliance with requirements related to timely beneficiary renewals, for which case managers are responsible for Elderly and Persons with Disabilities (EPD) Waiver beneficiaries. Oversight actions, such as those summarized below, are how DHCF fulfills its obligation to protect vulnerable populations. Our EPD Waiver regulations provide a compliance process that DHCF leverages to notify, engage, and retrain providers or remediate compliance issues, including those related to timely beneficiary renewals. Additionally, DHCF staff monitors the status of EPD waiver enrollees for whom a renewal has been initiated.

DHCF tracks EPD cohorts by renewal timeline for both fee-for-service cases, served by 18 Medicaid-enrolled case management agencies, and Dual Choice enrollees, served by UnitedHealthcare. For fee-for-service beneficiaries, DHCF staff provides a list of upcoming renewal cohorts (up to three months ahead for planning and prospective reconciliation of renewal data discrepancies) to each enrolled provider monthly and communicates twice weekly with these providers to obtain case updates on active cohorts (e.g., all cases due to recertify in the upcoming zero to 90 days), including beneficiary refusals/non-response, request for assessment, completion of the application and supplemental, submission of documents within the DCAS Partner Portal, and response to inquiries from eligibility processing staff.

DHCF tracks active EPD and other cohorts with UnitedHealthcare staff through data exchange and standing weekly meetings on similar milestones, including (as applicable) beneficiary refusals/non-responses, requests for assessment, completion of the application and supplemental, submission of documents within the DCAS Partner Portal, and processing of applications.

For our fee-for-service providers, the sanction process noted above permits DHCF to issue remediation requests, also called "discoveries," when violations of the timelines or requirements of Medicaid-enrolled providers are uncovered. Repeated discoveries lead to mandatory training and technical assistance and ultimately to provider sanctions outlined in our waiver regulations, up to provider termination.

In addition to pursuing action against providers demonstrating non-compliance (at any scale, large or small), DHCF actively engages partners like the Office of the Health Care Ombudsman, other home and community-based services providers like our assisted living residences or home health agencies, to provide additional case-specific assistance and engagement to support each beneficiary's timely completion of renewal.

3. *Your letter states that the Medicaid renewal process is inaccessible for people with disabilities, in violation of federal requirements.*

The *only* portion of the LTSS renewal process that is not accessible to all parties, District-wide, is the actual function of submitting such a renewal or application into the District's online system. This is compliant with federal requirements at 42 CFR §435.908(b).

The District's Medicaid program is continually working to improve beneficiaries' access to the Medicaid program, including ongoing improvements to the renewals process. This includes encouraging and

facilitating our healthcare providers' opportunities to assist beneficiaries throughout the renewal process and educating, informing, and conducting outreach to supporting family members, caregivers, and other formal and informal supports surrounding our beneficiaries and applicants.

The District works on an inter-agency basis and with community partners to assure there are dedicated resources available to beneficiaries during the application and renewal process. DHCF recognizes that many individuals require assistance, particularly with the often-complex task of compiling financial records and documentation or completing a renewal document. DHCF partners with the Department of Aging and Community Living, the Department on Disability Services, our contracted Managed Care Organizations, and enrolled long-term care providers to ensure support is available for beneficiaries at renewal.

4. *Your letter states that the District failed to transfer data that could facilitate ex parte renewal for this population, in violation of federal law....*

DHCF wants to correct DRDC's assumption that the District did not transfer available case information from the legacy eligibility system, ACEDS, to DCAS. The District transferred all information from ACEDS to DCAS; however, there is information required in DCAS that was not available from ACEDS. The additional information is collected through the one-time conversion renewal forms. The District's inability to conduct ex parte renewals for Non-MAGI populations, partially due to the switch from ACEDS to DCAS, has been noted to CMS, and the District has taken a specified set of actions to mitigate the impact of this deficiency.

The District reiterates that its LTSS renewal process, which stresses coordination across providers, family members, and the beneficiary in the completion of materials for submission at renewal, is consistent with federal accessibility requirements.

5. *Your letter attributes a low renewal rate for people with disabilities to DHCF's administrative renewal procedures.*

DHCF has shared information during biweekly Medicaid Renewal Community Stakeholder meetings to provide additional insight into Non-MAGI beneficiaries who are not renewing timely. Some of these beneficiaries do not appear to be actively using their Medicaid coverage, may be living outside of the District, or are deceased. As cited in your letter, at a rate of 39% as of September 18, 2023, people with disabilities and individuals 65 and older with renewals due May-August have had lower renewal rates than other Medicaid groups; however, an additional 20% of these beneficiaries had a pending renewal that confers an eligibility extension until a final determination is made. In addition, just under 3% were determined ineligible. For the remaining 39% of non-MAGI Medicaid beneficiaries due to renew in May-August and others who have faced termination due to non-response, DHCF continues to examine their characteristics to inform strategies for reaching these individuals.

6. *Your letter requests DHCF take additional steps to ensure individuals who remain eligible for LTSS do not lose access to their benefits.*

DHCF is committed to taking steps to ensure eligible individuals remain enrolled and retain access to services. DHCF has provided thirty (30) day extensions for all Non-MAGI cohorts since the beginning of restart. DHCF is also reviewing data to identify sub-sets of Non-MAGI beneficiaries to better tailor outreach strategies.

DRDC is aware that DHCF established procedures and protocols to grant authorizations for all LTSS enrollees. These measures are designed to ensure authorizations are aligned with eligibility upon completion of renewals. Additionally, DHCF issues emergency "gap" authorizations for providers in situations where a person cannot complete recertification, but services were delivered in good faith.

As mentioned during the recent biweekly Medicaid Renewal Community Stakeholder meeting and requested in prior meetings with DRDC, DHCF will report on EPD Waiver case management providers with a discovery and the number of beneficiaries served by these providers.

DRDC makes several other requests for relief that are already implemented by the District: DHCF prepopulates renewal forms with available information for MAGI and Non-MAGI beneficiaries, but DHCF notes that the agency has less information for converted cases; DHCF has already modified its systems to extend eligibility for cases that are identified as pending; and DHCF reminds DRDC that EPD waiver enrollees have the right to change to any willing case manager or case management agency at any time. DHCF lacks the authority to summarily reassign beneficiaries to different case managers and case management agencies under federal and District waiver policies.

Thank you to Disability Rights DC for your continued support of the Medicaid program and its enrollees. I look forward to our ongoing collaboration.

Sincerely,

Melisa Byrd

Melisa Byrd
Senior Deputy Director and Medicaid Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director

VIA E-MAIL: LNiles@uls-dc.org; Alison.Barkoff@acl.hhs.gov; mcmiller@aarp.org; TSnelson@aarp.org; maparker@aarp.org

July 28, 2023

Lyndsay Niles
Managing Attorney
Disability Rights DC
University Legal Services
220 I Street, NE, Suite 130
Washington, D.C. 20002

Mark Miller
D.C. Long-Term Care Ombudsman
Office of the D.C. Long-Term Care Ombudsman

Tina Smith Nelson
Managing Attorney
Economic & Healthcare Security Practice Group
Legal Counsel for the Elderly

Re: Medicaid Renewals for Long-Term Care Beneficiaries

Dear Ms. Niles, Mr. Miller, and Ms. Nelson:

Thank you for your letter. DHCF is grateful for the collaboration of partners like DRDC, LCE, and LTCOP in supporting our beneficiaries and program throughout the unwinding period, an unprecedented experience for Medicaid programs and the communities we serve. We are likewise appreciative of feedback around the specific pain points our beneficiaries and their families are experiencing throughout the process.

Based on the feedback provided, DHCF has obtained valuable input regarding the longer-term improvements or program changes, including system architecture or automation of currently manual processes. Additionally, some of this feedback presents us with options for operational changes that may require more immediate attention. Based on your letter and a letter submitted by your colleagues at the LTC Coalition, the Long Term Care Administration will meet with partners and providers. During these meetings, we will thoroughly evaluate the input and draw from our ongoing experience to identify and, where feasible, implement enhancements to the renewals process.

Currently, our authorization process is manual. A quality review determines the level of service approvable and issues authorization through a data entry process. These authorizations are not auto-generated nor automatically linked to eligibility. Instead, they are subject to eligibility and processing as a program integrity control.

We have established procedures and protocols in place to grant authorizations for all LTSS enrollees. These measures are designed to ensure authorizations are aligned with eligibility upon completion of renewals. Additionally, we intend to issue emergency "gap" authorizations for providers in situations where a person cannot complete recertification, but services were delivered in good faith. Issuing authorizations on an ad hoc basis is labor-intensive on top of existing operations. Both DHCF and our vendor partners anticipate that this process would require an additional thirty days to manually complete these authorizations. In most cases, this would obviate the need for authorization, making it an ineffective use of our shared and public resources.

In response to your questions about provider accountability:

1. As DHCF has repeatedly presented in various public forums, we have a regulatory framework in place to hold case managers accountable for their obligations. Our sanction process is outlined in 29 DCMR 4253. Since June 1, 2023, six case management agencies have been issued a formal request for remediation related to redeterminations, as of this past Tuesday. To provide context, these recent redetermination-related discoveries constitute nearly 90 percent of the remediation requests sent to providers through this channel in the last 12 months. DHCF anticipates additional remediation activities on an ongoing basis. It's important to note that DHCF does not have the legal authority to "automatically reinstate" Medicaid eligibility without completing a full renewal as directed by CMS during the unwinding period. DHCF will leverage any options within its authority to obtain and process the information required to complete a full renewal for beneficiaries.

2. As DHCF has repeatedly presented in various public forums, the EPD Waiver has a policy and regulatory framework that obligates a specific entity for action of completing a renewal. This responsibility has been affirmed multiple times in biweekly, monthly, and ad hoc meetings. The other partners, including HCBS providers, family members, and authorized representatives, absolutely have a role and an opportunity to support renewals. Providers have been encouraged for some years to assist case managers in completing renewals. No direct care agencies have ever had direct responsibility or the necessary system access to complete EPD Waiver applications at any point in the program, but they have always had an opportunity to collaborate with and support the case managers in this process.

In response to your other numbered questions:

1. DHCF has an array of processes in place that aim to operationalize the EPD Waiver policy in line with our Waiver (our agreement with the federal government that grants us the legal authority to operate the program), along with federal and local regulations. Our processes are designed to ensure compliance with these requirements, which include maximizing beneficiary choice, person-centeredness of care delivery, adhering to provider qualifications requirements, and more. Eligibility extensions only grant an additional 30 days of eligibility, with the expectation that applications will continue to be submitted, reviewed, and processed, leading to service planning and authorizations as a result. During the extension or reconsideration periods, DHCF anticipates that any case with a completed renewal and EPD Waiver eligibility will ultimately receive a new authorization covering all eligible dates of service. Furthermore, the providers will be adequately compensated for any services delivered to maintain continuity of care.

As noted above, the operationalization of PA extensions is a manual, laborious, and time-consuming process, which can sometimes be unnecessary and cause disruptions in downstream care. Fee-for-service authorizations are issued manually, and extensions cannot simply be auto-effectuated. EPD Waiver and other LTSS authorizations are issued through a quality review process and utilization management process conducted by the agency's vendor. As noted above, the process to extend all existing PAs to comply with this request would take 30 days to complete, which generally obviates the need for extensions. Extending existing authorizations requires adjustments to existing policy (for example, implementing 13-month authorizations, aligned with a prior service plan and potentially in conflict with a new, concomitant service plan) and future operations. Extended PAs disrupt the future PCSP and authorization process for every case with an extended authorization.

Of note, DHCF does issue "gap" or "emergency" authorizations in cases where routine processing fails. DHCF fully expects to initiate emergency authorizations in such cases where no new authorization is issued under existing authorities and operations (e.g., a beneficiary passes away before completing a renewal, but services have been rendered up until the date of death).

2. Several other regulatory requirements exist to protect Medicaid beneficiaries from disruptions to business processes that could adversely affect care delivery. Both DC Health and DHCF impose discharge procedures and regulatory requirements that prevent providers from discharging beneficiaries without adequate notice. For home health agencies and assisted living providers, notice requirements of 30 days preclude abrupt changes in care delivery, and improper discharges may also be appealed. Further, EPD Waiver providers are required to meet financial sufficiency standards to ensure that disruptions to providers' cash flow do not negatively impact beneficiary care. Although delays in authorizations for extended renewals impact providers' billing for a portion of 1/12 of their total census, our providers are required to have cash on hand sufficient to cover three months of all agency operations for their entire census.

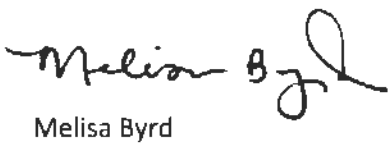
3. DHCF adheres to its policy, and the policy of virtually every health care payer in the nation, requiring that services listed on the fee schedule, necessitating prior authorization, must be accompanied by appropriate authorization information for payment. It is DHCF's position in this circumstance that authorizations will be issued through standard processes and that providers will be able to bill for any appropriate dates of service with eligibility, once renewed.

4. DHCF has been communicating with providers through various channels, including biweekly, monthly, and ad hoc provider presentations. Providers inquiring about their continuity of care obligations have been reminded of regulatory requirements regarding discharge. Providers seeking to discharge beneficiaries without eligibility have been directed to engage with the CM (Case Manager) and beneficiary directly to understand the status of eligibility renewal.

5. DHCF's regulatory structure for the EPD Waiver program is designed to protect beneficiaries from such disruptions. All beneficiaries may exercise their right to appeal termination if it is effectuated in error. DHCF will undertake a review of the June EPD waiver beneficiary cases that do not renew by the July 31, 2023, deadline. The purpose of the review is to better understand and hopefully determine any underlying causes non-responsiveness. The results of this review will inform whether additional agency action is needed related to the affected individuals and inform changes to our outreach and engagement activities.

Thank you again for your feedback, and we look forward to our continued close collaboration throughout the coming months.

Sincerely,



Melisa Byrd
Senior Deputy Director and Medicaid Director

Cc: Alison Barkoff, U.S. Department of Health and Human Services, Administration on Community Living

General Questions

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

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

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

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

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

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

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

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

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

Not applicable; please see the response above.

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

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

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

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

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

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

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

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

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

Please see the response above.

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

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

5th Interim Response 45

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

Please see Attachment 4.

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

Please see Attachment 5.

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

Please see Attachment 6.

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

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

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

TOTAL **$9.9**

Disproportionate Share Hospital Payments

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

Personal Services

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

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

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

Contracts

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

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

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

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

5th Interim Response 48

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

8. **Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2023 and FY 2024, to date, broken down by program and cost center:**
    a. **Grant Number/Title;**
    b. **Approved Budget Authority;**
    c. **Funding source.**
    d. **Expenditures (including encumbrances and pre-encumbrances);**
    e. **Purpose of the grant;**
    f. **Organization or agency that provided or received the grant;**
    g. **Grant amount;**
    h. **Grant deliverables;**
    i. **Grant outcomes, including grantee/subgrantee performance;**
    j. **Any corrective actions taken or technical assistance provided;**
    k. **Agency program and cost center supported by the grant;**
    l. **Agency employee responsible for grant deliverables; and**
    m. **Any grants where the funds have been reduced in FY 2024, and the amount of the reduction.**

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

9. **Please provide the following information for all contracts, including modifications, active during FY 2023 and FY 2024, to date, broken down by program and cost center:**
    a. **Contract number;**
    b. **Approved Budget Authority;**
    c. **Funding source;**
    d. **Expenditures (including encumbrances and pre-encumbrances); FY24**
    e. **Purpose of the contract;**
    f. **Name of the vendor;**
    g. **Original contract value;**
    h. **Modified contract value (if applicable);**
    i. **Whether it was competitively bid or sole sourced;**
    j. **Final deliverables for completed contracts;**
    k. **Any corrective actions taken or technical assistance provided;**

l. Agency employee(s) serving as Contract Administrator; and

m. Any grants where the funds have been reduced in FY 2024, and the amount of the reduction.

Please see Attachment 9.

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

Please see Attachment 10.

11. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2023 and FY 2024, to date. Please include the following:

a. Revenue source name and code;
b. Description of the program that generates the funds;
c. Cost center that the revenue in each special purpose revenue fund supports;
d. Total amount of funds generated by each source or program in FY 2023 and FY 2024, to date; and
e. FY 2023 and FY 2024, to date, expenditure of funds including reprogrammings, and the purpose of expenditure;
f. Fund balance at the end of FY 2023 and FY 2024 to date.

Please see Attachment 11.

12. For each grant lapse that occurred in FY 2023, please provide:

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

No grant lapses occurred in FY2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY23-24 PERFORMANCE OVERSIGHT QUESTIONS

13. Please provide DHCF's capital budgets for FY 2023 and FY 2024, to date, and include the following information:

a. The amount budgeted and actually spent;
b. Impact on operating budget; and
c. Programs funded by the capital budget.

Please see Attachment 13.

5th Interim Response 50

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

a. Source of funding;

b. Narrative explanation for changes; and

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

Please see Attachment 14.

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

a. Name of the vendor;

b. Purpose of the contract;

c. DHCF employee responsible for the contract;

d. Modification term;

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

f. Narrative explanation of the reason for the modification;

g. Funding source; and

h. Whether or not the contract was competitively bid.

Please see Attachment 15.

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

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

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

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

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

Please see Attachment 17.

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

5th Interim Response 51

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

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

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

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

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

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

Please see Attachment 9 for relevant information.

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

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

a. Contracts and procurements under $250,000.

Approximately one to two weeks.

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

Approximately one to nine months.

5th Interim Response 52

c. Contracts and procurements over $1 million.

Approximately nine months to 1.5 years.

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

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

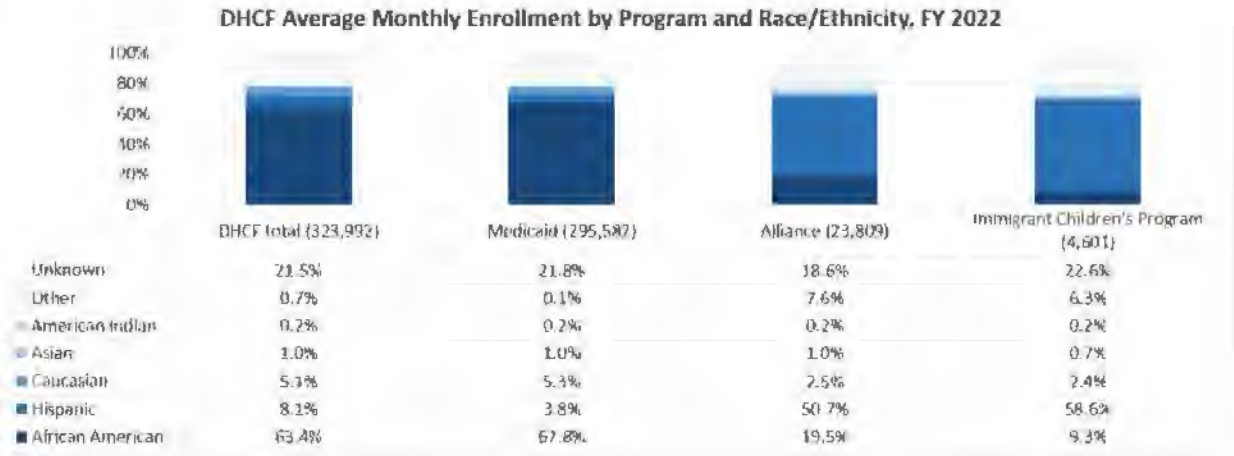
23. What changes to contracting and procurement policies, practices, or systems would help your agency deliver more reliable, cost-effective, and timely services?

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

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

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

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



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

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

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

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

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

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

1) Improving Performance Measurement and Data Collection;

2) Including Equity in Value-based Payment;

3) Ensuring Equity is Present in Care Design and

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

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

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

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

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

5th Interim Response 54

Medicaid

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

Please see Attachment 28.

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

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

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

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

DHC formulates the budget based on three main factors:

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

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

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

5th Interim Response 55

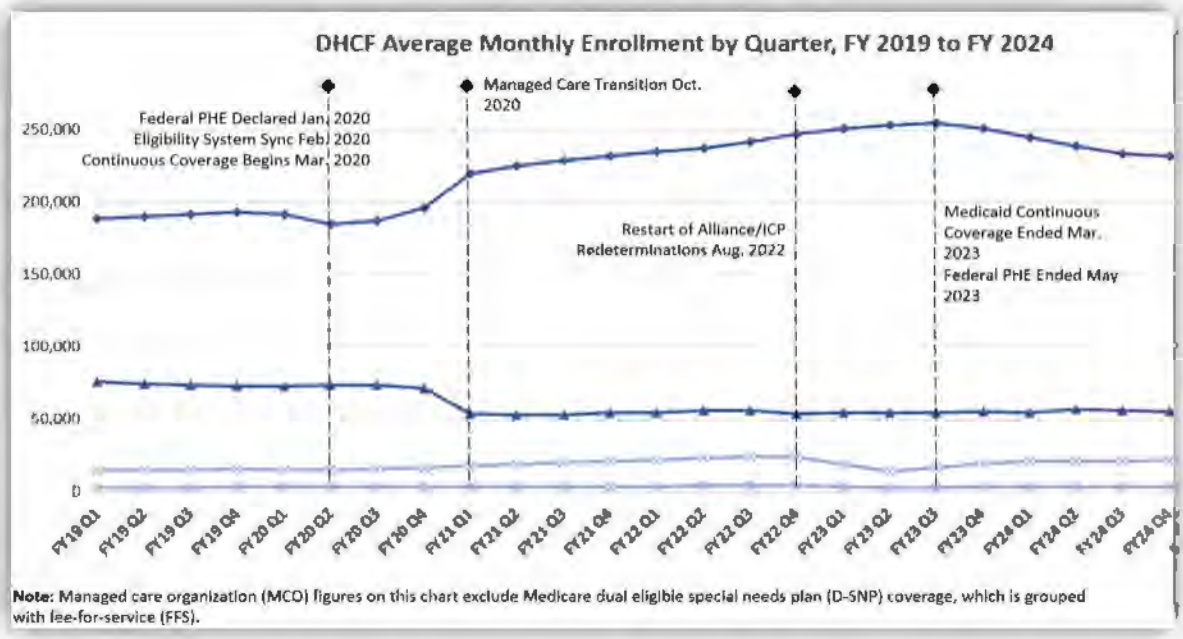
detect any shifts that were not anticipated and determine the reason and impact of the change on the forecast. It is also important to remember that enrollment does not always have a direct relationship to cost (unless analyzing MCO cost). It is possible to have a steady enrollment and experience increased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

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

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

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

See below chart for visual detailing of enrollment.



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

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

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

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

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

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

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

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

Please see response to 31(d) below.

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

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

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

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

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

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

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

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

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

5th Interim Response 58

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

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

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

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

Please see Attachment 32 for additional detailing.

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

5th Interim Response 59

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

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

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

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

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

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

5th Interim Response 60

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

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

TABLE 1

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

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

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

5th Interim Response 63

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

5th Interim Response 64

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

TOTAL - 139

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

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

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

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

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

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

The most recent review can be found here:

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

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

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

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

Findings

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

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

5th Interim Response 66

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

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

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

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

5th Interim Response 67

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

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

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

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

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

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

5th Interim Response 68

DHCF also reviews performance on:

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

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

Conclusion

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

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

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

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

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

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

5th Interim Response 69

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Reimbursement rates/methodologies in FY23 or FY24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

		Appropriations Act of 2022.	Submitted: 1.3.24		

Table 3: FY24 and FY25 Anticipated SPA/Waiver Submission

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1. PRTF Beneficiaries Served:

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

Length of Time from Determination to Placement

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

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

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

Table 2: Beneficiaries Served by State:

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

Beneficiaries' Length of Stay

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

Sister Agency Involvement

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

If the youth was recommended for placement by a sister agency (see Table 3 below) and approved by the Review Committee, the recommending agency works with the PRTF to ensure the

5th Interim Response 86

placement, appropriate reviews, and authorizations are obtained, and works collaboratively with DBH for monitoring the care of the youth in the PRTF. DBH has primary responsibility for the oversight of the care being provided by all youths in PRTFs.

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

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

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

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

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

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

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

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

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

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

5th Interim Response 88

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44: Regarding renewal notices:

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

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

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

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

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

5th Interim Response 93

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

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

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

DHCF has taken the following actions to address these issues:

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

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

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

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

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

a. Non-urgent prior authorizations?

b. Urgent prior authorizations?

c. Long-term care prior authorizations?

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

5th Interim Response 94

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

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

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

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

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

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

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

All upgrades are complete.

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

Please see chart below:

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

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

a. No confirmation of completed application;

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

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

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

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

c. Length of time newborn applications are pending.

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

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

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

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

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

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

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

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

See column 3 in tables below for each renewal form type. Most individuals who returned a renewal form prior to their certification date would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was added to

5th Interim Response 98

highlight additional individuals who retain coverage despite not returning a form prior to their certification date. This includes non-MAGI beneficiaries who responded during their one-month extension and MAGI children who were reinstated or had a termination paused while DHCF ensured compliance with federal ex-parte (passive) renewal requirements.

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

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

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

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

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

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

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

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

1	2	3	4	5	6
Recertification Date	**Total receiving conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-06-30	1,914	1,096	699	119	90
2023-07-31	1,852	988	716	148	80
2023-08-31	3,753	2,017	1,442	294	218
2023-09-30	3,667	1,870	1,508	289	255
2023-10-31	3,399	1,678	1,454	267	160
2023-11-30	5,840	2,681	2,758	401	8
Percent of total receiving conversion renewal form					
2023-05-31	0%	0%	0%	0%	0%
2023-06-30	100%	57%	37%	6%	5%
2023-07-31	100%	53%	39%	8%	4%
2023-08-31	100%	54%	38%	8%	6%
2023-09-30	100%	51%	41%	8%	7%
2023-10-31	100%	49%	43%	8%	5%
2023-11-30	100%	46%	47%	7%	0%

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

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

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

5th Interim Response 100

1	2	3	4	5	6
Recertification Date	**Total receiving non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-07-31	139	84	41	14	3
2023-08-31	160	89	62	9	17
2023-09-30	208	125	72	11	14
2023-10-31	202	118	70	14	11
2023-11-30	244	128	101	15	1
Percent of total receiving non-MAGI renewal form					
2023-05-31	0%	0%	0%	0%	0%
2023-06-30	100%	63%	33%	4%	5%
2023-07-31	100%	60%	29%	10%	2%
2023-08-31	100%	56%	39%	6%	11%
2023-09-30	100%	60%	35%	5%	7%
2023-10-31	100%	58%	35%	7%	5%
2023-11-30	100%	52%	41%	6%	0%

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

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

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

1	2	3	4	5	6
Recertification Date	**Total receiving non-passive D2 (MAGI) renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but reinstated or never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
2023-08-31	15,566	7,021	4,796	3,749	1,537
2023-09-30	3,878	1,918	1,191	769	393
2023-10-31	11,986	5,375	3,635	2,976	878
2023-11-30	11,707	4,778	3,700	3,229	688
Percent of total receiving D2 (MAGI) renewal form					
2023-05-31	100%	42%	39%	20%	11%
2023-06-30	100%	46%	34%	20%	12%
2023-07-31	100%	45%	31%	24%	10%
2023-08-31	100%	45%	31%	24%	10%
2023-09-30	100%	49%	31%	20%	10%
2023-10-31	100%	45%	30%	25%	7%
2023-11-30	100%	41%	32%	28%	6%

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

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

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

incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

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

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

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

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

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

a. See columns 5 and 6 below.

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

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

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries due for renewal**	**ABD beneficiaries passively renewed**	**ABD beneficiaries receiving non-passive renewal form**	**ABD beneficiaries required to complete the conversion form**	**ABD beneficiaries required to complete the non-MAGI form**
2023-06-30	100%	8%	92%	79%	13%
2023-07-31	100%	6%	94%	92%	2%
2023-08-31	100%	7%	93%	91%	2%
2023-09-30	100%	7%	93%	90%	3%
2023-10-31	100%	94%	6%	6%	0%
2023-11-30	100%	37%	63%	62%	1%

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

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

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

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

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries reqnired to complete the conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of tbeir 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 tbeir certification period (subset of 4)**
Number of beneficiaries					
2023-06-30	419	180	220	19	27
2023-07-31	431	173	234	24	25
2023-08-31	1,697	787	768	142	146

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

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

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

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

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

1	2	3	4	5	6
Recertification Date	**ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Number of beneficiaries					
2023-06-30	419	180	220	19	27
2023-07-31	431	173	234	24	25
2023-08-31	1,697	787	768	142	146
2023-09-30	1,744	741	862	141	164
2023-10-31	1,038	459	490	89	44
2023-11-30	2,589	979	1,419	191	1
Percent of total receiving non-MAGI renewal form					
2023-06-30	100%	43%	53%	5%	6%
2023-07-31	100%	40%	54%	6%	6%
2023-08-31	100%	46%	45%	8%	9%
2023-09-30	100%	42%	49%	8%	9%
2023-10-31	100%	44%	47%	9%	4%
2023-11-30	100%	38%	55%	7%	0%

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

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

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number

are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

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

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

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

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

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

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

1	2	3	4	5	6
Recertification Date	**QMB-only beneficiaries due for renewal**	**QMB-only beneficiaries passively renewed**	**QMB-only beneficiaries receiving non-passive renewal form**	**QMB-only beneficiaries required to complete the conversion form**	**QMB-only beneficiaries required to complete the non-MAGI form**
2023-09-30	100%	3%	97%	94%	4%
2023-10-31	100%	6%	94%	88%	6%
2023-11-30	100%	3%	97%	95%	3%

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

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

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

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

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

1	2	3	4	5	6
Recertification Date	**QMB-only beneficiaries required to complete the conversion renewal form (3+4+5)**	**Returned a renewal form prior to the end of their certification period**	**Terminated for failure to manually renew prior to the end of their certification period**	**Did not return renewal form prior to end of certification period but never terminated**	**Lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period (subset of 4)**
Percent of total receiving non-passive renewal form					
2023-06-30	100%	53%	44%	3%	4%
2023-07-31	100%	50%	46%	4%	3%
2023-08-31	100%	55%	39%	6%	3%
2023-09-30	100%	53%	40%	8%	5%
2023-10-31	100%	48%	42%	10%	2%
2023-11-30	100%	50%	43%	7%	0%

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

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

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

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

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

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

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

- Column 3 includes a small number of beneficiaries with an unknown response date and a small number who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included.
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension.
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension.
- Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number

are determined ineligible and disenrolled. The grace period for the October and November cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

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

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

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

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

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

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

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

a. Of those Medicaid participants who lost their coverage because they no longer qualified under their existing eligibility group, how many / what percentage of those participants were enrolled, in FY 2023 and in FY 2024 to date, in:

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

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

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

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

1	2	3	4	5	6	7	8	9	10
Recertification Date	Determined ineligible before or after their certification period	ABD	Long-term care	Children	Parent / caretaker relatives	Child-less adults	Pregnant indivi-duals	QMB-only	Other adults
Number of beneficiaries									
2023-05-31	77	0	0	28	7	41	1	0	0
2023-06-30	353	11	13	81	70	118	0	59	1
2023-07-31	1,366	2	7	534	235	528	8	42	10
2023-08-31	1,317	15	11	516	194	507	2	65	7
2023-09-30	148	14	4	34	25	39	0	32	0
2023-10-31	929	9	3	405	120	363	4	21	4
2023-11-30	436	12	4	150	53	163	3	48	3
Percent of total determined ineligible									
2023-05-31	100%	0%	0%	36%	9%	53%	1%	0%	0%
2023-06-30	100%	3%	4%	23%	20%	33%	0%	17%	0%
2023-07-31	100%	0%	1%	39%	17%	39%	1%	3%	1%
2023-08-31	100%	1%	1%	39%	15%	38%	0%	5%	1%
2023-09-30	100%	9%	3%	23%	17%	26%	0%	22%	0%
2023-10-31	100%	1%	0%	44%	13%	39%	0%	2%	0%
2023-11-30	100%	3%	1%	34%	12%	37%	1%	11%	1%

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

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

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

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

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

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

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

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

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

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

Month	Total applications	Online applications
Nov-23	994	881
Dec-23	1,025	868

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

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

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

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

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

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

applications and renewals that are impacting the overall timeliness of Medicaid, Alliance, and ICP eligibility determinations.

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

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

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

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

- **Resolution:** Improve the usability of the online application by collaborating with federal partners to fully align health and human services policies and thereby reduce the length of the application, and establish more efficient processes for customers with questions and issues
- DHS-DHCF have engaged Code for America and working with federal partners to streamline and update the integrated application with the use of predictive technology
- DCAS is procuring a new contact center vendor and will establish integrated contact center functions to serve all health and human services programs and make it easier for customers to obtain needed information and/or action.
- DHCF and DHS will explore further utilization of 1902(e)(14) waivers to align SNAP and Medicaid eligibility policy where possible.

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

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

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

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

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

Month	Total applications	Applications submitted in person	Percent of total applications submitted in person
Oct-22	1,077	365	34%
Nov-22	1,040	308	30%
Dec-22	1,057	302	29%
Jan-23	1,278	337	26%
Feb-23	918	246	27%
Mar-23	1,124	290	26%
Apr-23	860	194	23%

May-23	1,050	246	23%
Jun-23	1,135	272	24%
Jul-23	1,362	343	25%
Aug-23	1,294	224	17%
Sep-23	978	106	11%
Oct-23	965	128	13%
Nov-23	994	90	9%
Dec-23	1,025	365	11%

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

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

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

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

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

See response to Question 57(c).

b. For applications based on disability, please provide:

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

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

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

See response to Question 57 item c.

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

Month	Percent of MAGI Applications Processed Within 45 Days	Percent of Non-MAGI Applications Processed Within 90 Days
Oct-22	90%	94%

Nov-22	91%	92%
Dec-22	82%	92%
Jan-23	84%	86%
Feb-23	76%	98%
Mar-23	69%	89%
Apr-23	79%	90%
May-23	87%	95%
Jun-23	79%	96%
Jul-23	85%	98%
Aug-23	88%	93%
Sep-23	77%	91%
Oct-23	62%	93%
Nov-23	58%	93%
Dec-23	70%	85%

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

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

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

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

i. Applications submitted online;

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

iii. Applications submitted through any other means;

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

b. The causes of such backlog(s);

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

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

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

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

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

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

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

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

Not applicable.

61. **In its FY 2024 Budget Report, the Committee recommends that DHCF explore creating a Medicaid Buy-In for Workers with Disabilities program so that individuals with disabilities can work, earn an income, and buy into the Medicaid program. What are the benefits and downsides of this program, and is DHCF considering implementing it?**

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

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

DC Healthcare Alliance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1	2	3	4	5	6
Month	**Total enrolled**	**Ongoing enrolled and retaining coverage next month**	**Newly enrolled or re-enrolled after gap and retaining coverage next month**	**Losing coverage next month**	**Percent of total losing coverage next month**
FY 2022					
2022-08	30,900	28,489	441	1,970	6%
2022-09	29,332	26,534	445	2,353	8%
FY 2023					
2022-10	27,555	23,418	612	3,525	13%
2022-11	24,650	21,462	712	2,476	10%
2022-12	22,930	19,322	810	2,798	12%
2023-01	21,062	17,948	992	2,122	10%
2023-02	19,732	18,342	832	558	3%
2023-03	20,141	18,616	1,001	524	3%
2023-04	20,395	19,457	802	136	1%
2023-05	21,344	20,150	1,050	144	1%
2023-06	22,003	21,051	788	164	1%
2023-07	22,540	21,603	695	242	1%
2023-08	23,075	22,041	757	277	1%
2023-09	23,396	22,575	568	253	1%
FY 2024					
2023-10	23,687	22,611	503	573	2%
2023-11	23,499	22,535	371	593	3%
2023-12	23,388	22,328	448	612	3%

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

Notes: Following the end of the District's public health emergency, nearly all Alliance and ICP beneficiaries were due for a renewal during the six-month period of August 2022 through

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

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

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

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

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

Disability Services

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

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

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

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

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

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

DHCF does not require home health agencies to report all employed PCAs. However, PCAs employed in fee-for-service Medicaid are required to obtain a Medicaid number and enroll in the District's provider data management system. As of January 2024, there are 7,630 individuals with Medicaid IDs enrolled as Personal Care Aides.

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

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

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

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

DHCF does not track and categorize participants by whether they have experienced reductions in hours, and therefore cannot produce this as a data point without engaging in a complex analysis

over an extended period of time. Among other factors, there are multiple data sources (assessment data, claims data, authorization data, and appeals and grievance data) from multiple delivery systems and payers (CASSIP, DCHFP, Dual Choice, and fee-for-service) required to assess changes actually effectuated (and not pending appeal) due solely to changed authorizations. Medicaid beneficiaries have the right to appeal any changes to their Medicaid benefits initiated by their Medicaid payer and, if changes are appealed on a timely basis, no changes occur until their appeals rights are exhausted.

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

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

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

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

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

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

73. Please provide us with the total number of EPD waiver participants who are receiving their PCA hours through a Home Health Agency and through participant directed services, in FY 2023 and in FY 2024, to date. For each, provide:

a. How many is DHCF or an MCO reimbursing for the full number of approved PCA hours?
b. How many is DHCF or an MCO reimbursing for only some of the approved PCA hours?

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

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

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

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

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

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

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

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

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

The Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) provider rate was updated to include the cost impact of paying Direct Service Providers (DSPs) an average of 117.6% of the living/minimum wage in CY23. DHCF established a phased-in approach for Home

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

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

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

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

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

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

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

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

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

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

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

Direct Support Professional Payment Rates Report

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

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

Medical Respite Care

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

Value-Based Purchasing (VBP) Reporting

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

DHCF's oversight of the MCOs' VBP programs is structured to evaluate effectiveness, equity, and fairness amongst enrolled Medicaid providers. This includes ensuring providers are incentivized for rendering appropriate and timely access to care and achievement of improved health care outcomes for the populations served.

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

MCO Requested Metrics

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

Maternal Health

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

a. Group membership;

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

b. Timeline for reconvening the group in FY 2024;

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

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

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

c. Projected priorities for the Group in FY 2024.

We are seeking to broaden the purpose and objectives in order to institutionalize the group as a regular feature of the agency and also continue the momentum of the Perinatal Mental Health Task Force (PMHTF). The purpose of the MHAG will be to provide expert advice and recommendations to the Medicaid agency on matters related to maternal health, with a focus on both physical and mental well-being. The group aims to contribute insights, expertise, and evidence-based recommendations to enhance the quality and effectiveness of Medicaid services for pregnant individuals.

Objectives:

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

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

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

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

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

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

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

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

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

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

DHCF received a project proposal and budget for the First-Time Mother's Home Visiting Program at the end of December 2023. DHCF is currently reviewing the proposal and budget and

will then work to release a Notice of Grant Award (NOGA). DHCF anticipates awarding a $225,000 grant by the end of January 2024.

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

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

Table 1 – HEDIS, NCQA, and OPA measures

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

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

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

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

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

Measure	AmeriHealth Caritas DC			CareFirst Community Health Plan DC			Health Services for Children with Special Needs			MedStar Family Choice DC		
	MY 20 %	MY 21 %	MY22 %	MY 20 %	MY 21 %	MY 22 %	MY 20 %	MY 21 %	MY 22 %	MY 20 %	MY 21 %	MY 22 %
Prenatal and Postpartum Care												
Timelin ess of	84.91	86.59	82.55	76.92	76.40	77.86	76.19	82.98	66.67	-	82.00	77.12

Prenatal Care												
Postpartum Care	73.97	74.09	76.01	69.66	71.29	74.45	66.67	57.45	78.57	-	69.83	65.54
LARC – Women												
Ages 15-20	3.64	2.72	2.61	2.78	2.27	1.77	3.90	4.31	3.07	-	2.27	1.95
Ages 21-44	3.70	3.54	2.96	1.23	2.37	2.17	3.50	4.40	4.17	-	2.14	2.12
Most/Moderately Effective Contraception – Women												
Ages 15-20	24.34	20.52	20.02	15.43	15.58	14.05	26.34	25.12	23.93	-	18.77	18.42
Ages 21-44	25.24	22.34	21.19	14.44	14.56	13.74	20.23	29.60	26.52	-	16.61	15.64
LARC – Postpartum												
Ages 15-20, within 3 days	3.28	6.06	1.18	0.00	2.00	9.52	8.33	-	8.33	-	4.00	2.13
Ages 21-44 within 3 days	4.31	2.74	2.63	2.35	2.95	3.54	0.00	-	0.00	-	3.04	3.23
Ages 15-20, within 60 days	11.48	14.14	17.65	22.22	16.00	14.29	12.50	-	8.33	-	16.00	14.89
Ages 21-44, within 60 days	11.08	10.45	11.13	7.06	8.23	9.58	0.00	-	8.70	-	9.11	8.37
Most/Moderately Effective Contraception – Postpartum												
Ages 15-20, within 3 days	4.92	9.09	4.71	8.33	2.00	11.90	8.33	-	8.33	-	12.00	4.26
Ages 21-44, within 3 days	13.16	13.35	13.16	14.12	10.97	10.83	14.29	-	13.04	-	12.15	12.55

Ages 15-20, within 60 days	30.33	29.29	45.88	38.89	34.00	33.33	45.83	-	25.00	-	54.00	38.30
Ages 21-44, within 60 days	36.92	37.48	40.79	30.59	28.27	29.79	28.57	-	34.78	-	31.67	32.13

Note:. Red text indicates measure fell below national average for year of interest while green text indicates measure met or exceeded national average for year of interest. Black text indicates that national average was unavailable for comparison. HEDIS data are reported on the calendar year therefore the timeframe for reporting does not align with the fiscal year. The most recent HEDIS data available are measures from calendar year 2022. HEDIS data for calendar year 2023 will not be available until Summer or Fall of 2024.

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

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

Table 3. District Medicaid Managed Care Averages over Time

Measure	District Managed Care Plan Average		
	MY 2020	MY 2021	MY 2022
Timeliness of Prenatal Care	79.34%	81.99%	76.05%
Postpartum Care	70.10%	68.17%	73.64%

Women ages 15-20 - LARC	3.59%	2.58%	2.35%
Women ages 21-44 – LARC	3.33%	2.84%	2.85%
Women ages 15-20 – Most/Moderately Effective Contraception	23.74%	19.19%	19.10%
Women ages 21-44 – Most/Moderately Effective Contraception	23.53%	18.68%	19.27%
Postpartum Women 15-20 – LARC in 3 days	3.30%	4.74%	5.29%
Postpartum Women 21-44 – LARC in 3 days	4.03%	2.91%	2.35%
Postpartum Women 15-20 – LARC in 60 days	13.74%	14.69%	13.79%
Postpartum Women 21-44 – LARC in 60 days	10.50%	9.65%	9.44%
Postpartum Women 15-20 – Most/Moderately Effective Contraception – 3 days	6.04%	8.06%	7.30%
Postpartum Women 21-44 – Most/Moderately Effective Contraception – 3 days	13.28%	12.56%	12.40%
Postpartum Women 15-20 – Most/Moderately Effective Contraception – 60 days	34.07%	35.55%	35.63%
Postpartum Women 21-44 – Most/Moderately Effective Contraception – 60 days	36.09%	34.12%	34.37%

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

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

Currently, Community Health Workers (CHW) are not a licensed health care provider type recognized by DC Health. Nonetheless, DHCF does provide a few pathways for payment for CHWs or comparable provider-types. For example, DHCF includes Community Health Workers in the rate formulation for Federally Qualified Health Centers under the category enabling services/CHW as a staffing cost that is a component of the medical, behavioral health, or dental service billed by health centers. Additionally, the My Health GPS care coordination program

includes a requirement that the participating primary care providers include a peer navigator on their team. This staffer is defined as a health educator capable of linking beneficiaries with the health and social services they need to achieve wellness.

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

Office of the Health Care Ombudsman and Bill of Rights

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

Please see Attachment 83.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Timeline for DHCF to submit the required report to the Council after consulting with CMS on whether in vitro fertilization and standard fertility preservation services are medically reasonable and necessary procedures under federal law, possible methods for covering in-vitro fertilization and standard fertility preservation services as a Medicaid covered benefit for both FFS and MCOs, including any potentially applicable waiver authorities, and the amount of money that would need to be allocated to federal and local funds for such coverage.

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

Behavioral Health

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

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

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

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

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

5th Interim Response 138

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

(3) Beneficiary Engagement & Communication Planning and Activities including-
- in-person forums,
- social media,
- outreach & marketing from Government Agencies as well as the MCPs.

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

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

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

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

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

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

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

Declaration of Public Emergency: Opioid Crisis ("The Order")

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

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

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

Not applicable.

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

Not applicable.

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

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

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

Not applicable.

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

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

5th Interim Response 140

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

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

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

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

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

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

Not applicable.

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

Not applicable.

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

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

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

Not applicable.

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

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

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

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

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

To:	Anscombe, Madeline (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1d86174fed854667a7f79ece3b07ee17-499aadd9-38 <Madeline.Anscombe@hhs.gov>
Subject:	FW: 1pm deadline - Weekly WH Medicaid report
Date:	2023/10/20 10:02:33
Priority:	Normal
Type:	Note

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Friday, October 20, 2023 6:55 AM
To: Besaw, Rebecca (HHS/OCR) <Rebecca.Besaw@hhs.gov>
Cc: Husain, Naba (HHS/OS/IOS) <Naba.Husain@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>
Subject: Fwd: 1pm deadline - Weekly WH Medicaid report

Rebecca- can you pls make sure we have Melanie's ocr unwinding activity? Thanks-

Get Outlook for iOS

From: Lonardo, Sara (CMS/OC) <sara.lonardo@cms.hhs.gov>
Sent: Friday, October 20, 2023 9:35:41 AM
To: Cross-Call, Jesse (OS/IEA) <Jesse.Cross-call@hhs.gov>; Graf, Alex (HHS/ASL) <Alex.Graf@hhs.gov>; Turcios, Yosselin (HHS/IEA) <Yosselin.Turcios@hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kahan, Zach (OS/IEA) <Zach.Kahan@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Burns, Samira (HHS/ASPA) <Samira.Burns@hhs.gov>; Kaplun, Brian (HHS/IOS) <Brian.Kaplun@hhs.gov>; Rangel, Isabel (HHS/IOS) <Isabel.Rangel@hhs.gov>; Egorin, Melanie (HHS/ASL) <Melanie.Egorin@hhs.gov>; Langford, Kelly (HHS/ASPA) <Kelly.Langford@hhs.gov>; Nesbit, Jeff (HHS/ASPA) <Jeffrey.Nesbit@hhs.gov>; Wieand, Elizabeth (Betsy) (HHS/IEA) <Elizabeth.Wieand@hhs.gov>
Cc: Tesfaye, Eden (CMS/OA) <eden.tesfaye@cms.hhs.gov>; Tsai, Daniel (CMS/CMCS) <Daniel.Tsai@cms.hhs.gov>; Walen, Alyssa (CMS/OC) <Alyssa.Walen@cms.hhs.gov>; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>; Wallace, Mary (CMS/OC) <Mary.Wallace@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Dervan, Elizabeth (CMS/OL) <elizabeth.dervan@cms.hhs.gov>; Hammarlund, John (CMS/OPOLE) <john.hammarlund@cms.hhs.gov>; Wagner, Rachel (CMS/OC) <Rachel.Wagner@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Wieand, Elizabeth (Betsy) (HHS/IEA) <Elizabeth.Wieand@hhs.gov>
Subject: 1pm deadline - Weekly WH Medicaid report

HHS friends – It's that time of the week! Coming at you with this week's Medicaid renewals report for the White House. You know the routine. Just as we do every week I'm requesting that HHS send me back **ONE** document with edits with everyone from HHS in there.

As usual, I'll circulate news clips when they come in.

Here's the timeline:

1pm Friday – HHS edits are due back to Sara
4pm Friday – Final report goes to WH

Thanks in advance for your work on this! And give me a shout with any questions/concerns.

Sara

--
Sara Lonardo
Senior Advisor and Press Secretary
CMS
771-216-0985

Recipient:	Anscombe, Madeline (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1d86174fed854667a7f79ece3b07ee17-499aadd9-38 <Madeline.Anscombe@hhs.gov>
Sent Date:	2023/10/20 10:02:17
Delivered Date:	2023/10/20 10:02:33
Message Flags:	Unread Unsent

Weekly Medicaid Unwinding Report: October 20

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- Georgia Public Broadcasting: Georgia reinstates Medicaid coverage for thousands who got kicked off after error in renewals

Earned Media

-

Commented [LS(1]: Will remove if we don't have anything to add

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@SecBecerra:
https://twitter.com/SecBecerra/status/1714017649405882401

@HHSGov:
https://twitter.com/HHSGov/status/1713932829954908193

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1714334210712838296

Hill Engagement

-

Commented [LS(2]: Will remove if we don't have anything to add

Engagement with External Partners

- Oct 14: HHS Region 7 Regional Director gave remarks at a Medicaid Renewal Family Event with Kansas City Councilwoman Melissa Robinson.
- Oct 16: HHS Region 3 Acting RD presented on Medicaid renewals to a group representing Black Leaders of Delaware co-chaired by Delaware Lt. Gov. Bethany Hall-Long
- Oct 16: HHS Region 4 Executive Officer joined a panel presentation for the Kennesaw (Georgia) State University School of Nursing and provide key highlights about Medicaid renewals.

- Oct 17: IEA IGA meeting with officials from Allegheny County, PA and the Pittsburgh Mayor.
- Oct 17: HHS Region 4 team hosted a federal interagency conversation about the Medicaid Renewal process with DOL, HUD, IRS, USDA and HHS partners to leverage regional outreach/education efforts and resources related to Medicaid renewals.
- Oct 18: Rachel Pryor and Jesse Cross-Call spoke about Medicaid renewals at the Catholic Health Association's fall advocacy conference in Washington, DC.
- Oct 18: HHS Region 4 Public Affairs Specialist attended the CMS Atlanta Marketplace stakeholder meeting to discuss Medicaid renewals.
- Oct 19: IEA Center for Faith-based and Neighborhood Partnerships hosted a call with CMS and USDA around Medicaid renewals, rural health, and the role of faith communities.
- Oct 19: IEA IGA hosted a call with CMCS and CDC for intergovernmental stakeholders around the fall vaccine campaign and Medicaid renewals.
- Oct 19: HHS Region 7 RD met with Washington University in St. Louis to learn more about their Home-Grown Program and to discuss Medicaid renewals.
- Oct 19: HHS Region 7 RD met with the Webster Groves, MO City Manager, Marie Peoples, to discuss Medicaid renewals.
- Oct 20: HHS Region 5 RD participated in the monthly State Health Official Meeting to discuss best practices and strategies for Medicaid renewals within the region.
- Oct 20: HHS Region 7 RD met with NAACP St. Louis County President John Bowman to discuss Medicaid renewals.
- Oct 20: HHS Region 7 RD met with Kansas City, MO Councilwomen Melissa Robinson and Melissa Patterson-Hazley to discuss Medicaid renewals.
- OPOLE added 10 new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to people with Medicaid/CHIP.
- OPOLE engaged in 51 outreach events this past week to spread renewals messaging and encourage partners to do the same.

Look Ahead

- Oct 24: Secretary Becerra, Sean McCluskie, and Erin Richardson will host a roundtable with Inflation Reduction Act (IRA) and Medicare stakeholder advocates to discuss IRA implementation, Medicare open enrollment, and ways to reach seniors being disenrolled from Medicaid during OE.
- Oct 25: Jesse Cross-Call will speak on a panel around renewals at the American Cancer Society's Priorities and Partners conference in Arlington, VA.
- TENTATIVE Oct 27: CMS release of updated renewals data.
- Late October: Briefing for "Quad Caucus" (Black, Hispanic, Asian American, and Native American) of state legislators).
- Nov 1: IEA IGA renewals webinar with the US Conference of Mayors, led by Mayor Romero of Tucson and Mayor Stoney of Richmond.

- Nov 1: ACA open enrollment kickoff event with Secretary Becerra that will include a renewals message.
- TENTATIVE Nov 3: CMS will publish an interim final rule with comment period on the Consolidated Appropriations Act (CAA), 2023, provision on civil monetary penalties related to unwinding of the COVID-19 Medicaid continuous enrollment condition. This item will have a reactive statement, internal questions-and-answers, and listserv messages.
- Week of Nov 12: USPS to ship and post renewals information.
- Briefing for state advocate validators.
- HHS and Dept of Ed Joint Secretary PSA Video (English and Spanish).
- Deputy Secretary Palm will call PA Medicaid to encourage them to accept help on ex parte.
- ASPE Medicaid renewals context report
- E14 strategies state implementation tool.
- CIB on policies states should be adopting on kids' coverage.

Weekly Medicaid Unwinding Report: October 13

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- Alaska Public Media: Alaska health department changes Medicaid renewal process to keep thousands covered
- WyoFile: Medicaid, Kid Care disenrollments fall amid 'unwinding'

Earned Media

- Oct 12: CMS Deputy Administrator Dan Tsai interview with Noah Weiland from *The New York Times* for a story on keeping kids, especially those now eligible for CHIP, covered.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1712092942200942633

Hill Engagement

- Sent "event in a box" toolkit to targeted hill offices. Toolkit provides materials on Medicaid renewals and Administration efforts to lower health care costs and provides example events with stakeholders and/or Secretary Becerra and other Department Principals.

Engagement with External Partners

- Oct 10: HHS Region 1 Regional Director spoke with seniors at the Beverly Senior Center in Beverly, MA about the importance of Medicaid renewals.
- Oct 10: HHS Region 7 RD gave remarks regarding Medicaid renewals during the Black Male Health Workgroup meeting.
- Oct 10: HHS Region 8 RD provided a keynote speech at the Utah Hispanic Chamber of Commerce Conference in Salt Lake City, UT and attended a roundtable meeting with 30 Latino leaders discussing Medicaid renewals.
- Oct 10: HHS Region 8 RD met with Utah State Senator Nate Blouin in Salt Lake City, UT and shared updates on Medicaid renewals.

- Oct 11: HHS Region 3 Acting RD presented on Medicaid renewals to members of the Delaware Black Chamber of Commerce.
- Oct 11: HHS Region 5 RD met with leadership of Health Management Associates to learn how Medicaid renewals are proceeding.
- Oct 11: HHS Region 8 RD met with Latino leaders from the Salt Lake City area to discuss Medicaid renewals.
- Oct 12: HHS WHIAANHPI Executive Director, Senior Advisor, and Deputy Assistant to the President and AA and NHPI Senior Liaison met with the Asian Community Development Council (ACDC) leadership and discussed Medicaid renewals.
- Oct 12: HHS Region 4 RD met with members of the North Carolina Get Covered and Care Share coalition to discuss updates regarding Medicaid renewals.
- Oct 12: HHS Region 6 Acting RD participated in a panel discussion on Medicaid renewals at the Texas Chapter of the NAACP Convention in Pflugerville, TX.
- Oct 12: HHS Region 6 Acting RD met with Derek Lewis, Executive Administrator with the National Medical Association, to discuss Arkansas Medicaid renewals.
- Oct 12: HHS Region 6 Acting RD met with Kenya Eddings, Director of the Arkansas Office of Minority Health to discuss Arkansas Medicaid renewals.
- Oct 12: HHS Region 7 RD gave opening remarks at the National Association of State Offices of Minority Health (NASOMH) board meeting about Medicaid renewals.
- Oct 12: HHS Region 7 team met with Jeremy Smith, enrollment project coordinator for First Choice Services, the only statewide navigator in Iowa, and Nicole Johnston, project officer for the Division of Assister Programs at the Center for Consumer Information and Insurance Oversight, to discuss Medicaid renewals.
- Oct 13: HHS Region 1 RD spoke with seniors at the Leon Mathieu Senior Center in Pawtucket, R.I. on the importance of Medicaid renewals.
- Oct 13: HHS Region 5 team met with Minnesota Acting Assistant Commissioner Julie Marquardt and promising practices and barriers on Medicaid renewals were discussed.
- Oct 13: HHS Region 6 Acting RD provided welcome remarks on Medicaid renewals during a meeting with Region 6 Health and Human Services Secretaries in Dallas.
- OPOLE added 15 new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to people with Medicaid/CHIP.
- OPOLE engaged in 38 outreach events this past week to spread renewals messaging and encourage partners to do the same.
- The Office of the Deputy Secretary briefed the Aspen Institute Financial Resilience Program State Benefits Leadership Cohort (eight state health and/or human services leaders participating in a quarterly professional development program around improved integrated benefits delivery) and APHSA Leadership Council (a representative body of state and local human services agency Secretaries/Commissioners) on Financial Shocks projects and opportunities to receive federal TA, including on renewals ex parte, and those listed above.

Look Ahead

- Oct 14: HHS Region 7 RD will give remarks at a Medicaid Renewal Family Event with Kansas City Councilwoman Melissa Robinson.
- Oct 16: HHS Region 3 Acting RD will present on Medicaid renewals to a group representing Black Leaders of Delaware co-chaired by Delaware Lt. Gov. Bethany Hall-Long
- Oct 16: HHS Region 4 Executive Officer will join a panel presentation for the Kennesaw (Georgia) State University School of Nursing and provide key highlights about Medicaid renewals.
- Week of Oct 17: IEA IGA meeting with officials from Allegheny County, PA and the Pittsburgh Mayor.
- Oct 17: HHS Region 4 team will host a federal interagency conversation about the Medicaid Renewal process with DOL, HUD, IRS, USDA and HHS partners to leverage regional outreach/education efforts and resources related to Medicaid renewals.
- Oct 18: Rachel Pryor and Jesse Cross-Call will speak about Medicaid renewals at the Catholic Health Association's fall advocacy conference in Washington, DC.
- Oct 18: HHS Region 4 Public Affairs Specialist will attend the CMS Atlanta Marketplace stakeholder meeting to discuss Medicaid renewals.
- Oct 19: IEA Center for Faith-based and Neighborhood Partnerships will host a call with CMS and USDA around Medicaid renewals, rural health, and the role of faith communities.
- Oct 19: IEA IGA will host a call with CMCS and CDC for intergovernmental stakeholders around the fall vaccine campaign and Medicaid renewals.
- Oct 19: HHS Region 7 RD will meet with Washington University in St. Louis to learn more about their Home-Grown Program and to discuss Medicaid renewals.
- Oct 19: HHS Region 7 RD will meet with the Webster Groves, MO City Manager, Marie Peoples, to discuss Medicaid renewals.
- Oct 20: HHS Region 5 RD will participate in the monthly State Health Official Meeting to discuss best practices and strategies for Medicaid renewals within the region.
- Oct 20: HHS Region 7 RD will meet with NAACP St. Louis County President John Bowman to discuss Medicaid renewals.
- Oct 20: HHS Region 7 RD will meet with Kansas City, MO Councilwomen Melissa Robinson and Melissa Patterson-Hazley to discuss Medicaid renewals.
- TENTATIVE Oct 23: CMS will publish an interim final rule with comment period on the Consolidated Appropriations Act (CAA), 2023, provision on civil monetary penalties related to unwinding of the COVID-19 Medicaid continuous enrollment condition. This item will have a reactive statement, internal questions-and-answers, and listserv messages.
- TENTATIVE Oct 27: CMS release of updated renewals data.
- Late October: Briefing for "Quad Caucus" (Black, Hispanic, Asian American, and Native American) of state legislators)

- Briefing for state advocate validators
- HHS and Dept of Ed Joint Secretary PSA Video (English and Spanish)
- CIB on policies states should be adopting on kids' coverage.
- E14 strategies state implementation tool.
- Deputy Secretary Palm will call PA Medicaid to encourage them to accept help on ex parte.

Weekly Medicaid Unwinding Report: October 6

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- The Center Square: West Virginia restoring Medicaid for 5,500 children after notice from CMS
- Anchorage Daily News: Alaska pauses some Medicaid renewals after thousands lose coverage they may still qualify for
- Fierce Healthcare: CMS letter to states demands children remain on Medicaid, CHIP

Earned Media

- The Association for Community Affiliated Plans (ACAP), which represents non-profit safety net hospitals, posted the latest episode of their ACAP Coffee Break podcast, which featured a conversation with CMS Administrator Brooks-LaSure on Medicaid renewals and other topics.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1709557236375130302

https://twitter.com/HealthCareGov/status/1707745545542828453

Engagement with External Partners

- Oct 2: HHS Region 7 Regional Director met with Washington University to learn more about their Home-Grown Program and to discuss Medicaid renewals.
- Oct 2: HHS Region 9 RD and Acting CMS Regional Administrator hosted a NV Medicaid Renewals convening with NV Medicaid and NV Health Link to collaborate on Medicaid renewals outreach and education.
- Oct 2: HHS Region 7 RD met with Missouri Legislative Black Caucus to discuss Medicaid renewals.
- Oct 3: HHS Intergovernmental Affairs held a joint webinar with the National League of Cities' Small Cities Council to discuss Medicaid renewals.

- Oct 3: HHS Region 5 team joined the monthly Illinois Coalition for Health Access (ICHA) call to promote Medicaid renewals and share resources to navigators and community leaders.
- Oct 4: HHS Center for Faith-based and Neighborhood Partnerships disseminated a stakeholder newsletter (to 1200 + grasstops and network leaders) promoting HHS letters to states reinforcing need to cover children in Medicaid/CHIP for 12 months and upcoming webinar cohosted with USDA CFBNP on coverage for children and families in rural communities.
- Oct 4: HHS Region 2 RD gave Grand Rounds in the Department of Emergency Medicine at Lincoln Hospital Bronx, NY to discuss the intersection of emergency care and Medicaid renewals with faculty and staff.
- Oct 4: HHS Region 4 Public Affairs Specialist participated in the Covering Tampa Bay Leadership meeting, provided updates on behalf of the ORD and relayed any Medicaid specific questions and concerns to the appropriate OpDiv.
- Oct 4: HHS Region 7 RD attended the job fair at El Centro, to speak with the Hispanic community about Medicaid renewals.
- Oct 4: HHS Region 8 RD met with CEO Donna Lynne from Denver Health to discuss Medicaid renewals process.
- Oct 4: HHS Region 9 RD participated in a Medicaid Renewals press conference with Protect Our Care Nevada.
- Oct 5: HHS Region 3 Acting RD participated in a Health Insurance Educational and Resource Session with Philadelphia-based Black clergy and discussed Medicaid renewals.
- Oct 5: HHS Region 7 Public Affairs Specialist met with Jeremy Smith, enrollment project coordinator for First Choice Services, the only statewide navigator in Iowa, and Nicole Johnston, project officer for the Division of Assister Programs at the Center for Consumer Information and Insurance Oversight to discuss efforts to enroll people who lose Medicaid coverage.
- Oct 6: HHS Region 5 RD met with Shriver Center leadership to discuss future collaborations and programs regarding Medicaid renewals.
- Oct 7: HHS Region 7 RD will give remarks about Medicaid renewals during the Midwest Soul Vegfest at Swope Park in Kansas City.
- OPOLE added 20 new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 48 outreach events this past week to spread Medicaid renewal messaging and encourage partners to do the same.

Look Ahead

- Oct 10: HHS Region 1 RD will speak with seniors at the Beverly Senior Center in Beverly, MA about the importance of Medicaid renewals.

- Oct 11: HHS Region 3 Acting RD will present on Medicaid renewals to members of the Delaware Black Chamber of Commerce.
- Oct 11: HHS Region 5 RD will meet with leadership of Health Management Associates to learn how Medicaid renewals are proceeding.
- Oct 12: HHS Region 4 RD will meet with members of the NC Get Covered and Care Share coalition to discuss updates regarding Medicaid renewals.
- Oct 12: HHS Region 6 Acting RD will participate in a panel discussion on Medicaid renewals at the Texas Chapter of the NAACP Convention in Pflugerville, Texas.
- Oct 12: HHS Region 7 RD will be giving opening remarks at the National Association of State Offices of Minority Health (NASOMH) board meeting about Medicaid renewals.
- Oct 13: HHS Region 1 RD will speak with seniors at the Leon Mathieu Senior Center in Pawtucket, RI on the importance of Medicaid renewals.
- Oct 13: HHS Region 6 Acting RD will provide welcome remarks on Medicaid renewals during a meeting with Region 6 Health and Human Services Secretaries in Dallas.
- Late October: Briefing for "Quad Caucus" (Black, Hispanic, Asian American, and Native American) of state legislators)
- CMS will publish an interim final rule with comment period on the Consolidated Appropriations Act (CAA), 2023, provision on civil monetary penalties related to unwinding of the COVID-19 Medicaid continuous enrollment condition. This item will have a reactive statement, internal questions-and-answers, and listserv messages.
- Briefing for state advocate validators
- HHS and Dept of Ed Joint Secretary PSA Video (English and Spanish)
- CIB on policies states should be adopting on kids' coverage.
- E14 strategies state implementation tool

Weekly Medicaid Unwinding Report: September 29

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- West Virginia Watch: WV to restore Medicaid coverage to 5,500 children
- Associated Press: Medicaid coverage restored to about a half-million people after computer errors in many states

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1707127532615508059

@HHSGov:
https://twitter.com/HHSGov/status/1707757204240044239

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1706720290930082013

Rollouts

- Sept 28: Release of updates to *ex parte* compliance issue table with additional information from Kentucky and Virginia.
- Sept 29: Release of monthly renewal data, including first available coverage transition data.
- HRSA awarded nearly $6 million to help ensure that new mothers and their families are supported during the Medicaid renewals process.
- HUD and HHS partnered to hold a series of events at public housing or multifamily housing sites where community health centers can encourage HUD-assisted households to get care at a Community Health Center and share information on Medicaid renewals/insurance access.

Hill Engagement

- Sept 29: Secretary Becerra spoke with Congressman Doggett
- Secretary Becerra spoke with Rep. Barragan

- Resources on ex parte shared with tri-caucus

Engagement with External Partners

- CMS secured an agreement with the US Postal Service for USPS to provide access to approximately 31,000 USPS Post Office lobby locations in U.S. States, Districts and Territories to expand messaging on awareness and education around Medicaid renewals to targeted audiences. Messaging to be displayed starting this fall will include:
    - Digital signage in approximately 4,000 USPS Post Office lobby locations
    - Posters in approximately 31,000 USPS Post Office lobby locations
    - Tear pads in approximately 31,000 USPS Post Office lobby locations
- Sept 25-27: Administrator Brooks-LaSure participated in a three-day visit to the Kansas City area. Those events included meetings with El Centro and Samuel U. Rodgers leaderships in Kansas City to discuss Medicaid renewals, where she was joined by HHS Region 7 RD.
- Sept 25: HHS Region 3 Acting Regional Director met with President, CEO Ayanna Khan Delaware of the Black Chamber of Commerce to discuss Medicaid renewals.
- Sept 25: HHS Region 5 team met with Shriver Center immigrant justice counsel to discuss Medicaid renewals programming for Spanish speaking communities.
- Sept 25: HHS Region 6 ARD participated in a Texas Ambassador meeting to learn more about their Phase 3 Medicaid renewals enrollment processes.
- Sept 25: HHS Region 8 Regional Director met with Executive Director Aubrey Hill from Youth Healthcare Alliance (YHA) and Health Center Operations Director Suzanne Smith from CO Community Health Network (CCHN) to discuss the impacts of Medicaid renewals on students.
- Sept 26: HHS Hispanic Summit, included panel on expanding access to Medicaid in Hispanic communities.
- Sept 26: HHS Intergovernmental Affairs team and Region 8 RD met with members of Adams County, Colorado Board of Commissioners to discuss Medicaid renewals. Following the meeting, HHS Intergovernmental Affairs team sent follow up materials for the office to review.
- Sept 26: HHS Region 2 RD spoke to seniors at the Westchester LOFT Seniors Connections in White Plains, NY about Medicaid renewals.
- Sept 26: HHS Region 4 Executive Officer joined ACF as they hosted a meeting with the United Way of Greater Atlanta (UWGA), VP of Strategic Partnerships Alvin Glymph to discuss opportunities to leverage the UWGA support for Medicaid renewals outreach and education.
- Sept 26: HHS Region 8 RD met with Director Tracy Gruber from the Utah Department of Health and Human Services to discuss the Medicaid renewal letter sent from CMS in July.

- Sept 27: CMS hosted the "What to Know and How to Prepare, National Partner Education Monthly Series" webinar to educate stakeholders and help them prepare for Medicaid and CHIP renewals. Focus on young adults.
- Sept 27: HHS IEA organized a briefing, led by Rachel Pryor, for the National Association of Counties, (NACo) health steering committee to discuss Medicaid renewals.
- Sept 27: HHS IGA team met with the executive director of the African American Mayors Association (AAMA) and their policy director about Medicaid/CHIP renewals. HHS IGA shared Medicaid renewals resources with AAMA that they will then disseminate to their members in their monthly newsletter.
- Sept 27: HHS Region 1 RD gave opening remarks and hold a listening session with the state of New Hampshire on the Medicaid renewals process.
- Sept 27: HHS Region 5 RD met with Elizabeth Hertel, Commissioner of the Michigan Department of Health and Human Services (MDHHS) to discuss Medicaid renewals.
- Sept 27: HHS Region 5 Executive Officer met with Illinois Department of Health and Family Services to learn more about the state's 70% Medicaid renewal rate as well as promising practices.
- Sept 27: HHS Region 6 ARD participate in a Get Covered Texas meeting to discuss Medicaid renewals.
- Sept 27: HHS Region 7 met with a coalition of stakeholders in Kansas to discuss outreach to Medicaid enrollees.
- Sept 28: HHS Center for Faith-based and Neighborhood Partnerships Director presented on Medicaid renewals at the annual national Board of Bishops Conference for the Church of God in Christ (COGIC) in Los Angeles. Participants included the 250 Bishops representing all states/jurisdictions for their 6.5 million congregants.
- Sept 28: HHS IGA team met with the Mayor of Tampa's office to discuss Medicaid renewals. Following the meeting, HHS IGA sent follow up materials for the office to review.
- Sept 28: Region 1 RD gave remarks on Medicaid renewals at the Southern Maine Area Agency on Aging in Portland, ME.
- Sept 28: HHS Region 2 RD met with Jennifer Jacobs the NJ State Medicaid Director for their regular check in. There are no issues to flag for the federal government at this time.
- Sept 28: HHS Region 5 Public Affairs Specialist joined Daniela Velez-Clucas, Shriver Center Healthcare Justice/Immigration Attorney, at a Spanish-speaking presentation on Victims of Trafficking Torture or other Serious Crimes (VTTC) and spoke on the importance of Medicaid renewals and guide participants through the process.
- Sept 28: HHS Region 5 RD attended the Cook County Men's Health Fair presented at the Apostolic Church of God with Pastor Byron Brazier, and spoke about the importance of Medicaid renewals and encouraged families with young children to fully complete Illinois' renewals forms.

- Sept 28: HHS Region 7 RD met with Scott Hazelrigg, President of NorthStar to discuss Medicaid renewals.
- Sept 28: HHS Region 7 RD met with Veronica Halloway, Executive Director of National Association of State Offices of Minority Health, to discuss Medicaid renewals.
- Sept 28: HHS Region 7 RD met with Homer G. Phillips Black Nurses to discuss Medicaid renewals.
- Sept 29: HHS Region 5 team met with the Indiana State Medicaid Director, Dr. Cora Steinmetz and her team to discuss Medicaid renewals, lessons learned/barriers, and how CMS and ORD can support them.
- OPOLE added eight new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 58 outreach events this past week to spread redetermination messaging and encourage partners to do the same.

Look Ahead

- Oct 2: Renewals call with membership of the National League of Cities.
- Oct 2: HHS Region 7 RD will meet with Washington University to learn more about their Home-Grown Program and to discuss Medicaid renewals.
- Oct 2: HHS Region 9 RD and Acting CMS Regional Administrator will host a NV Medicaid Renewals convening with NV Medicaid, NV Health Link to collaborate on Medicaid renewals outreach and education.
- Oct 2: HHS Region 7 RD will meet with Missouri Legislative Black Caucus to discuss Medicaid renewals.
- Oct 3: HHS Region 5 team will join the monthly Illinois Coalition for Health Access (ICHA) call to promote Medicaid renewals and share resources to navigators and community leaders.
- Oct 4 (tentative): CMS will publish an interim final rule with comment period on the Consolidated Appropriations Act (CAA), 2023, provision on civil monetary penalties related to unwinding of the COVID-19 Medicaid continuous enrollment condition. There will be a reactive statement, internal questions-and-answers, and listserv messages for this item.
- Oct 4: HHS Region 2 RD will give Grand Rounds in the Department of Emergency Medicine at Lincoln Hospital Bronx, NY to discuss the intersection of emergency care and Medicaid renewals with faculty and staff.
- Oct 4: HHS Region 4 Public Affairs Specialist will participate in the Covering Tampa Bay Leadership meeting, provide updates on behalf of the ORD and relay any Medicaid specific questions and concerns with the appropriate OpDiv.

- Oct 4: HHS Region 7 RD will attend the job fair at El Centro, to speak with the Hispanic community about Medicaid renewals.
- Oct 4: HHS Region 9 RD will participate in a Medicaid Renewals press conference with Protect Our Care Nevada.
- Oct 6: HHS Region 5 RD will meet with Shriver Center leadership to discuss future collaborations and programs regarding Medicaid renewals.
- TBD: Briefing for state advocate validators
- Briefing for "Quad Caucus" (Black, Hispanic, Asian American, and Native American) of state legislators)
- HHS and Dept of Ed Joint Secretary PSA Video (English and Spanish)
- TBD: CIB on policies states should be adopting on kids' coverage.
- TBD: E14 strategies state implementation tool

Weekly Medicaid Unwinding Report: September 22

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- Reuters: US makes 30 states pause Medicaid disenrollments after glitch
- CNN: Half a million children and families regain Medicaid coverage
- The New York Times: Following State Errors, Nearly 500,000 Americans Will Regain Health Insurance
- Washington Post: Half a million children, others being reinstated after removal from Medicaid
- Axios: Medicaid coverage will be restored for 500K after state reviews
- Modern Healthcare: Under federal pressure, 30 states curtail Medicaid unwinding
- Richmond Times-Dispatch: Va. reinstates almost 45,000 people to Medicaid programs to fix eligibility glitch
- The Nevada Independent: 114,000 Nevadans who were booted from Medicaid rolls over paperwork allowed back on

Earned Media

- Sept 21: Press call with Administrator Brooks-LaSure and Deputy Administrator Dan Tsai to brief media on 500,000 people who are having their coverage restored thanks to CMS's swift action (clips and supportive statements attached).

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1704928158300955067

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1704572944838496713

Rollouts

- Sept 21: Update on automatic renwals (ex parte) shared with Hill, stakeholders and media.

Hill Engagement

- Sept 18: Sec. Becerra spoke with Congressman Doggett to discuss HHS/CMS action in the state.
- Sept 21: In addition to a full hill notification of the automatic enrollment update, ASL/OL reached out directly to leadership and committee staff, caucuses, and offices with a history of engagement on the issue.
- Follow up with Congressional Asian Pacific American Caucus (CAPAC) on language access and enrollment.

Engagement with External Partners

- Sept 18: HHS Region 3 Acting Regional Director Herd met with President Dr. Aminta Breaux and faculty with Bowie State University to discuss the importance of Medicaid renewals in Maryland. The ARD will follow up with the HHS/CMS Medicaid renewal toolkit.
- Sept 18: HHS Region 4 RD met with members of the Clayton County Minister's Association (CCMA) and informed CCMA members that the ORD is available to partner locally to make sure Georgians, and particularly residents in areas like Clayton County with a significant number of Medicaid and CHIP consumers, are aware of Medicaid renewals.
- Sept 18: HHS Region 4 RD and staff hosted a Health Equity & Healthcare Access Briefing with southeast Urban Leagues CEOs along with other HHS divisional leadership to discuss Medicaid renewals.
- Sept 18: HHS Region 5 team met with Wisconsin State Medicaid Director Jamie Kuhn to learn more about their Medicaid renewals program.
- Sept 18: HHS Region 5 RD met with Cristal Gary, the new CEO and Plan President of Meridian Health Plan of Illinois, Inc., to discuss Illinois' Medicaid renewals process.
- Sept 18: HHS Region 7 RD discussed Medicaid Renewals with Constituents of the 13th ward with Alderwoman Pamela Boyd, in St. Louis, MO.
- Sept 18: HHS Region 8 team met with North Dakota State Health Officer, Dr. Nizar Wehbi and Sarah Aker, the state Medicaid Director to learn about the state's Medicaid renewals process.
- Sept 18: HHS Region 10 Executive Officer presented at the Washington State Senior Citizen's Lobby on Medicaid renewals.
- Sept 18: Sec. Becerra met with Kentucky Governor Beshear.
- Sept 19: Office of Intergovernmental and External Affairs attended the CHCI conference and distributed Medicaid renewals resources to participants.
- Sept 19: HHS Region 5 RD presented the opening keynote address at the WHIAANHPI Great Lakes Regional Network Community Roundtable in Milwaukee, Wisconsin, and promoted Medicaid renewals and shared Wisconsin's BadgerCare renewal information.

- Sept 19: HHS Region 5 RD met with Dr. Mike Totoraitis, the new Milwaukee Health Department Commissioner and shared the Medicaid renewal toolkit to use in Milwaukee Health Department Clinics.
- Sept 19: HHS Region 5 RD met with Milwaukee Mayor Cavalier Johnson's Chief of Staff Nick DeSiato and Director of Intergovernmental Relations Jim Bohl, and discussed ways Milwaukee Public Schools could promote Medicaid renewals among parents and students.
- Sept 19: HHS Region 10 Executive presented at the Alaska Commission on Aging Meeting on Medicaid renewals.
- Sept 20: HHS Center for Faith-based and Neighborhood Partnerships sent a stakeholder newsletter to over 70,000 leaders featuring new resources for promoting Medicaid enrollment efforts as well as the CMS toolkit for faith leaders.
- Sept 20: HHS Intergovernmental Affairs team met with the mayor of Tucson's office to discuss Medicaid renewals. Following the meeting, HHS IGA sent follow up materials for the office to review.
- Sept 20: HHS Region 2 RD met with Grand Rounds in the Department of Emergency Medicine at Maimonides Medical Center: Brooklyn NY and discussed Medicaid renewals.
- Sept 20: HHS Region 6 ARD participated in a tele-town hall hosted by Every Texan along with partners in Seguro, Texas and the Texas Association of Community Health Centers focused on informing Medicaid families about renewals. More than 18,000 people connect to hear about the importance of renewing their Medicaid coverage.
- Sept 20: HHS Region 7 RD discussed Medicaid renewals with faith leaders in Lincoln, NE.
- Sept 20: HHS Region 8 RD met with Director of Operations and Cabinet Affairs David Oppenheim and Senior Policy Advisor Elisabeth Arenales from Colorado Governor Polis' office to discuss Medicaid renewals.
- Sept 21: CMS Deputy Administrator Tsai spoke at the Council of State Government's Medicaid Leadership Academy in Alexandria, VA.
- Sept 21: Office of Intergovernmental and External Affairs hosted a state stakeholder webinar for patient advocacy groups from FL, GA, IL, NV, NY, OH, PA, TX and VA to discuss Medicaid renewals and newly released automatic renewal data.
- Sept 21: HHS Region 1 RD participated in the New Hampshire Health Coverage Collaborative Monthly Meeting and heard updates on consumers returning to Medicaid coverage.
- Sept 21: HHS Region 2 team met with OLA of Eastern Long Island, Inc. (Organización Latino Americana), a nonprofit Latino-focused advocacy organization working in the five East End towns, and discussed Medicaid renewals.
- Sept 21: HHS Region 6 ARD participated in a Dallas Fort Worth Hospital Council CEO Forum and discussed Medicaid renewals.

- Sept 21: HHS Region 5 Executive Officer attended Indiana Medicaid stakeholders monthly meeting to learn more about Medicaid renewals in Indiana and how they work with their respective stakeholders as well as lessons learned/barriers.
- Sept 21: HHS Region 5 met with Michigan Health Commissioner Elizabeth Hertel to discuss Michigan's Medicaid renewal efforts.
- Sept 21: HHS Region 7 RD discussed Medicaid Renewals with Pastors in Omaha, NE.
- Sept 21: HHS Region 7 team met with Jeremy Smith, enrollment project coordinator for First Choice Services, the only statewide navigator in Iowa, and Nicole Johnston, project officer for the Division of Assister Programs at the Center for Consumer Information and Insurance Oversight. They discussed efforts to enroll people who lose Medicaid coverage.

Look Ahead

September

- Sept 25-27: Administrator Brooks-LaSure will participate in a three-day visit to the Kansas City area. One of three planned events will be a roundtable meeting with El Centro in Kansas City to discuss Medicaid renewals, where she will be joined by HHS Region 7 RD.
- Sept 25: HHS Region 3 ARD will meet with President, CEO Ayanna Khan Delaware of the Black Chamber of Commerce to discuss Medicaid renewals.
- Sept 25: HHS Region 6 ARD will participate in a Texas Ambassador meeting to learn more about their Phase 3 Medicaid renewals enrollment processes.
- Sept 26: HHS Hispanic Summit, will include panel on expanding access to Medicaid in Hispanic communities.
- Sept 27: CMS will host the "What to Know and How to Prepare, National Partner Education Monthly Series" webinar to educate stakeholders and help them prepare for Medicaid and CHIP renewals.
- Sept 27: HHS Region 1 RD will give opening remarks and hold a listening session with the state of New Hampshire on the Medicaid renewals process.
- Sept 27: HHS Region 6 ARD will participate in a Get Covered Texas meeting to discuss Medicaid renewals.
- Sept 27: HHS Region 7 will meet with a coalition of stakeholders in Kansas to discuss outreach to Medicaid enrollees.
- Sept 28: Release of monthly renewal data, including first available coverage transition data.
- Sept 28: HHS Region 5 Public Affairs Specialist will join Daniela Velez-Clucas, Shriver Center Healthcare Justice/Immigration Attorney, at a Spanish-speaking presentation on Victims of Trafficking Torture or other Serious Crimes (VTTC) to speak on the importance of Medicaid renewals and guide participants through the process.

- Sept 28: HHS Region 7 RD will meet with Scott Hazelrigg, President of NorthStar to discuss Medicaid renewals.
- Sept 28: HHS Region 7 RD will meet with Veronica Halloway, Executive Director of National Association of State Offices of Minority Health, to discuss Medicaid renewals.
- Sept 29: HHS Region 5 team will meet with the Indiana State Medicaid Director, Dr. Cora Steinmetz and her team to discuss Medicaid renewals, and how CMS and ORD can support them.
- Sept 29: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule.
- TENT/TBD: HHS and ED Joint Secretary PSA Video (English and Spanish).
- TBD: Briefing for state advocate "validators"
- TBD: Briefing for Quad Caucus (Black, Hispanic, Asian American and Native American) of state legislators.

<u>October</u>

- Oct 2: Renewals call with membership of the National League of Cities.
- TBD: CIB on policies states should be adopting on kids' coverage.
- TBD: E14 strategies state implementation tool

Weekly Medicaid Unwinding Report: September 15

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers

- Total e14 waivers approved: **321**
- Total states/territories with waivers: **52**

Top Headline (full clips package attached)

- Inside Health Policy: CMS: About 178K Former Medicaid Enrollees Selected QHPs As Of May

Earned Media

- CMS Deputy Director Dan Tsai taped an interview with NBC News Now (NBC News' streaming platform) for a piece on how the federal government is sounding the alarm to ensure states review their Medicaid rolls appropriately.
- CMS' Carolina Fortin-Garcia (Media Relations Group) participated in a Connecting Kids to Coverage National Campaign Back to School Radio Media Tour (RMT) to reach Spanish-speaking communities.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1701711035193786517

Hill Engagement

- Sept. 14: Secretary Becerra spoke to House Democratic Caucus at the Whip's breakfast. Discussed the all-hands-on-deck effort to help people stay covered. HHS provided materials on Medicaid renewals to members and staff.
- Sept. 14: Secretary Becerra spoke to the chairs of the Congressional Tri-Caucus about Medicaid renewals. Discussed the all-hands-on-deck effort to help people stay covered and urged them to help in their communities. HHS provided materials on renewals to co-chairs and staff.

Engagement with External Partners

- Sept 11: HHS Intergovernmental Affairs spoke with Jacksonville, FL mayor's team to share resources on Medicaid renewals.
- Sept 11: HHS Region 4 team hosted a follow-up meeting with NC DHHS Secretary Kody Kinsley to discuss Medicaid renewals.
- Sept 11: HHS Region 6 Acting Regional Director joined a Texas ambassador meeting about Medicaid renewals.
- Sept 11: HHS Region 9 RD joined Deputy Secretary Andrea Palm for a tour of San Ysidro Health Clinic and moderated a discussion on progress with Medi-Cal renewals.
- Sept 12: HHS Intergovernmental Affairs spoke with Western Governors' Association staff on Medicaid renewals.
- Sept 12: HHS Region 1 gave opening remarks to the Massachusetts Medicaid Renewal Listening Session.
- Sept 12: HHS Region 4 Special Assistant joined a monthly meeting with key stakeholders and partners in Alabama including Doctors of America, League of Municipalities, Alabama Arise and various other partners to discuss Medicaid renewals.
- Sept 12: HHS Region 5 RD met with Cong. Greg Landsman (OH-01) staff regarding Medicaid renewals in Ohio.
- Sept 12: HHS Region 8 RD met with State Director, Amy Friedman, from U.S. Senator Bennet's office to discuss Medicaid renewals.
- Sept 12: HHS Region 10 team met with leadership and toured the Chinese Information and Service Center and discussed Medicaid renewals.
- Sept 12: HHS Region 1 gave opening remarks to the CT Medicaid Renewal Listening Session.
- Sept 13: HHS Intergovernmental Affairs spoke with Manchester, NH mayor's team to share resources on Medicaid renewals.
- Sept 13: HHS Intergovernmental Affairs spoke with Portland, ME mayor's team to share resources on Medicaid renewals.
- Sept. 14: IEA Director of External Affairs spoke on a National Organization for Rare Disorders (NORD) webinar focused on Medicaid renewals. Approximately 140 advocates attended the webinar.
- Sept 14: HHS Region 1 gave opening remarks to the Rhode Island Medicaid Renewal Listening Session.

- Sept 14: HHS Region 1 gave opening remarks to the Vermont Medicaid Renewal Listening Session.
- Sept 14: Rachel Pryor spoke at Community Catalyst Advocates webinar on Medicaid renewals. 75 advocates from around the nation participated.
- Sept 15: HHS Region 3 team met with Ex. Dir. Rev. Jeffrey S. Allen, West Virginia Council of Churches to discuss Medicaid renewals.
- Sept 15: HHS Region 5 Executive Officer participated in monthly call with Region 5 State Health Officers and updated SHOs on Medicaid renewals.
- OPOLE added 29 new community partners to the roster of over 1,000 local community groups we've already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 56 outreach events this past week to spread redetermination messaging and engage our partners to do the same.

Look Ahead

September

- Sept 18: HHS Region 4 RD will meet with members of the Clayton County Minister's Association on September 18 to speak about Medicaid renewals
- Sept 18: HHS Region 4 RD and staff will host a Health Equity & Healthcare Access Briefing with southeast Urban Leagues CEOs along with other HHS divisional leadership to discuss Medicaid renewals
- Sept 18: HHS Region 5 team will meet with Wisconsin State Medicaid Director Jamie Kuhn to learn more about their Medicaid renewals program.
- Sept 18: HHS Region 7 RD will discuss Medicaid Renewals with Constituents of the 13th ward with Alderwoman Pamela Boyd, in St. Louis, MO.
- Sept 18: HHS Region 10 Executive Officer will present at the Washington State Senior Citizen's Lobby on Medicaid renewals
- Sept 19: HHS Region 10 Executive Officer will present at the Alaska Commission on Aging Meeting on Medicaid renewals
- Sept. 20: Update on automatic renewals (ex parte) to be shared with Hill, stakeholders and media.
- Sept 20: HHS Region 2 RD will give Grand Rounds in the Department of Emergency Medicine at Maimonides Medical Center: Brooklyn NY and discuss Medicaid renewals
- Sept 20: HHS Region 6 ARD will participate in a tele-town hall hosted by Every Texan along with partners in Seguro, Texas and the Texas Association of Community Health Centers focused on informing Medicaid families about renewals.
- Sept 20: HHS Region 7 RD will discuss Medicaid renewals with faith leaders in Lincoln, NE.
- Sept 21: HHS Region 5 will meet with Michigan Health Commissioner Elizabeth Hertel to discuss Michigan's Medicaid renewal efforts.

- Sept 21: HHS Region 7 RD will discuss Medicaid Renewals with Pastors in Omaha, NE.
- Sept. 26: HHS Hispanic Summit, will include panel on expanding access to Medicaid in Hispanic communities.
- Sept. 28: Release of monthly renewal data, including first available coverage transition data.
- Sept. 29: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule.
- TENT/TBD: HHS and ED Joint Secretary PSA Video (English and Spanish).
- TBD: Briefing for state advocate "validators"
- TBD: Briefing for Quad Caucus (Black, Hispanic, Asian American and Native American) of state legislators.
- TBD: Printed Outreach materials available for ordering.

<u>October</u>

- CIB on policies states should be adopting on kids' coverage.
- E14 strategies state implementation tool

Weekly Medicaid Unwinding Report: September 8

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **321**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- Axios: Federal Health programs may not be immune to a shutdown (article attached)
- Healthcare Finance News: CMS prods states to examine auto-renewal as possible cause of Medicaid disenrollments
- Disability Scoop: Feds Warn Medicaid Programs Against Wrongly Dropping Beneficiaries

Earned Media

- Sept. 5: The Spanish market campaign completed a second value-add integration that aired on Univision's 'Despierta America' show. The integration was led by Univision's Chief Medical Correspondent Dr. Juan and amplified through Despierta America's Facebook channel.
- Sept. 7: CMS Deputy Director Dan Tsai did a live interview with Scripps News on issues with automatic enrollment and keeping children covered.
- Sept. 7: Connecting Kids to Coverage Back to School Radio Media Tour began with Dr. Aditi Mallick (Acting Director, Office of Minority Health) and Dr. Jessica Lee (Acting Chief Medical Officer, Center for Medicaid and CHIP Services) reminding families about Medicaid and Children's Health Insurance Program (CHIP) availability so children can start the school year with health coverage.

- Next week: Deputy Director Tsai is scheduled to tape an interview with NBC News Now (NBC News' streaming platform) for a piece on how the federal government is sounding the alarm to ensure states review their Medicaid rolls appropriately.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@HHSGov:
https://twitter.com/HHSGov/status/1699583516445397222

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1699539728180138172

Hill Engagement

- Sept. 7: Hill briefing
- Sept. 7: HHS sent Hill offices a renewals toolkit for members that combines relevant CMS outreach materials into a single PDF and comes with a cover letter from ASL Assistant Secretary Melanie Egorin.

Engagement with External Partners

- Sept. 5: HHS Region 3 team met with PA Dept. Of Human Services Secretary Dr. Val Arkoosh to discuss Medicaid renewals.
- Sept 5: HHS Region 4 team participated in a joint stakeholder meeting with CMS Regional Administrator McKie, CMS staff and representatives from the Southern Economic Advancement Project including founder Stacey Abrams and executive director Sara Gehl to discuss Medicaid renewals.
- Sept. 5: HHS Region 5 team attended Illinois Primary Health Care Association's monthly call to discuss Medicaid renewals.
- Sept 5: HHS Region 5 team met with Illinois Coalition for Health Access to discuss Medicaid renewals.
- Sept. 6: Secretary Becerra joined Secretary Cardona on a visit to a school in St. Louis where they discussed Medicaid renewals, among other issues.
- Sept. 6: HHS Region 4 Regional Director joined Region 4 ACF as they meet with the NC Dept. of Health and Human Services Secretary to discuss Medicaid renewals.
- Sept 6: HHS Region 9 RD spoke at a Health Care Town Hall with Congresswoman Syndey Kamlager-Dove on Medicaid renewals at the Kedren Community Health Center in South Los Angeles, CA.

- Sept 7: HHS Region 4 Public Affairs Specialist participated in the TN Health Disparity Task Force Meeting to discuss Medicaid renewals.
- Sept 7: HHS Region 8 RD met with Montana State Representative SJ Howell to discuss Medicaid renewals in the state.
- Sept 7: HHS Region 10 Executive Officer gave opening remarks on Medicaid renewals at the Region 10 Tribal Child Welfare Convening at the Cowlitz Indian Tribe.
- Sept 7: HHS Region 10 Executive Officer worked with CMS on their visit to the Immigrant & Refugee Community Organization (IRCO) to discuss Medicaid renewals.
- Sept 7: HHS Intergovernmental Affairs met with Miami-Dade County (FL) mayor's team to discuss Medicaid renewals.
- Sept. 7: Coalition-specific webinar, one-pager for American Indian/Alaskan Native population.
- Sept 8: HHS Region 5 RD met with Michigan Commissioner for Health and Community Services Elizabeth Hertel to discuss Medicaid renewals.
- OPOLE added five new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 38 outreach events this past week to spread redetermination messaging and encourage partners to do the same.

Look Ahead

September

- Sept 11: HHS Intergovernmental Affairs will speak with Jacksonville, Florida mayor's team to share resources on Medicaid renewals.
- Sept 11: HHS Region 6 Acting RD will join a Texas ambassador meeting about Medicaid renewals.
- Sept 12: HHS Region 10 team will meet leadership and tour the Chinese Information and Service Center, and discuss Medicaid renewals.
- Sept 12-14: HHS Region 1 will give opening remarks to the CT Medicaid Renewal Listening Session.
- Sept 13: HHS Intergovernmental Affairs will speak with Manchester, NH mayor's team to share resources on Medicaid renewals.
- Sept 15: HHS Region 3 team will meet with Ex. Dir. Rev. Jeffrey S. Allen, West Virginia Council of Churches to discuss Medicaid renewals.
- Sept. 14: IEA speaking about renewals on National Organization for Rare Disorders (NORD) webinar.
- Sept. 20: Update on automatic renewals (ex parte) to be shared with Hill, stakeholders and media.
- Sept. 26: HHS Hispanic Summit, will include panel on expanding access to Medicaid in Hispanic communities.
- Sept. 29: Release of monthly renewal data, including first available coverage transition data.

- TENT/TBD: HHS and ED Joint Secretary PSA Video (English and Spanish).
- TBD: Briefing for state advocate "validators"
- TBD: Briefing for Quad Caucus (Black, Hispanic, Asian American and Native American) of state legislators.
- TBD: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule.
- TBD: Printed Outreach materials available for ordering.

October

- CIB on policies states should be adopting on kids' coverage.
- E14 strategies state implementation tool

Weekly Medicaid Unwinding Report: September 1

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **321**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

- Politico: CMS threatens to strip funds from states terminating eligible Medicaid recipients
- Inside Health Policy: CMS Orders State Medicaid To Test Ex Parte Processes For Glitch By Sept. 13
- Bloomberg Law: HHS Tackles Errant Cancellations of Kids' Medicaid Coverage
- STAT News: Medicaid rebukes states for mistakenly disenrolling children

Earned Media

- Aug. 29: Ellen Montz spoke with Amy Goldstein of the *Washington Post* for a story on connections between Medicaid renewals and marketplace coverage.
- Aug. 30: Medicaid Director Dan Tsai briefed reporters on the release of pre-compliance letters to states regarding ex parte renewals.
- Aug. 31: CMS Regional Administrator Sharon Graham did an interview with the Columbus, GA ABC affiliate.
- Next week: Director Tsai interviews with NBC News Now (NBC News' streaming platform) taped interview for a piece that will run in early-to-mid September on how we are sounding the alarm to ensure states review their Medicaid rolls appropriately, and Scripps News on the ex parte letter and keeping children covered.

Paid Media

- Radio ads began running that aim to encourage affected consumers to take applicable actions to update contact information, complete a renewal form, and visit the Marketplace to look for other options. It includes geo-targeted outreach to those with limited English proficiency and those who rely on language-specific resources from CMS. Translated languages are Chinese, Hindi, Korean, Tagalog, and Vietnamese, and states include TX, NJ, FL, PA, MN, NV, CA, NY, WA, IL, VA, MA, HI, MD, AK, and GA.
- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@CMSGov:
https://twitter.com/CMSGov/status/1697318299887919168
https://twitter.com/CMSGov/status/1697318301578281270

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1696521341497745562

Rollouts

- Aug. 30: Ex parte letters to states.
- Aug. 31: Release of monthly renewal data. Targeted stakeholder and hill notification as needed. Internal QA and reactive statement. No proactive press.

Hill Engagement

- Shared Medicaid ex parte pre-compliance letters with hill committees and staff.

Engagement with External Partners

- Aug 28: HHS Region 6 Acting Regional Director participated in the Texas Ambassador convening on Medicaid renewals.
- Aug 28: HHS Region 8 RD participated in a meeting with the Montana chapter of the American Academy of Pediatrics to discuss Medicaid renewals.
- Aug 28: HHS Region 8 RD met with Mayor Yemi Mobolade of Colorado Springs and Regional Administrator Aikta Marcoulier from the U. S. Small Business Administration to discuss Medicaid renewals.
- Aug 29: HHS Region 2, along with NYS Department of Health, hosted a Medicaid renewal Town Hall with Westchester Jewish Community Services.
- Aug 29: HHS Region 3 ARD gave a presentation to the Northwest Philadelphia Health Equity (NWPHE) committee and discussed Medicaid renewals.
- Aug 29: HHS Region 4 team hosted a briefing with various stakeholders in Alabama to discuss Medicaid renewals.
- Aug 29: HHS Region 7 RD met with Keino Marbury, manager of the Department of Clinical Operations at the University of Missouri School of Medicine, to discuss Medicaid renewals.

- Aug 29: HHS Region 7 RD made remarks regarding Medicaid renewals at the Missouri Institute of Minority Aging Conference.
- Aug 29: HHS Region 8 RD convened a NHPI multi-regional stakeholder call with regions 9 & 10 to discuss Medicaid renewals.
- Aug. 29: CMS OMH "unwinding 101" blog post ran on websites for National Health Care for the Homeless Council (NHCHC), The ARC, and National Institute on Minority Health and Health Disparities (NIMHD)
- Aug 30: HHS Region 2 RD gave Grand Rounds in the Department of Emergency Medicine at Maimonides Medical Center: Brooklyn NY and discussed Medicaid renewals.
- Aug 30: HHS Region 4 team attended the Atlanta Hospital Association meeting facilitated by Desmica Head from CMS to provide updates on Medicaid renewals.
- Aug 30: HHS Region 5 RD met with Congressman Danny Davis (IL-07) and his District Director to discuss the status of Medicaid renewals in his district.
- Aug 31: HHS Region 4 team hosted a briefing with various stakeholders in Georgia to discuss Medicaid renewals.
- Sept 1: HHS Region 1 RD spoke at the seniors center in Bennington, VT about Medicaid renewals.
- OPOLE added 16 new community partners to the roster of over 1,000 local community groups they have already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 52 outreach events this past week to spread renewals messaging and encourage partners to do the same.

Look Ahead

- Sept. 5: HHS Region 3 team will meet with PA Dept. Of Human Services Secretary Dr. Val Arkoosh to discuss Medicaid renewals.
- Sept. 5: HHS Region 5 team plan to attend Illinois Primary Health Care Association's monthly call to discuss Medicaid renewals.
- Sept. 6: Secretary Becerra will join Secretary Cardona on a visit to a school in St. Louis where they will discuss Medicaid renewals, among other issues.
- Sept. 6: HHS Region 4 RD will join Region 4 ACF as they meet with the NC Dept. of Health and Human Services Secretary to discuss Medicaid renewals.
- Sept 7: HHS Region 10 Executive Officer will give opening remarks on Medicaid renewals at the Region 10 Tribal Child Welfare Convening at the Cowlitz Indian Tribe.
- Sept. 7: Coalition-specific webinar, one-pager for American Indian/Alaskan Native population.
- Sept. 29: Release of monthly renewal data, including first available coverage transition data.
- TENT/TBD: HHS and ED Joint Secretary PSA Video (English and Spanish).
- TBD: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule.
- TBD: Printed Outreach materials available for ordering.
- TBD: Connecting Kids to Coverage: Radio Media Tour Begins.

Weekly Medicaid Unwinding Report: August 25

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **321**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

Bloomberg: HHS Moves to Restore Medicaid Coverage to 90,000 in Texas
Modern Healthcare: Florida sued over mass Medicaid disenrollments

Earned Media

- Ongoing conversations with Amy Goldstein of the *Washington Post* for a story on connections between Medicaid renewals and marketplace coverage. Interview scheduled with Amy and CCIIO Director Ellen Montz for Tuesday at 10:30.

Next week:

- Aug. 30: virtual pen and pad with select reporters and Medicaid Director Dan Tsai to coincide with the release of pre-compliance letters to states regarding ex parte renewals.
- CMS is working to finalize and distribute a drop-in article for local newspapers related to Medicaid unwinding. The article will address state action and compliance as wake for a previously issued fact sheet on the unwinding process.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.

- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1694737887109988604

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1693989504837926944
https://twitter.com/HealthCareGov/status/1692521734719623584

Rollout

- Aug. 23: Monthly renewals webinar. Topic: faith-based and neighborhood engagement. Toolkit was released in conjunction.
- Aug. 24: Coalition-specific webinar, one-pager for rural community.

Engagement with External Partners

- Aug 21: HHS Region 7 Regional Director met with Keino Marbury, manager of the Department of Clinical Operations at the University of Missouri School of Medicine, to discuss Medicaid renewals.
- Aug 21: HHS Center for Faith-based and Neighborhood Partnership Center hosted a conversation between CMS Administrator and the Presiding Bishop and senior leadership of the Church of God in Christ (COGIC) on Medicaid renewals. Church leadership agreed to promote renewal messaging to its 6.5 million members, as well as work with the administration to include outreach at its forthcoming national and state conventions.
- Aug 23: HHS Center for Faith-based and Neighborhood Partnership Center presented on a CMS Trainer to Trainer webinar reaching faith leaders and promoting the newly released communications toolkit for faith leaders.
- Aug 23: HHS Center for Faith-based and Neighborhood Partnerships Center Director presented on CMS webinar on the role of faith and community leaders in addressing Medicaid renewals.
- Aug 23: HHS Region 4 RD and R4 CMS staff participated in the Healthcare Access tele-townhall hosted by Congresswoman Lucy McBath to increase outreach and education about Medicaid renewals.
- Aug 23: HHS Region 7 RD discussed Medicaid renewals at the Community Action Planning Breakfast Workshop at Union Station in Kansas City.
- Aug 23: HHS Region 7 team visited the Community Health Council of Wyandotte County in Kansas City, KS to discuss Medicaid renewals.
- Aug 23: HHS Region 8 RD met with Director of Government Affairs Ellen Stern from Children's Hospital Colorado to discuss Medicaid renewals.
- Aug 23: HHS Region 4 RD participated in the Healthcare Access tele-townhall hosted by Congresswoman Lucy McBath to increase outreach and education about Medicaid renewals.

- Aug 23: HHS Region 7 RD discussed Medicaid renewals at the Community Action Planning Breakfast Workshop at Union Station in Kansas City.
- Aug 24: HHS Region 7 RD spoke with TriFaith Leadership about outreach in the Omaha Community about Medicaid renewals.
- Aug 24: HHS Region 7 RD spoke with TriFaith Leadership about Medicaid renewals outreach in the Omaha Community.
- Aug 24: HHS Region 7 team met with Jeremy Smith, enrollment project coordinator for First Choice Services, the only statewide navigator in Iowa, and Nicole Johnston, project officer for the Division of Assister Programs at the Center for Consumer Information and Insurance Oversight to discuss Medicaid renewals.
- Aug 24: HHS Region 7 RD discussed Medicaid renewals with treatment providers and clients at Rockhurst University.
- Aug 25: HHS Region 7 Public Affairs Specialist attended the Regional Area Public Information Officer's meeting, hosted by the Mid-America Regional Council in Kansas City, MO to provide updates and messaging for Medicaid Renewals.
- OPOLE added 28 new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 62 outreach events this past week to spread redetermination messaging and encourage partners to do the same.

Look Ahead

Week of Aug 28

- Aug 28: HHS Region 6 Acting RD will participate in the Texas Ambassador convening on Medicaid renewals.
- Aug 29: HHS Region 2 along with NYS Department of Health will host Medicaid renewal Town Hall with Westchester Jewish Community Services.
- Aug 29: HHS Region 4 team will host a briefing with various stakeholders in Alabama to discuss Medicaid renewals.
- Aug 29: HHS Region 7 RD will meet with Keino Marbury, manager of the Department of Clinical Operations at the University of Missouri School of Medicine, to discuss Medicaid renewals.
- Aug 29: HHS Region 7 RD will make remarks regarding Medicaid renewals at the Missouri Institute of Minority Aging Conference.
- Aug 30: HHS Region 2 RD will give Grand Rounds in the Department of Emergency Medicine at Maimonides Medical Center: Brooklyn NY and discuss Medicaid renewals
- Aug. 30: Ex parte letters to states
    - Press briefing led by Dan Tsai at 12:30, letters public at 1
- Aug. 31: Release of monthly renewal data. Targeted stakeholder and hill notification as needed. Internal QA and reactive statement. No proactive press.
- Aug 31: HHS Region 4 team will host a briefing with various stakeholders in Georgia to discuss Medicaid renewals.

- Sept 1: HHS Region 1 RD is scheduled to speak at the Seniors Center in Bennington, VT about the Medicaid renewals.
- TENT/TBD: HHS and ED Joint Secretary PSA Video (English and Spanish)
- TENT/TBD: CMS "unwinding 101" blog post on websites for National Health Care for the Homeless Council (NHCHC), The ARC, and National Institute on Minority Health and Health Disparities (NIMHD) (TENTATIVE)

September

- Sept. 6 (tentative): ED/HHS Sec Back-to-School Bus Tour Event
- Sept. 7 (tentative): Coalition-specific webinar, one-pager for American Indian/Alaskan Native population
- Sept. 29: Release of monthly renewal data, including first available coverage transition data
- TBD: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule
- TBD: Printed Outreach materials available for ordering
- TBD: Connecting Kids to Coverage: Radio Media Tour Begins

Weekly Medicaid Unwinding Report: August 18

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers (please note that not all this information is public)

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **292**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

Becker's Payer Issues: 36 states are falling short on Medicaid redetermination compliance, HHS says
Politico: Medicaid narrative misleading, officials say
Associated Press: Feds raise concerns about long call center wait times as millions dropped from Medicaid
Tampa Bay Times: Feds say Florida is failing to help many at risk of losing Medicaid

Earned Media

- Aug. 17: CMS spokespeople participated in an English- and Spanish-language radio/satellite media tour about Medicaid renewals and CMS efforts to ensure impacted individuals have access to high-quality, person-centered, affordable health care coverage. The focus is on getting consumers engaged in renewing their coverage.
- Two pending requests from the Washington Post:
    - CMS is exploring a potential interview with McKenzie Beard of the Washington Post. The interview would focus on the role pharmacies can play in the eligibility redetermination process.
    - Amy Goldstein is writing about how often people who are no longer eligible for Medicaid are getting onto marketplace plans. Request to speak with someone is pending.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.
- Unwinding Hybrid Campaign in early July 2023. This effort expands unwinding outreach by combining messaging into one effort to reach across the U.S. with both "mail back your renewal form" and, "if you've lost Medicaid/CHIP" go to HealthCare.gov

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1691132091751190541

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1691492150339416083

Rollout

- Aug. 17: Coalition-specific webinar, one-pager for disability community

Hill Engagement

- Aug. 17: Hill briefing

Engagement with External Partners

- Aug. 12: HHS Center for Faith-based and Neighborhood Partnerships Newsletter Center presented on Medicaid renewals at the MOMS Tour launch in Detroit, MI. Over 400 expectant mothers and their families attended along with local provider stakeholders.
- Aug. 12: HHS Region 5 Regional Director spoke about Medicaid renewals at the community health fair presented by Hamdard Health Alliance in Chicago's Rogers Park neighborhood.
- Aug 14: HHS Region 1 RD met with the Massachusetts Health Equity Compact to discuss Medicaid renewals.
- Aug. 14: HHS Region 5 RD met with Congressman Krishnamoorthi to tour and connect with the SUD team at the Access Health-Martin Russo and discuss Medicaid renewals.
- Aug. 14: HHS Region 5 Executive Officer met with Green Bay's Mayor's Office, Chief of Staff to discuss Medicaid renewals.
- Aug. 14: HHS Region 6 Acting RD joined a Texas Ambassador meeting about Medicaid renewals.
- Aug. 14: HHS Region 2 RD met with Bridgeway CCBHC to plan a Medicaid renewals event with their staff.
- Aug. 14: HHS Region 4 team met with Jodi Ray (FL Covering Kids & Families) and Miriam Harmatz (FL Health Justice) to discuss establishing a Medicaid renewals small group in Florida.

- Aug 14: HHS Region 2 Executive Officer visited Richmond Community Health Center, Staten Island, NY to encourage patients to make sure they follow-up on their Medicaid renewal applications.
- Aug. 15: HHS Region 9 RD spoke during Congressman Panetta Congressional Town Hall about the process of Medi-Cal renewals.
- Aug. 16: HHS Region 2 team met with the leadership of the NJ DHS to discuss outreach strategy for the renewals work in NJ.
- Aug. 16: HHS Region 4 team convened a monthly call with Medicaid renewals key stakeholders in NC.
- Aug. 16: HHS Region 7 met with Keino Marbury, Manager Department and Clinical Operations, University of Missouri School of Medicine to discuss Medicaid renewals.
- Aug 16: HHS Intergovernmental Affairs met with NYC Council staff to discuss Medicaid renewals and shared toolkits ASPA and CMS have created.
- Aug 17: HHS Region 1 RD participated in the NH Health Coverage Collaborative with Health Market Connect (HMC) to learn about the current Medicaid renewals process in New Hampshire.
- Aug. 17: HHS Region 7 RD met with IA Medicaid to discuss progress of Medicaid renewals.
- Aug. 17: HHS Region 4 team convened a monthly call with Medicaid renewals key stakeholders in MS to discuss the process of Medicaid renewals.
- Aug. 17: HHS Region 5 RD spoke on Medicaid renewals at the FEB Summer Spotlight Series with the Chicago Urban League.
- Aug. 17: HHS Region 5 Executive Officer met with Saint Paul County, MN Public Health & Human Services and MN Dept. of Health to discuss Medicaid renewals.
- Aug 17: HHS Region 5 Executive Officer met with Saint Louis County, MN Public Health & Human Services and Three Addiction Centers to discuss Medicaid Renewals.
- Aug 17: HHS Region 7 RD met with officials from the Iowa Medicaid program to discuss progress on Medicaid renewals.
- Aug. 17: HHS Region 9 RD participated in the Protect our Care Bus Tour and made stops to promote AHCCCS Renewals.
- Aug 17: HHS Region 9 RD met with State Medicaid Renewals Outreach Coalition to discuss the statewide and targeted campaign efforts on Medicaid Renewals.
- Aug 18: HHS Region 1 RD visited the Seniors Center in Bennington, VT to speak with Director Carrie Fabricius and 40 seniors about the Medicaid Renewals.
- Aug 18: HHS Intergovernmental Affairs spoke with Nashua, NH mayor's team to share resources on Medicaid renewals.
- Aug 18: HHS Intergovernmental Affairs spoke with Dover, NH mayor's team to share resources on Medicaid renewals.
- Aug. 18: HHS Region 5 RD met with the Region 5 state health officers to discuss Medicaid renewals.
- Aug. 18: HHS Region 4 RD and CMS RA McKie attended the ARCHI Quarterly Breakfast to deliver joint opening remarks about HHS priorities including Medicaid renewals.

- OPOLE added 25 new community partners to the roster of over 1,000 local community groups already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 70 outreach events this past week to spread renewals messaging and encourage partners to do the same.

Look Ahead

Week of Aug. 21

- Aug 21: HHS Region 7 RD will meet with Keino Marbury, manager of the Department of Clinical Operations at the University of Missouri School of Medicine, to discuss Medicaid renewals.
- Aug. 23: Monthly renewals webinar. Topic: faith-based and neighborhood engagement. Toolkit will be released in conjunction.
- Aug. 23 (tentative): Public announcement of ex parte letters.
- Aug 23: HHS Region 4 RD will participate in the Healthcare Access tele-townhall hosted by Congresswoman Lucy McBath to increase outreach and education about Medicaid renewals.
- Aug 23: HHS Region 7 RD will discuss Medicaid renewals at the Community Action Planning Breakfast Workshop at Union Station in Kansas City.
- Aug. 24: Coalition-specific webinar, one-pager for rural community.
- Aug 24: HHS Region 7 RD will speak with TriFaith Leadership about outreach in the Omaha Community about Medicaid renewals.
- TBD (tentative): CMS OMH unwinding "101" blog posts on websites for National Health Care for the Homeless Council (NHCHC), The ARC, and National Institute on Minority Health and Health Disparities (NIMHD)
- TBD (tentative): Newspaper drop-in article for general population. The article will address state action and compliance as wake for CMS' previously issued fact sheet.

Week of Aug 28

- Aug 28: HHS Region 6 Acting RD will participate in the Texas Ambassador convening on Medicaid renewals.
- Aug 29: HHS Region 2 along with NYS Department of Health will host Medicaid renewal Town Hall with Westchester Jewish Community Services.
- Aug 29: HHS Region 4 team will host a briefing with various stakeholders in Alabama to discuss Medicaid renewals.
- Aug 29: HHS Region 7 RD will meet with Keino Marbury, manager of the Department of Clinical Operations at the University of Missouri School of Medicine, to discuss Medicaid renewals.
- Aug 29: HHS Region 7 RD will make remarks regarding Medicaid renewals at the Missouri Institute of Minority Aging Conference.
- Aug 30: HHS Region 2 RD will give Grand Rounds in the Department of Emergency Medicine at Maimonides Medical Center: Brooklyn NY and discuss Medicaid renewals.
- Aug. 30: Release of monthly renewal data. Targeted stakeholder and hill notification as needed. Internal QA and reactive statement. No proactive press.

- TBD: HHS and ED Joint Secretary PSA Video (English and Spanish)
- TBD (tentative): Ex parte letters to states

September

- Sept. 6 (tentative): ED/HHS Sec Back-to-School Bus Tour Event
- Sept. 7 (tentative): Coalition-specific webinar, one-pager for American Indian/Alaskan Native population
- Sept. 29: Release of monthly renewal data, including first available coverage transition data
- TBD: e14 Strategies Implementation Tool
- TBD: CIB on policies states should be doing on kids coverage
- TBD: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule
- TBD: Printed Outreach materials available for ordering
- TBD: Connecting Kids to Coverage: Radio Media Tour Begins

Weekly Medicaid Unwinding Report: August 11

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers (please note that not all this information is public)

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **292**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

Washington Post (editorial): Paperwork mistakes should not end a child's health coverage
Politico: Biden administration warns states as millions lose Medicaid
Bloomberg: Biden HHS Presses States Over Obstacles to Medicaid Renewal
State of Reform: Minnesota temporarily pauses procedural disenrollments for Medicaid

Earned Media

- Aug. 10: HHS IEA Director participated in a phone interview with Radio Bilingüe, the National Latino Public Radio Network, to discuss the impact of Medicaid renewals among Latino communities.
- Worked with Megan Messerly (Politico) and Noah Weiland (New York Times) on stories they reached out about on renewals.
- Pitched call center pre-compliance letters to AP, USA Today, Bloomberg, STAT and CNN. See clips in previous section.

Paid Media

- The Phase 1 effort to remind people to update their address and look in the mail was launched in February 2023 and was initially slated to end May 2023, but has been extended into Fall 2023.
- Phase 2 started in April 2023 and will run into the summer of 2024. It promotes HealthCare.gov to people who have lost Medicaid/CHIP.

- Unwinding Hybrid Campaign in early July 2023. This effort expands unwinding outreach by combining messaging into one effort to reach across the U.S. with both "mail back your renewal form" and, "if you've lost Medicaid/CHIP" go to HealthCare.gov

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1688967006026928132
https://twitter.com/BrooksLaSureCMS/status/1687479787101560833

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1689384059112148992
https://twitter.com/HealthCareGov/status/1687494105637523457

Rollouts

- Aug. 8: Renewals Stakeholder Coalition Call, Latino community, over 1,000 people attended, Office of Intergovernmental and External Affairs Director Marvin Figueroa provided opening remarks. One-pager released in conjunction with the call.
- Aug 9: State operations pre-compliance letters (call center letters)
  - Posted to Medicaid.gov and sent listserv.
- Aug. 10: Renewals Stakeholder Coalition Call and one pager - Black Americans, HHS Center for Faith-Based and Neighborhood Partnerships Director Dr. Rev. Que English provided remarks.
- Aug. 10: National Training Program, Current Topics webinar for partners
- Aug. 11: Faith groups toolkit
- Aug. 11: Back-to-school toolkit
- Aug. 11: Kids deck (outreach/strategies)

Hill Engagement

- Aug. 10: Flagged pre-compliance letters for hill offices

Engagement with External Partners

- Aug. 5: HHS Region 1 Regional Director attended the 8th Annual Harambee Community celebration that saw over 2,000 attendees and raised awareness regarding Medicaid renewals with low-income families.
- Aug. 7: HHS Region 7 RD participated in a site visit to Great Mines Health Center to discuss workforce and Medicaid renewals in Potosi, MO with Region 7 HRSA.
- Aug. 7: HHS Center for Faith-based and Neighborhood Partnerships sent a stakeholder newsletter to over 70,000 leaders featuring the Center's new FAQ and PSA to support faith leaders in Medicaid enrollment efforts. It also promoted the Aug 23 CMS Trainer to Trainer webinar for faith leaders.
- Aug. 7: HHS Region 5 RD participated in a ribbon cutting for the Community Health Partnership of IL and discussed Medicaid renewals.
- Aug. 7: HHS Region 6 Acting RD co-led a RAC meeting with the ASPR Regional Administrator and spoke about Medicaid renewals in Region 6 states.

- Aug. 7: HHS Region 7 RD visited Dr. Kendra Holmes and staff at Affinia Health Care in St. Louis to discuss Medicaid renewal efforts.
- Aug. 8: HHS Region 5 RD joined Dr. Allison Arwady, Chicago Department of Public Health Commissioner, on a Facebook live broadcast to discuss Medicaid renewals.
- Aug. 8: HHS IEA Director provided remarks on the CMS Medicaid and CHIP Renewals webinar focused on reaching Latino communities.
- Aug. 8: HHS Region 4 team hosted a Healthcare Community Conversation with HHS Chief of Staff Sean McCluskie hosted by HRSA-funded FQHC - Saint Joseph's/Mercy Care Services, Inc. located Atlanta, GA. This visit included a 60-minute discussion focused on HHS priority policies and programs, including Medicaid renewals.
- Aug. 8: HHS Region 5 RD discussed the importance of Medicaid renewals at the Milwaukee Black Health Fair and Vaccination Event.
- Aug. 8: HHS Region 8 RD met with Nick Lesley, Director and Dr. Jan Jenkins, Psychologist, from the State of Colorado Refugee Mental Health and informed them of the Secretary's prioritization of Medicaid renewals.
- Aug. 8: HHS Region 8 RD met with Executive Director Jennifer Gremmert from Energy Outreach Colorado to discuss the importance of Medicaid renewals.
- Aug. 8: HHS Region 8 RD met with President Laura Shunk, CEO Sonia Riggs and Vice President Devany McNeill from the Colorado Restaurant Association and introduced them to Secretary Becerra's priorities, including Medicaid renewals.
- Aug. 8: HHS Region 3 RD participated in a National Health Center Week event hosted by Westside Family Healthcare in Dover, DE and discussed Medicaid renewals.
- Aug. 9: HHS Region 9 RD participated in a National Health Center Week site visit with Region 9 HRSA RA and provided Medicaid renewals remarks at Santa Rosa Community Health Center in Santa Rosa, CA.
- Aug. 9: HHS IEA sent pre-compliance letters to governors' offices.
- Aug. 9: HHS IEA sent key Medicaid renewals links and fact sheets to the Communications Director of The Democratic Mayors Association.
- Aug. 9: HHS Region 5 Public Affairs Specialist joined the TCA Health Center Back to School event to promote Medicaid renewals. TCA also had navigators on site for additional assistance with Medicaid renewals.
- Aug. 9: HHS Region 7 RD and staff met with Missouri state Reps. Patty Lewis, Ashley Aune, Kathy Steinhoff and others along with officials of the Missouri Foundation for Health to discuss Medicaid renewals.
- Aug. 9: HHS Region 7 RD met with Carlos Gomez and Sal Valadez, President of the Hispanic Chamber of Commerce of Greater Kansas City, to discuss Medicaid renewals.
- Aug. 9: HHS Region 8 RD met with Executive Director Skye McGinty from All Nations Health Center and provided an overview of HHS priorities including Medicaid renewals.
- Aug. 9: HHS Region 9 team joined the CMS Local Engagement Group and met with California Department Health Care Services Leaders including Medi-Cal Director Jaycee Cooper and Deputy Director Rene Morrow to discuss Medi-Cal renewals and how our federal outreach team can best partner with the state group to assist with Medi-Cal renewals.

- Aug. 10: HHS Center for Faith-based and Neighborhood Partnerships Director provided remarks and a call to action on the CMS trainer to trainer Medicaid renewals webinar focused on reaching Black American populations.
- Aug. 10: HHS Region 4 Public Affairs Specialist attended a Medicaid renewals event hosted by Georgia StandUp and members of the state legislature to provide important information related to Medication renewals.
- Aug. 10: HHS Region 7 RD visited with William Wells, Executive Director of aSTEAM Village, a non-profit that partners with Lincoln University to teach students STEAM topics, and spoke with parents about Medicaid renewals.
- Aug. 11: HHS Region 8 RD participated in a National Health Center Week site visit with Region 8 HRSA RA and provided Medicaid renewals remarks at a FQHC in CO.
- Aug. 11: HHS Region 4 team met with representatives from the Urban League of Greater Atlanta (ULGA) and Urban League of Greater Columbus (ULGC) to discuss plans for the upcoming Health Equity Forum focused on Medicaid renewals process.
- Aug. 11: HHS Region 5 RD toured and met with the Polish American Association leadership to discuss collaboration on Medicaid renewals within the Polish community.
- Aug. 11: HHS Region 8 RD presented at Clinica Family Health's National Health Center Week event and discussed Medicaid renewals.
- Aug. 11: HHS Region 7 RD and CMS RA Kim Stupica-Dobbs met with Sarah Fertig, Director of Medicaid and Health Care Finance, Kansas Department of Health and Environment, to discuss the progress on Medicaid renewals.
- OPOLE added 28 new community partners to the roster of over 1,000 local community groups they've already enlisted to get critical messaging out to people with Medicaid or CHIP.
- OPOLE engaged in 41 outreach events this past week to spread redetermination messaging and encourage our partners to do the same.

Look Ahead

- Aug. 12: HHS Center for Faith-based and Neighborhood Partnerships Newsletter Center will present on Medicaid renewals at the MOMS Tour launch in Detroit, MI. Over 400 expectant mothers and their families are anticipated along with local provider stakeholders.
- Aug. 12: HHS Region 5 RD will speak about Medicaid renewals at the community health fair presented by Hamdard Health Alliance in Chicago's Rogers Park neighborhood.

Week of Aug. 14

- Aug. 14: HHS Region 5 RD will meet with Congressman Krishnamoorthi to tour and connect with the SUD team at the Access Health-Martin Russo and discuss Medicaid renewals.
- Aug. 14: HHS Region 5 Executive Officer will meet with Green Bay's Mayor's Office, Chief of Staff to discuss Medicaid renewals.
- Aug. 14: HHS Region 6 Acting RD will join a Texas Ambassador meeting about Medicaid renewals.

- Aug. 14: HHS Region 2 RD will meet with Bridgeway CCBHC to plan a Medicaid renewals event with their staff.
- Aug. 14: HHS Region 4 team will meet with Jodi Ray (FL Covering Kids & Families) and Miriam Harmatz (FL Health Justice) to discuss establishing a Medicaid renewals small group in Florida.
- Aug. 15: HHS Region 9 RD will speak during Congressman Panetta Congressional Town Hall about the process of Medi-Cal renewals.
- Aug. 16: HHS Region 2 team will meet with the leadership of the NJ DHS to discuss outreach strategy for the renewals work in NJ.
- Aug. 16: HHS Region 4 team will convene a monthly call with Medicaid renewals key stakeholders in NC.
- Aug. 16: HHS Region 7 will meet with Keino Marbury, Manager Department and Clinical Operations, University of Missouri School of Medicine to discuss Medicaid renewals.
- Aug. 17: One-pager for Partners - Disability community
- Aug. 17: Renewals Stakeholder Coalition Call - Disability community
- Aug. 17: Earned Media Tour (Radio/Satellite)
- Aug. 17: Hill briefing
- Aug. 17: HHS Region 7 RD will meet with IA Medicaid to discuss progress of Medicaid renewals.
- Aug. 17: HHS Region 4 team will convene a monthly call with Medicaid renewals key stakeholders in MS to discuss the process of Medicaid renewals.
- Aug. 17: HHS Region 5 RD will speak on Medicaid renewals at the FEB Summer Spotlight Series with the Chicago Urban League.
- Aug. 17: HHS Region 5 Executive Officer will meet with Saint Paul County, MN Public Health & Human Services and MN Dept. of Health to discuss Medicaid renewals.
- Aug. 17: HHS Region 9 RD will participate in the Protect our Care Bus Tour and make stops to promote AHCCCS Renewals.
- Aug. 18: HHS Region 5 RD will meet with the Region 5 state health officers to discuss Medicaid renewals.
- Aug. 18: HHS Region 4 RD and CMS RA McKie will attend the ARCHI Quarterly Breakfast to deliver joint opening remarks about HHS priorities including Medicaid renewals.

Week of Aug. 21

- Aug. 23: Monthly renewals webinar. Topic: faith-based and neighborhood engagement
- TBD (tentative): CMS OMH unwinding "101" blog posts on websites for National Health Care for the Homeless Council (NHCHC), The ARC, and National Institute on Minority Health and Health Disparities (NIMHD)
- TBD: Renewals one page: Rural Community
- TBD: Renewals Stakeholder Coalition Call: Rural community
- TBD: e14 Strategies Implementation Tool
- TBD: CIB on policies states should be doing on kids coverage
- TBD: Ex parte letters to states

Week of Aug 28

- Aug. 30: Release of monthly renewal data
- TBD: HHS and ED Joint Secretary PSA Video (English and Spanish)

September

- Sept. 6 (tentative) ED/HHS Sec Back-to-School Bus Tour Event
- Sept. 29: Release of monthly renewal data, including first available coverage transition data
- Late Sept TBD: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule
- TBD: Printed Outreach materials available for ordering
- TBD: Connecting Kids to Coverage: Radio Media Tour Begins

Weekly Medicaid Unwinding Report: August 4

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Key Numbers (please note that not all this information is public)

14 states that CMS has worked with to pause terminations to address issues related to full compliance with renewal requirements for part or all their populations.
11 states have elected a new CMS option to delay procedural terminations for at least a month to conduct outreach.
Total e14 waivers approved: **292**
Total states/territories with waivers: **52**

Top Headlines (full clips package attached)

Washington Post (Opinion): Turns Out Babies Are Really Bad at Filling Out Paperwork
Inside Health Policy: Becerra To States: Keep Eligible Kids On Medicaid During Unwinding

Earned Media

- Aug. 2: Drop-in article on state action and compliance for use by local newspapers
- Aug. 3: Administrator Brooks-LaSure beneficiary-focused interviews with local outlets in North Carolina, Michigan, Chicago and Tampa - FFM states that have the high Medicaid/CHIP disenrollment numbers for the Black population
- Aug. 3: HHS press release reported the nation's uninsured rate reached an all-time low in early 2023, including information on the resumption of Medicaid renewals since then and HHS efforts to protect coverage

Paid Media

- Customized TV ads in states TBA

Social

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1685003188842135552

Rollouts

- Aug. 3: ASPE Uninsured Brief
- Aug. 3: One-pagers for Partners: AANHPI and African American

Hill Engagement

- Aug. 2: Hill briefing
- Aug. 3: Hill briefing

Engagement with External Partners

- July 29: HHS Region 4 Special Assistant attended a back-to-school event with Live Healthy Gwinnett and Gwinnett County Sheriff's office in Lawrenceville, GA and provided attendees with informational materials to assist people through the Medicaid renewal process.
- July 31: HHS Region 6 Executive Officer collaborated with the regional director for the National Medical Association to provide an HHS panel discussion on Medicaid renewals and other priorities.
- July 31: HHS Region 6 Regional Director participated in an Ambassador Program meeting to hear about Texas Medicaid renewals.
- July 31: CMS provided updates on tri-agency employer-sponsored care letter and CMS release of March/April data to state departments of insurance through a National Association of Insurance Commissioners meeting and disseminated data release to key Marketplace renewal stakeholders.
- July 31: HHS Region 7 RD met with Missouri Legislative Black Caucus Director Cheryl Dozier and Cami Thomas to discuss Medicaid renewals.
- Aug 1: HHS Center for Faith-based and Neighborhood Partnerships presented on Medicaid renewals in a meeting cohosted SAMHSA with over 40 leaders at seminaries and universities from around the country.
- Aug. 1: Over 800 people attended the interagency Medicaid renewals Train-the-Trainer National Webinar.
- Aug. 1: HHS Region 5 RD updated the Illinois Coalition for Health Access on Medicaid renewals.
- Aug. 1: HHS Region 7 RD made remarks about mental health and Medicaid renewals at the Silent No More: Addressing the Mental Health and Opioid Crises in St. Louis, hosted by the Ethnic Communities Opioid Response Network in Missouri.
- Aug 1: HHS Region 7 RD met with Saint Louis Housing Authority's Latasha Barnes, and Lincoln University Extension's Sheryl Maxwell to discuss Medicaid renewals.
- Aug 1: HHS Region 4 team met with Georgia Standup and Georgia Legal Aid to get feedback about client experiences and challenges with the Medicaid renewal and SNAP appeals process.
- Aug 1: HHS Region 4 team met with John Moye, Police Director of the Urban League of Greater Atlanta, to discuss opportunities for continued outreach to educate communities of color about HHS priorities, including Medicaid renewal process.
- Aug. 2: HHS Intergovernmental Affairs spoke with Savannah, Georgia mayor's team to share resources on Medicaid renewals.
- Aug. 2: HHS Region 5 RD met with Wisconsin Lt. Gov. Sara Rodriguez and Gov. Evers' health policy team to discuss Medicaid renewals efforts in WI.
- Aug. 3: Renewals Stakeholder Coalition Call – AAHNPI community.

- Aug. 3: Meeting between IEA, CMS and Oklahoma Governor's office, State Health Secretary Kevin Corbett, and Medicaid Director Traylor Rains on Medicaid renewals.
- Aug. 3: HHS Intergovernmental Affairs and CMS participated in the National Governor's Association monthly Governors' Medicaid unwinding call.
- Aug 3: HHS WHIAANHPI and External Affairs hosted a webinar with CMS on ways to reach the AANHPI communities around Medicaid renewals.
- Aug 3: HHS Region 2 team attended New York State Medicaid Communication Strategy Meeting to review details on New York state's renewal process.
- Aug 3: HHS Region 2 team met with the CEO of Postgraduate Center for Mental Health, a New York City based mental health services center to discuss outreach around Medicaid renewals.
- Aug 4: HHS Region 7 RD and CMS RA Kim Stupica-Dobbs met with Kevin Bagley, Director of Medicaid and Long Term Care, Nebraska DHHS to discuss the progress on Medicaid renewals.
- Aug 4: HHS Region 7 RD met with Alderwoman Pam Boyd of St. Louis to discuss Medicaid renewals.
- Aug 4: HHS Region 8 RD partnered with Colorado's State Medicaid Director, Adela Flores-Brennan, to present on Medicaid renewals, IRA, and Women's Equity day.
- OPOLE added nine new community partners to the roster of over 1,000 local community groups enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 38 outreach events this past week to spread renewals messaging and encourage partners to do the same.
- Administrator Brooks-LaSure met with over 30 patient and consumer groups to discuss Medicaid renewals.

Look Ahead

Week of Aug. 7

- Aug 7: HHS Region 5 RD will participate in a ribbon cutting for the Community Health Partnership of IL and discuss Medicaid renewals, IRA and the Secretary's agenda.
- Aug 7: HHS Region 4 team will meet with Jodi Ray (FL Covering Kids & Families) and Miriam Harmatz (FL Health Justice) to discuss establishing a Medicaid renewals small group in Florida and begin preliminary planning for a meeting with the director of the OCR.
- Aug 7: HHS Region 7 RD will visit Dr. Kendra Holmes and staff at Affinia Health Care in St. Louis, to promote FQHC work during Health Center Week and discuss HHS workforce and Medicaid renewal efforts.
- Aug 7: HHS Region 7 RD and HRSA RA Nancy Rios will visit Great Mines Health Center in Potosi, MO and discuss HHS workforce and Medicaid renewal efforts.
- Aug 8: State operations pre-compliance letters (call center letters)
    - Will post to Medicaid.gov and send listserv
- Aug. 8: Renewals Stakeholder Coalition Call - Hispanic and Latino community
- Aug. 8: One-pager for Partners - Hispanic and Latino community
- Aug. 8: toolkits for faith groups and back-to-school

- Aug 8: HHS Region 4 team will host a Healthcare Community Conversation with HHS Chief of Staff Sean hosted by HRSA funded FQHC - Saint Joseph's/Mercy Care Services, Inc. located Atlanta, GA. This visit will include a 60-minute discussion focused on HHS priority policies and programs, including Medicaid renewal Process.
- Aug 8: HHS Region 5 RD will join Dr. Allison Arwady, Chicago Department of Public Health Commissioner on a Facebook live broadcast to discuss the 988 program and anniversary as well as Medicaid renewals.
- Aug 8: HHS Region 3 RD will participate in a National Health Center Week event hosted by Westside Family Healthcare in Dover, Delaware and discuss the Inflation Reduction Act and Medicaid renewals.
- Aug 8: HHS Region 4 Public Affairs Specialist will participate in the Cover Alabama Full Coalition meeting to provide updates on Medicaid renewals and relay any Medicaid specific questions and concerns with the appropriate OpDiv.
- Aug 9: HHS Region 5 Public Affairs Specialist will join the TCA Health Center Back to School event to promote Medicaid renewals, IRA priorities and back to school physicals as well as updated vaccines for underserved communities. TCA will also have navigators on site for additional assistance with Medicaid renewals.
- Aug. 9: Drop-in Article
- Aug. 10: Kids deck (outreach/strategies)
- Aug. 10: Renewals Stakeholder Coalition Call - Black Americans
- Aug 10: HHS Region 4 Public Affairs Specialist will attend a Medicaid renewal event hosted by Georgia StandUp and members of the state legislature to provide important information related to Medication renewals including deadlines, requirements, and available resources for consumers.
- Aug 11: HHS Region 5 RD will tour and meet with the Polish American Association leadership to discuss collaboration on Medicaid renewals within the Polish community.
- Aug 11: HHS Region 7 RD and CMS RA Kim Stupica-Dobbs will meet with Sarah Fertig, Director of Medicaid and Health Care Finance, Kansas Department of Health and Environment to discuss the progress on Medicaid renewals.

Week of Aug. 14

- Aug. 17: One-pager for Partners - Disability community
- Aug. 17: Renewals Stakeholder Coalition Call - Disability community

Week of Aug. 21

- Aug 22: OMH unwinding blog posts on websites for National Health Care for the Homeless Council (NHCHC), The ARC, and National Institute on Minority Health and Health Disparities (NIMHD)
- Aug. 23: Monthly renewals webinar. Topic: faith-based and neighborhood engagement
- Aug. 24: Renewals Stakeholder Coalition Call: Rural community
- Aug. 25 (tentative): CIB on policies states should be doing on kids coverage
- Aug. 25 (tentative): e14 Strategies Implementation Tool

Week of Aug 28

- Aug. 30: Release of May renewals data
- TBD: Ex parte letters to states
    - Will post to Medicaid.gov and send listserv

September

- Sept. 5-8 (tentative) ED/HHS Sec Back-to-School Bus Tour Event
- Release of April Data Part II
- Release of June Data Part I
- Sept 25: Reg: Corrective Action and Enforcement Authority to Support State Compliance with Federal Medicaid and Children's Health Insurance Program Renewal Requirements Interim Final Rule

Weekly Medicaid Unwinding Report: July 28

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
WFLD-TV Chicago (FOX affiliate): HHS Secretary Urges Illinoisans To Take Action Or Risk Losing Medicaid Coverage
Minneapolis Star Tribune: Minnesota Delays Deadline For Second Batch Of Medicaid Renewals
Inside Health Policy: CMS: Nine States Have Agreed To Pause Procedural Medicaid Terminations
Earned Media
July 28: Rachel Pryor, Dan Tsai and Ellen Montz participated in a press call to release March and April renewal data.
Social
@SecBecerra:
https://twitter.com/SecBecerra/status/1683535928227184655
@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1682435774698889228
@HealthCareGov:
https://twitter.com/HealthCareGov/status/1684624495967879168
https://twitter.com/HealthCareGov/status/1683891869166469135

Rollouts
July 28: Public Reporting of CMS Unwinding Data
Hill Engagement

- July 24: Briefed Tri-Caucus Staff
- July 28: Included unwinding materials in recess packet for hill
- July 28: Targeted outreach on Secretary's letter to governors

Engagement with External Partners

- July 23: HHS Office of Intergovernmental and External Affairs Director participated in a panel discussion on Medicaid renewals at the UnidosUS conference in Chicago, IL.
- July 24: HHS Region 5 RD staffed Secretary Becerra at an IRA/Medicare Event at Sinai Chicago Hospital where the benefits of the Inflation Reduction Act/Medicare as well as the importance of Medicaid renewals in Chicago and Cook County were discussed, including strategies to increase Medicaid renewals.
- July 24: HHS Region 6 RD spoke with Harris County Judge Lina Hidalgo about her participation in a Medicaid renewals event with Secretary Becerra.

- July 25: HHS Region 6 RD provided welcoming remarks and information on Medicaid renewals at a HRSA Grants 101 Community Partners training.
- July 25: HHS Region 3 staff met with the PA Deputy Secretary of Health Policy and Planning to get an update on their work, including on Medicaid renewals.
- July 25: HHS Region 1 RD and Executive Officer participated in CMS/HHS Maine Medicaid Redetermination Listening Session to discuss the status of Medicaid Renewals.
- July 25: HHS Region 7 RD met with Dr. Sherrita Strong and Dr. Ada Walker, with the University of Nebraska's Medical Centers, Diversity and Inclusion Team, to discuss Secretary Becerra's priorities including Medicaid renewals.
- July 26: HHS Region 7 RD made welcoming remarks at the Winnebago Comprehensive Healthcare System (WCHS) 5 Year Anniversary CMS Certification and discussed Medicaid Redetermination and other priorities.
- July 26: HHS Region 6 RD participated in a Get Covered Texas Statewide Advisory Committee call to discuss Medicaid Renewals.
- July 26: HHS Region 8 RD met with Jen Davis from Governor Gordon's office and WY Medicaid Director Lee Grossman discuss renewal messaging to highlight health plan affordability.
- July 26-27: HHS Tribal Affairs attended second day of CMS Tribal Technical Advisory Group meeting. Conversation again focused on Medicaid unwinding, with an emphasis on analyzing the "churn" that results in a coverage gap.
- July 26: Back to school webinar with over 1,700 partners
- July 27: HHS Center for Faith-based and Neighborhood Partnerships Center launched a new PSA designed for faith leaders and their community members as a guide for what they can do to prevent the loss of their health care coverage.
- July 27: HHS Region 2 RD and Public Affairs Specialist met leadership at Westchester Jewish Community Services who run 3 CCBHC's to set up multiple events around renewals.
- July 27: HHS Region 2 RD and Public Affairs Specialist met with the communications team at New York State Department of Health to review details on New York states renewal process.
- July 27: HHS Region 4 team participated in a Medicaid Awareness event with Georgia Standup and State Rep. Gabe Okoye in Lawrenceville, GA. to provide attendees with informational materials about the Medicaid renewal process.
- July 27: HHS Region 4 Public Affairs Specialist attended the Navigators Grantee meeting facilitated by CMS Alexander DeAbreu and included various navigators from Region 4 and HHS divisions. Navigators provided updates regarding the Medicaid Redetermination/Renewal process in their states and identified common outreach efforts and shared challenges.
- July 27: HHS Region 4 team met with Congresswoman McBath's district office to discuss HHS and CMS partnering on community conversations related to Medicare, Medicaid and Marketplace policies.

- July 27: HHS Region 5 team met with Rush University Leadership to discuss potential collaborations for future events regarding Medicaid renewals, vaccine events and talk about the Secretary's priorities and agenda.
- July 27: HHS Region 7 Public Affairs Specialist met with Patrick Hampton, Constituent Advocate Manager for Rep. Sharice Davids of the 3rd District-Kansas to discuss Medicaid Renewals.
- July 27: HHS Region 7 Public Affairs Specialist met with the Regional Area Public Information Officers hosted by the Mid-America Regional Counsel and shared HHS messaging and resources about Medicaid renewals and other HHS initiatives for the group to share across their social media and other publications.
- July 27: HHS Region 8 RD convened a roundtable discussion with OCR Director Melanie Fontes Rainer in Missoula, MT on reproductive health and discussed several HHS priorities including the importance of Medicaid renewals.
- July 27: HHS Region 8 RD convened a roundtable discussion with OCR Director Melanie Fontes Rainer in Missoula, MT on LGBTQ+ rights and discussed several HHS priorities including the importance of Medicaid renewals.
- July 27: HHS Region 9 RD participated in a virtual townhall with Nevada Rep. Dina Titus and local health advocacy organizations and addressed Medicaid renewals, what this means for Nevadans and what recipients can do to check their status.
- July 28: Secretary Becerra and Administrator Brooks-LaSure spoke at National Urban League annual conference in Houston
- July 28: Secretary Becerra took part in a renewals event at Hope Health & Wellness Center in Houston, TX focused on the Latino and Asian American communities.
- July 28: HHS Region 4 team participated in a Medicaid Awareness event with Georgia Standup and State Rep. Burnough in Riverdale, GA to provide attendees with informational materials about the Medicaid renewal process.
- July 28: HHS Region 2 RD will join the New York State Medicaid leadership for their Medicaid unwinding information session for provider associations.
- OPOLE added nine new community partners to the roster of over 1,000 local community groups getting critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 59 outreach events this past week to spread redetermination messaging and encourage partners to do the same.
- PRG meetings with African Methodist Episcopal Church (AME), American College of Nurse Midwives, National Asian Pacific American Women's Forum (NAPAWF)

Look Ahead

- July 29: Secretary Becerra to speak at National Medical Association annual conference in New Orleans
- July 29: HHS Region 4 Special Assistant will attend a back-to-school event with Live Healthy Gwinnett and Gwinnett County Sheriff's office in Lawrenceville, GA and provide attendees with informational materials to assist people through the Medicaid redetermination/renewal process.

Week of July 31:

- Customized TV ads in states TBA
- July 31: HHS Region 6 Executive Officer collaborated with the regional director for the National Medical Association to provide an HHS panel discussion on Medicaid renewals and other priorities.
- July 31: HHS Region 6 RD will participate in an Ambassador Program meeting to hear about Texas Medicaid renewals.
- Aug. 1: Interagency Medicaid renewals Train-the-Trainer National Webinar
- August 1: HHS Region 5 RD will update the Illinois Coalition for Health Access on Medicaid Renewals
- Aug. 1: HHS Region 7 RD will make remarks about mental health and Medicaid Renewals at the Silent No More: Addressing the Mental Health and Opioid Crises in St. Louis, hosted by the Ethnic Communities Opioid Response Network in Missouri.
- Aug. 2: Drop-in article on state action and compliance for use by local newspapers
- Aug. 2: HHS Intergovernmental Affairs will speak with Savannah, Georgia mayor's team to share resources on Medicaid renewals
- Aug. 2: HHS Region 5 RD will meet with Wisconsin Lt. Gov. Sara Rodriguez and Gov. Evers' health policy team to discuss Medicaid renewals efforts in WI.
- Aug. 3: Administrator Brooks-LaSure beneficiary-focused interviews with local outlets in Atlanta, Chicago and Tampa - FFM states that have the highest Medicaid/CHIP disenrollment numbers for the Black population
- Aug. 3: Renewals Stakeholder Coalition Call – AAHNPI community
- Aug. 3: Meeting between IEA, CMS and Oklahoma Governor's office, State Health Secretary Kevin Corbett and Medicaid Director Traylor Rains on Medicaid renewals.
- Aug. 3: HHS Office of Intergovernmental and External Affairs and CMS will participate in the National Governor's Association monthly Governors' Medicaid unwinding call.

August:

- Aug. 8: Renewals Stakeholder Coalition Call - Hispanic and Latino community
- Aug. 10: Renewals Stakeholder Coalition Call - Black Americans
- Aug. 17: Renewals Stakeholder Coalition Call - Disability community
- Aug. 23: Monthly renewals webinar
- Aug. 24: Renewals Stakeholder Coalition Call: Rural community
- State operations pre-compliance letters (call center letters)
- e14 Strategies implementation tool

Weekly Medicaid Unwinding Report: July 21

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
Associated Press: Biden administration asks employers to give more help to workers who lose Medicaid

CNN: Medicaid disenrollments paused in a dozen states after failure to comply with federal rules

Bloomberg: Biden HHS Steps In Amid Wave of Medicaid Coverage Cancellations

Fierce Healthcare: CMS urges states to abide by Medicaid renewal requirements

Modern Healthcare: CMS announces actions against states over Medicaid redeterminations

Earned Media
July 18: Readout distributed following roundtable regarding the role pharmacists can play in educating customers about Medicaid renewals as well as prescription drug savings through the Inflation Reduction Act

July 19: Administrator Brooks-LaSure and Deputy Administrator Dan Tsai held a virtual pen and pad on the state improvements/compliance fact sheet. Almost 40 members of the media attended (readout attached).

Paid Media
Ad campaign launched on radio across all 33 FFM states

Social
@SecBecerra:
https://twitter.com/SecBecerra/status/1681299271470002182
https://twitter.com/SecBecerra/status/1681027336278269957

@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1681740055130394624

@HHSgov:
https://twitter.com/HHSGov/status/1681027359548354560
https://twitter.com/HHSGov/status/1681299291376107520
https://twitter.com/HHSGov/status/1681394668271960093

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1681720275451228160

Rollouts

- July 18: Secretary Becerra, Administrator Brooks-LaSure, Neera Tanden hosted roundtable with large pharmacy chains and pharmacy associations to discuss Medicaid renewals and IRA implementation
- July 18: Compliance Fact Sheet and Mitigation Plan Summary released
- July 19: Virtual pen and pad featured Administrator Brooks-LaSure and Dan Tsai on compliance fact sheet
- July 20 ESI Tri-Dept letter to employers
    - Briefing for employer groups led by IEA, CMS and DOL
    - AP story

Hill Engagement

- July 18: Flagged Compliance Fact Sheet and Mitigation Plan Summary for hill offices
- July 20: Flagged ESI Tri-Dept letter for hill offices
- July 20: Hill briefing

Engagement with External Partners

- July 17: AHIP coordinated a meeting with health plans in regions 5, 6 and 7 to share their work and experiences around renewals.
- July 17: HHS Region 4 Public Affairs Specialist attended a Medicaid Awareness event with Georgia representatives to focus on renewals.
- July 17: HHS Region 5 Regional Director met with the President/CEO of Mt. Sinai Chicago to discuss Medicaid renewals, and priorities of the Secretary and Administration.
- July 17: HHS Region 5 RD met with Medicaid plans and partners operating in region 5 - including Aetna, Molina Healthcare and CVS - regarding their efforts to promote Medicaid renewals.
- July 17: HHS Region 6 RD provided remarks regarding redetermination at a Region 6 Harm Reduction workgroup with federal, state, local, tribal and academic organizations.
- July 17: HHS Region 2 RD presented on the benefits of the IRA at the Four Seasons at Great Notch and spoke in depth about Medicaid renewals.
- July 17: Region 4 Public Affairs Specialist participated in a Medicaid Awareness event with Georgia Standup and state Rep. Terry Cummings in Mableton, GA to provide attendees with informational materials about the Medicaid renewals process.
- July 17: HHS Region 6 RD initiated a call with the HOPE Clinic director in Houston to discuss their hosting an event on Medicaid renewals for Secretary Becerra.

- July 17: HHS Region 6 RD joined a Texas Ambassador call about Texas Medicaid renewal activities.
- July 17: HHS Region 7 RD gave remarks at the Bridging the Gap in Agriculture conference hosted by Lincoln University in Malden, Missouri regarding Medicaid renewals, 988 and mental health, and the Inflation Reduction Act.
- July 18: HHS Region 2 team had an Introductory Meeting with Maryland Department of Health, and shared the Department's priorities including Medicaid renewals, Inflation Reduction Act and health equity.
- July 18: CMS OA and CMCS met with key stakeholders to discuss the compliance releases, including a coalition of patient groups, a coalition of disability groups, state-based legal services organizations and several consumer services organizations.
- July 19: HHS Intergovernmental Affairs spoke with Columbus, GA mayor's team to share resources on Medicaid renewals.
- July 19: HHS Intergovernmental Affairs met with Reno, Nevada mayor team to share resources on Medicaid renewals.
- July 19: HHS Region 7 regional staff met with Missouri Foundation for Health and United Way of Greater Kansas to discuss renewals.
- July 19: HHS Region 9 RD participated in United for Health Equity in Aging Summit to discuss HHS priorities: IRA, renewals, Health Equity etc.
- July 19: HHS Region 2 RD presented on the benefits of the IRA to seniors at the Yonkers Senior Center and spoke in depth about Medicaid renewals.
- July 19: HHS Region 4 Public Affairs Specialist attended the South Florida Enrollment Coalition Meeting Miami-Dade & Broward Counties and was provided Medicaid renewal related updates.
- July 19: HHS Region 7 RD met with Kelsha Lee, CEO of Annie Malone Children & Family Services to discuss Medicaid renewals and 988.
- July 20: Champions for Coverage webinar shared information about Medicaid and CHIP renewals, and their role in helping keep people covered.
- July 20: CMCS, CMS and IEA briefed regions 8 & 10 staff on renewals work of states in their regions.
- July 20: HHS Region 7 RD provided remarks to the St. Louis Ecumenical Council of Clergy with President Clarence Jackson to discuss Medicaid renewals.
- July 20: HHS Intergovernmental Affairs engaged with California Governor Newsom's office to disseminate disenrollment numbers across HHS.
- July 20: HHS Region 8 RD convened a roundtable discussion with Rocky Mountain's Agency on Aging in Helena, Montana and discussed the challenges associated with Medicaid renewals.
- July 20: HHS Region 1 RD spoke at the New Hampshire Health Coverage Collaborative about Medicaid renewals.
- July 20: HHS Region 6 RD participated in a call with the Arkansas Advocates for Children and Families to discuss the state's disenrollment of Medicaid beneficiaries.

- July 20: HHS Region 7 RD Palm met with Derrick Jones, CEO, LIV Sober Living Recovery Center to discuss IRA, Medicaid renewals and behavioral health services, including the 988 Suicide & Crisis Lifeline.
- July 21: CMCS, CMS and IEA briefed region 9 staff on renewals work of states in their region.
- July 21: HHS Region 5 RD met with regional State Health Officials to discuss Medicaid renewals and other concerns.
- July 21: HHS Region 1 RD attended Senator Elizabeth Warren's senior event at the Pittsfield Senior Center, MA to provide remarks on key provisions of the Inflation Reduction Act as well as unwinding and renewals.
- July 21: HHS Region 5 RD attended standing meeting with the Region 5 State Health Officials and received updates on Medicaid renewals and discuss any issues within the region.
- July 21: HHS Region 6 RD participated in a call with Houston Mayor Sylvester Turner's team to further discuss the mayor's participation in a Medicaid renewals event with HHS Secretary Becerra on July 28 in Houston.
- July 21-24 HHS Intergovernmental Affairs attended National Association of Counties (NACo) annual conference in Austin, TX.
- IOS met with USDA regional directors to discuss how they can support.
- OPOLE added 11 new community partners to the roster of over 1,000 local community groups they've already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.
- OPOLE engaged in 76 outreach events this past week to spread renewals messaging and encourage partners to do the same.

Look Ahead

Week of July 24:

- July 24: Faith groups toolkit
- July 24: HHS Region 9 RD will visit Southern Indian Health Council, Inc, Alpine CA with IHS Director Tso and California IHS Area Director Bev Miller to discuss HHS priorities, including Medicaid renewals.
- July 24: HHS Region 9 RD will meet with the Sycuan Band of the Kumeyaay Indians, El Cajon, CA to discuss HHS priorities, including Medicaid renewals.
- July 24: HHS Region 9 RD will visit the San Diego American Indian Health Center to discuss HHS priorities, including Medicaid renewals.
- July 24: Secretary Becerra to speak at UnidosUS annual conference in Chicago.
- July 25: HHS Region 6 RD will deliver welcome remarks and information about Medicaid renewals at a HRSA Grants 101 – Resources, Tools and Tips for Community Partners training.
- July 25: HHS Region 9 RD will visit the Indian Health Council, Inc in Valley Center, CA to discuss HHS priorities, including Medicaid renewals.
- July 26: Drop-in article on state action and compliance for use by local newspapers
- July 26: Monthly renewals webinar

- July 26: HHS Region 6 RD will participate in a Get Covered Texas Statewide Advisory Committee call to discuss Medicaid renewals.
- July 26: HHS Region 7 RD will make welcoming remarks at the Winnebago Comprehensive Healthcare System 5 Year Anniversary CMS Certification, and will discuss Medicaid renewals and other priorities.
- July 26: HHS Region 9 RD will visit Riverside San Bernardino County Indian Health, Inc to discuss HHS priorities, including Medicaid renewals.
- July 26: HHS Region 9 RD will visit be interviewed by Protect Our Care and discuss access to care in light of the Medicaid renewal requirement along with other HHS priorities.
- July 27: HHS Region 7 RD will meet with Dr. Sherrita Strong and Dr. Ada Walker, with the University of Nebraska's Diversity and Inclusion Team, to discuss Secretary Becerra's priorities, Medicaidrenewals and 988.
- July 27: HHS Region 5 team will meet with Rush University Leadership to discuss potential collaborations for future events regarding Medicaid renewals, vaccine events and talk about the Secretary's priorities and agenda.
- July 28: Secretary Becerra and Administrator Brooks-LaSure to speak at National Urban League annual conference in Houston
- July 28: Data page on Medicaid.gov and CMS release of April data Part 1
    - Will be accompanied by a press release and press call with Dan Tsai
- July 28: Kids deck (outreach/strategies)
- July 28: Back-to-school toolkit
- July 29: Secretary Becerra to speak at National Medical Association annual conference in New Orleans
- July 29: Administrator Brooks-LaSure to speak at NAACP annual conference in Boston
- Ad campaign launch on national TV

Week of July 31:

- July 31: "Training the Trainer" interagency partners call
- Customized TV ads in states TBA

August:

- State operations pre-compliance letters (call center letters)
- e14 Strategies implementation tool
- Coalition-specific webinars, with one-pagers released in conjunction
    - African-American (Aug. 3)
    - Hispanic/Latino (Aug. 8)
    - AANHPI (Aug. 10)
    - Disability (Aug. 17)
    - Rural (Aug. 24)

Weekly Medicaid Unwinding Report: July 14

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
CT Mirror: Most CT residents enduring Medicaid 'unwinding' keep coverage

Maryland Matters: As thousands lose Medicaid coverage, health officials working on solutions to keep people enrolled

Earned Media
July 11: Secretary Becerra Telemundo hit
July 12: Secretary Becerra CNN, The Hill Live and Spectrum Los Angeles hits

- The Hill hit aired at their "Dialing Into Mental Health" event with the National Alliance on Mental Health.

July 13: Worked with Axios for story on pandemic-era policies expiring (running over the weekend)
July 15: Administrator Brooks-LaSure participating in Rev. Al Sharpton's Saturday Action Rally (nationwide radio and streaming)

Ongoing inquiries:

- Amy Goldstein (Washington Post) general unwinding update, focus on why states have such different rates of procedural terminations
- Ganny Belloni (Bloomberg) on children losing Medicaid/CHIP coverage during unwinding
- NBC News Now (streaming) request for end of July/beginning of August

Paid Media
July 7: Ad campaign launched on social in English and Spanish across all 33 FFM states
July 10: Ad campaign launched on display across all 33 FFM states
July 14: National Spanish-language TV ad launched

Social
@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1678857816403070984
https://twitter.com/BrooksLaSureCMS/status/1679136328733057027

@HHSgov:
https://twitter.com/HHSGov/status/1679173781607284736
https://twitter.com/HHSGov/status/1678818942691733506

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1679147606587633664

Engagement with External Partners

OPOLE added 5 new community groups to the roster of over 1,000 local community partners they have already enlisted to get critical messaging out to Medicaid and CHIP beneficiaries.

OPOLE engaged in 33 outreach events this past week to spread redetermination messaging and encourage partners to do the same.

CMS partnership group met with South Asian Public Health Association and Asian Pacific Islander American Chamber of Commerce & Entrepreneurship (ACE).

CMS met with local and regional health plans in Regions 8, 9 and 10 in partnership with AHIP and MHPA to discuss unwinding.

IOS spoke to American Academy of Pediatrics at their annual meeting re: Medicaid renewals.

IOS and CMS spoke to the Medicaid RWJF "War Room."

IOS met with DOT to discuss their ongoing work.

IOS and CMS met with FCC, FTC, CFPB.

July 10: HHS Intergovernmental Affairs spoke with Union City, Georgia mayor team to share resources on Medicaid renewals.

July 11: HHS Center for Faith-based and Neighborhood Partnerships distributed, through its White House Office, unwinding one pager and bulletin inserts to the faith leaders of The Circle of Protection – a coalition of church bodies and related ministries representing close to 100 million members.

July 11: HHS Region 2 RD team met with Amir Bissari, New York State Medicaid director to discuss collaborations on public relations and outreach for the state's renewals as well the new focus on events in New York City and New York State.

July 11: HHS Region 3 RD led a discussion on Medicaid renewals with representatives from Philadelphia area Asian American organizations.

July 12: HHS Center for Faith-based and Neighborhood Partnerships coordinated with American Muslim Health Professionals to share the Partnership Center one pager on renewals and actions consumers can take renew coverage to AMHP's its NY/NJ and Texas Chapters, as well as its national provider members.

July 12: HHS Intergovernmental Affairs met with representatives from NY, OK, AZ, OK, MD, CO and HI during the National Governors Association Annual Meeting to discuss Medicaid renewals.

July 13: HHS Center for Faith-based and Neighborhood Partnerships coordinated Dan Tsai's participation briefing faith leaders about renewals on the White House Faith and Neighborhood Partnerships Engagement Call. The call, which typically draws between 250 – 500 attendees, was at capacity.

July 13: HHS Intergovernmental Affairs met with representatives from PA and MI during the National Governors Association Annual Meeting to discuss Medicaid renewals.

July 13: HHS Center for Faith-based and Neighborhood Partnerships sent a newsletter highlighting a call to action for faith leaders to education community members on renewals. The newsletter is sent to 70,000 faith and community leaders.

July 13: HHS Region 1 RD provided remarks for 200+ seniors at the Black & Aging Wellness Fair at the West End Community Center in Providence, RI to remind individuals and families about renewals, and to work with the RI Department of Health to ensure they do not lose health coverage.

July 13: HHS Region 2 RD was joined by HHS Region 7 RD and Assistant Secretary Delphin-Rittman for a tour of VIP healthcare in the Bronx, and discussed Medicaid renewals.

July 14: HHS Region 1 RD along with his CMS Regional Administrator met with the NH Equity Taskforce on the impacts of the renewals process currently taking place across the country.

July 14: CMCS, CMS and IEA briefing for region 6 staff on renewals work of states in their region.

Look Ahead

Week of July 17:

- July 18: Secretary Becerra, Administrator Brooks-LaSure, Neera Tanden hosting roundtable with large pharmacy chains and pharmacy associations to discuss Medicaid renewals and IRA implementation
- July 18: Compliance Fact Sheet and Mitigation Plan Summary release

- July 19: Virtual pen and pad featuring Administrator Brooks-LaSure and Dan Tsai on compliance fact sheet
    - Wake: drop-in article on state action and compliance for use by local newspapers
- July 20 (TENTATIVE): ESI Tri-Dept letter to employers
    - Briefing for employer groups led by IEA, CMS and DOL
    - ASPA/OC finalizing press tactics
- July 20: Champions for Coverage webinar to share information about Medicaid and CHIP renewals, and their role in helping keep people covered
- July 20: CMCS, CMS and IEA briefing for regions 8 & 10 staff on renewals work of states in their regions.
- July 21: Faith groups toolkit
- July 21: CMCS, CMS and IEA briefing for region 9 staff on renewals work of states in their region
- July 21-24 HHS Intergovernmental Affairs to attend National Association of Counties (NACo) annual conference in Austin, TX
- Ad campaign launch on radio across all 33 FFM states
- IOS meeting with USDA regional directors to discuss how they can support

Week of July 24:

- July 26: Monthly renewals webinar
- July 28: Data page on Medicaid.gov and CMS release of April data Part 1 (Press tactics TBD)
- July 28: e14 Strategies implementation tool
- July 28: Kids deck (outreach/strategies)
- July 28: Back-to-school toolkit
- July 28: One-pagers for partners:
    - African-American
    - Hispanic
    - API
    - Disability
    - Rural
- Ad campaign launch on national TV
- (TENTATIVE) State operations pre-compliance letters (call center letters)

Week of July 31:

- Customized TV ads in states TBA

Weekly Medicaid Unwinding Report: July 7

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
July 2: ABC News "Through the Cracks" https://abcnews.go.com/US/video/cracks-families-lose-medicaid-coverage-pandemic-protections-end-100555040

July 5: Managed Healthcare Executive "Understanding the Long-Term Implications of Medicaid Unwinding" https://www.managedhealthcareexecutive.com/view/understanding-the-long-term-implications-of-medicaid-unwinding

July 7: WUSF radio "Florida is one of two states declining federal waivers to help with Medicaid unwinding" https://wusfnews.wusf.usf.edu/health-news-florida/2023-07-07/florida-declining-federal-waivers-help-medicaid

Earned Media
July 5: Virtual pen-and-pad featuring Dan Tsai speaking with Florida-based reporters from the following outlets:

- Sun Sentinel
- Orlando Sentinel
- KFF Health News
- WUSF Public Media
- Miami Herald
- Tampa Bay Times

Social
@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1675872707685040129
https://twitter.com/BrooksLaSureCMS/status/1675872709861883907

@HealthCareGov:
https://twitter.com/HealthCareGov/status/1675853905903644672

Engagement with External Partners

July 5: HHS Region 6 RD met with Harris County Commissioner Leslie Briones to discuss Medicaid redeterminations.

July 6: HHS Region 4 team met with Medicaid Redetermination statewide partners Atlanta Regional Collaborative for Health Improvement (ARCHI) and Georgia StandUp to continue redetermination outreach across Georgia.

July 6: HHS Region 8 RD met with Regional Administrator Aikta Marcoulier from the Small Business Association.

July 6: Dan Tsai met with National Urban League affiliates

12 new community groups added to the roster of over 1,000 local partners getting out critical messages to Medicaid/CHIP beneficiaries.

54 outreach events to spread redetermination messaging and encourage partners to do the same.

Look Ahead

Upcoming Key Dates/Events

Week of July 10

- July 11: Secretary Becerra TV hits
- July 12: Secretary Becerra Telemundo and Univision hits

Week of July 17:

- July 17: Compliance Fact Sheet and Mitigation Plan Summary release, accompanied by July 18 virtual pen and pad featuring Administrator Brooks-LaSure
- ESI Tri-Dept letter to employers
- State operations pre-compliance letters (call center letters)

Week of July 24:

- July 28: Data page on Medicaid.gov and CMS release of April data Part 1 (Press tactics TBD)

Weekly Medicaid Unwinding Report: June 30

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
Minnesota Star Tribune: Thousands of Minnesotans at risk of losing health insurance get a one-month reprieve

Washington Post: Will more states press pause on Medicaid disenrollments?

The Oakland Press: Michigan extending deadline for Medicaid renewal forms

Earned Media
June 26: CMS coordinated a virtual pen-and-pad for reporters from California and Nevada. The call was attended by representatives from:

- California Capital Public Radio
- San Diego Union-Tribune
- Los Angeles Times
- L.A. Focus
- Black Voice News
- Las Vegas Review-Journal
- The Nevada Independent

June 27: Spanish language interviews:
Carolina Fortin-Garcia in Virginia, Indiana, Florida
Brenda Delgado in Iowa, Phoenix, Tucson, Indiana

June 28: HHS Deputy Secretary Palm talked with USDA Radio (900 stations nationwide) and the National Association of Rural Broadcasters (1,300 stations nationwide) about Medicaid renewals

Pending interview this week or next for Secretary for Spectrum News (television outlet with nationwide broadcasts)

June 29: CMS Regional Administrator Sharon Graham radio interviews in Cedar Rapids, Tulsa, Toledo, Omaha and Scripps (nationally syndicated).

June 29: HHS Region 4 RD was interviewed by Cara Kneer on the 11Alive, Atlanta & Co. midday show to discuss redetermination.

Releases this Week

June 28: Monthly Unwinding Webinar rolled out Train-the-Trainer training slide deck to over 4,000 partners and stakeholders.

June 30: FMAP Reduction FAQs (technical document for states)

June 30: Renewal Timelines state document

Engagement with External Partners

"Renewal Outreach Materials" added to the Medicaid.gov homepage carousel to link directly to outreach materials.

CMS-led Medicaid and Children's Health Insurance Program Continuous Enrollment Partner Education webinar.

14 new community groups added to CMS roster of over 1,000 local community partners we've already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries.

CMS participated in 59 outreach events this past week to spread redetermination messaging, including the American Association of Nurse Practitioners Conference.

June 26: CMS met with eight Black civil rights organizations (NAACP, NUL, NAN, BWR and others) to discuss upcoming opportunities for CMS principals to participate in to amplify unwinding efforts.

June 26: CMS met with AMA to discuss potential avenues to partner with AMA to engage providers around the administration's efforts on unwinding.

June 26: CMS issued listserv to 'Marketplace Champions for Coverage' to engage them in Medicaid unwinding work related to Marketplace.

June 26: DPC and HHS hosted follow-up call with for Medicaid Outreach IPC.

June 26: CMS briefing call for Region 4 regional director and administrator

June 27: Secretary Becerra discussed the role of schools and school administrators around redeterminations during his keynote address at the School-Based Health Alliance's national conference in Washington, DC.

June 27: CMS briefing call for Region 2 regional director and administrator

June 28: CMS met with the National Council of Black State Legislatures. Organization verbally committed to partnering on hosting an unwinding briefing, committed to pushing out CMS materials to their membership and proposed CMS participate in an in person convening with their caucus leadership during CBC week.

June 28: CMS met with the Southern Poverty Law Center. SPLC committed to hosting an unwinding briefing with their state affiliate chapters on unwinding for CMS to participate in. Moving forward SPLC will meet with CMS monthly to share trends they're seeing in the states.

June 28: HHS and CMS met with CBPP to discuss the trends advocates have identified on the ground and how to move forward collaborative on messaging nuanced unwinding topics.

June 28: Rachel Pryor spoke on IEA's monthly check-in call with pharmacies.

June 28: Sean McCluskie discussed redeterminations with Carmen Heredia, Director, Arizona Health Care Cost Containment System (AHCCCS), and Chad Campbell, Chief of Staff to Governor Hobbs, while in Phoenix.

June 28: HHS and CMS held one-on-one meetings with the VA and HUD to solicit additional high-impact commitments. VA is looking into possibility of emailing 700,000 veterans on Medicaid directly about redeterminations.

June 29: CMS met with the YMCA on how to engage the YMCA on outreach and renewal assistance, especially for children.

June 29: CMS met with Centene to hear about successes and challenges from specific states while working with states on Medicaid renewals.

June 29: Ellen Montz and Rachel Pryor took part in a Business Forward member briefing, which included Exact Sciences, AdvaMed, DaVita and Aflac.

June 29: IEA and CMS met with American College of Obstetricians and Gynecologists (ACOG) and discussed ways to reach the population receiving maternal health care services.

June 29: HHS Region 3 Acting Director joined HRSA leadership for a tour and roundtable discussion on Medicaid Redetermination with providers at the Wright Center (FQHC) in Scranton, PA.

June 29: HHS Region 8 RD met with David Oppenheim and Elisabeth Arenales from Governor Polis' office.

Hill/other Departmental Engagement
June 26: Hill staff briefing.

June 29: Hill staff briefing.

Look Ahead

Upcoming Key Dates/Events
July 2: ABC News "Through the Cracks" story on Medicaid redeterminations (with a focus on procedural terminations in Florida) is expected to run on Sun., 7/2. CMS previously coordinated an interview with CMCS Director and Deputy Administrator Dan Tsai for this piece.

July 5: Virtual pen-and-pad featuring Dan Tsai speaking with Florida-based reporters.

July 5: HHS Region 6 RD will meet with Harris County Commissioner Leslie Briones to discuss Medicaid redeterminations.

July 6: HHS Region 4 team will meet again with Medicaid Redetermination statewide partners Atlanta Regional Collaborative for Health Improvement (ARCHI) and Georgia StandUp to continue redetermination outreach across Georgia.

July 6: HHS Region 8 RD will meet with Regional Administrator Aikta Marcoulier from the Small Business Association.

Week of July 10:

ESI Tri-Dept letter to employers – week of July 10 (at the earliest)
Mitigation Plan Summary – media push, tactics being finalized

Weekly Medicaid Unwinding Report: June 23

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines (full clips package attached)
Minneapolis Star Tribune: Thousands of Minnesotans could lose health insurance if they don't take action

MPR News: As Medicaid sign-up deadline looms, Minnesota health officials urge recipients to act now

Atlanta Journal-Constitution: Top Medicaid officials worry about disenrollments in Georgia, U.S.

Post and Courier (SC): More than 100,000 in SC lost Medicaid coverage so far, feds express concern

Earned Media
Setting up USDA radio and National Association of Rural Broadcasters interview for an HHS principal (likely Deputy Secretary Palm)

Administrator Brooks-LaSure, Dan Tsai and HHS Region 4 Director Antrell Tyson held a press call with a half dozen reporters from Georgia and South Carolina, including the Atlanta Journal-Constitution,

Kamara Jones (Acting Assistant Secretary for Public Affairs) did an interview with the Black Information Network on what the end of the PHE means when it comes to protecting oneself from COVID-19 and staying covered under Medicaid.

Interest from Estamos Contigo in airing interview with Carolina Fortin Garcia and Brenda Delgado on June 27. Markets include: Phoenix, Tuscon, Atlanta, Miami, Orlando, Tampa, Boston, Philadelphia, Reading, Lancaster

Secretary Becerra interview with ABC News for GMA3 coverage of Medicaid renewal process.

Social
@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1671554690222374912

Engagement with External Partners
Nine new community groups added to the roster of over 1,000 local community partners who serve Medicaid/CHIP beneficiaries and are trusted voices in their communities. New partners include: the North Atlanta Labor Council, which is comprised of 60 unions with nearly 70,000 members; the Vietnamese American Community of Greater Dallas; Mississippi Health Services School-based Clinics; Mississippi Center for Justice; Disability Rights North Carolina; and the Office of the Mayor of Rincon, Puerto Rico.

53 outreach events to spread redetermination messaging, including: Kitchen Cabinet calls with stakeholders and advocates in Florida, Mississippi, and North Carolina

June 17: HHS Region 4 Director participated in the Don't Lose Your Medicaid Coverage event with Georgia State Rep. Glaize
June 19: HHS Region 3 Acting Director provided remarks on Medicaid Redetermination at the Celebrate Healthcare Juneteenth celebration in Hampton, VA

June 21: CMS Administrator met with Choose Healthy Life

June 21: HHS Center for Faith-Based and Neighborhood Partnerships Center Director provided remarks focused on redeterminations and the role faith leaders can play in National Baptist Convention Health Summit event for approximately 100 faith leaders in Louisville, KY

June 22: CMS met with Costco Wholesale (Costco entity that oversees Costco pharmacies)

June 22: CMS met with American Medical Association

June 22: CMS met with the American Academy of Family Physicians

June 22: CMS joined state partner call convened by Families USA

June 22: HHS Center for Faith-Based and Neighborhood Partnerships Center Director spoke to Southern New England Conference of the United Church of Christ about collaboration around redeterminations. The Conference is comprised of 615 churches, more than 1,800 authorized ministers, and nearly 120,000 members.

June 23: HHS Region 4 Director convened stakeholders in Mississippi and Alabama to discuss unwinding in their respective states

Hill/other Departmental Engagement
Recess packet went to the Hill on June 22 including the unwinding communications toolkit, fact sheet and call to action deck.

Look Ahead

Upcoming Key Dates/Events
June 25: "Through the Cracks" segment featuring Dan Tsai interview scheduled to run on This Week, will post later on streaming

June 26: DPC and HHS will host follow-up call with for Medicaid Outreach IPC

June 26: Hill staff briefing

June 27: Spanish language interviews:
Carolina Fortin-Garcia in Virginia, Indiana, Florida
Brenda Delgado in Iowa, Phoenix, Tucson, Indiana

June 28: Monthly Unwinding Webinar to roll out Train-the-Trainer training slide deck

June 28: Rachel Pryor will speak on IEA's monthly check-in call with pharmacies

June 28: Sean McCluskie will discuss redeterminations with Carmen Heredia, Director, Arizona Health Care Cost Containment System (AHCCCS), and Chad Campbell, Chief of Staff to Governor Hobbs, while in Phoenix.

June 29: Ellen Montz and Rachel Pryor will take part in a Business Forward member briefing

June 29: Hill staff briefing

June 29: CMS Regional Administrator Sharon Graham radio interviews in Cedar Rapids, Tulsa, Toledo, Omaha and Scripps nationally syndicated

June 30: FMAP Reduction FAQs (technical document for states)

June 30: Updated renewals timeline

July: Tri-Agency letter to employers and plan sponsors to match the steps taken by the federal Marketplace and extend the SEPs of their health plans beyond the minimum 60-day requirement for individuals; will be sent jointly from the CMS Administrator, Assistant Secretary for Employee Benefits Security, and Assistant Secretary for Tax Policy

Weekly Medicaid Unwinding Report: June 16

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines *(full clips package attached)*
Arkansas Democrat Gazette: Federal official urges Arkansas, other states not to rush Medicaid eligibility reviews (6/10)
Arkansas Times: Federal officials are keeping a close eye on Arkansas's hasty Medicaid purge (6/10)
Associated Press: Biden administration urges states to slow down on dropping people from Medicaid (6/12)
Modern Healthcare: CMS reiterates call to action on Medicaid terminations (6/13)
The Hill: White House urges states to slow Medicaid cuts (6/13)
NC Health News: As NC begins Medicaid 'unwinding,' federal official warns of worrying trends (6/13)

Earned Media
Press call with Administrator Chiquita Brooks-LaSure, Counselor to the Secretary Rachel Pryor, Deputy Administrator Dan Tsai on Secretary Becerra's letter to governors and all hands on deck effort. Almost 40 reporters attending (national, local, radio and TV) on 6/13
Pitching in English and Spanish for Sharon Graham, Carolina Fortin-Garcia and Brenda Delgado to speak with local outlets in states that started terminations in April and May on June 27 and 29.
Paid Media
Phase 1 and Phase 2 campaigns underway across the country. The team is working to develop and implement a new hybrid national campaign funded from Marketplace user fees over the next several weeks that will help with people not responding to renewal forms and also have a call to action for those who have lost coverage healthcare.gov.

Social
@SecBecerra:
https://twitter.com/SecBecerra/status/1669336461965918209
https://twitter.com/SecBecerra/status/1668357503799685123
@BrooksLaSureCMS:
https://twitter.com/BrooksLaSureCMS/status/1668362050072879106?cxt=HHwWhICx9b6cm6cuAAAA
@HHSGov:
https://twitter.com/HHSGov/status/1668641877938130945
https://twitter.com/HHSGov/status/1668617508751048710
https://twitter.com/HHSGov/status/1668373053422686210

Engagement with External Partners
- Kitchen cabinet calls with advocates in Idaho (6/12) and Georgia (6/14)
- Governor staff stakeholder call (6/13) with HHS and CMS principles

- Medicaid outreach IPC for administration partners to brief them on redeterminations and request support with outreach and engagement. Over 70 people attended (6/15)
- Call for intergovernmental partners around the Secretary's letter and state flexibilities (6/13) with HHS and CMS Principles.
- Event with Secretary Becerra and Nevada AG Ford in UNLV (6/14)
- Office hours for administration partners to answer questions about how they can support redetermination effort (6/14)
- Targeted outreach to HHS divisions with strong links to low-income communities (6/14)
- Dan Tsai and Rachel Pryor participated in stakeholder call with call to action going out to over 1,400 virtual participants (6/14)
- Civil rights orgs engagement/planning meeting with National Council for Negro Women (health lead for the eight Black civil rights groups) (6/14)
- Dan Tsai spoke at the ACAP Membership Council meeting, focused on unwinding (6/14)
- Dan Tsai spoke at the Federation of American Hospitals Policy Conference, discussion focused in part on unwinding (6/14)
- HHS Center for Faith-Based and Neighborhood Partnerships Center Director spoke about redeterminations when addressing faith leaders at the Suicide and Black Church conference in Memphis, TN (6/14)
- Administrator Brooks-LaSure participated in APHA panel, with remarks/panel discussion focused on unwinding (6/15)
- Administrator Brooks-LaSure participated in ACAP CEO summit and addressed unwinding (6/15). ACAP has committed funding to an outreach campaign.
- Roundtable with about 15 insurers and associations, and Sean McCluskie, Rachel Pryor, Ellen Montz and Dan Tsai (6/15)
- HHS Center for Faith-Based and Neighborhood Partnerships Center spoke about redeterminations on unwinding at the inaugural Men's Mental Health Summit at HHS with faith leaders from around the country (6/15)
- CMS hosted its monthly large stakeholder call with over 60 participants from across the stakeholder and advocacy community (6/15)
- Region 4 Director convened calls with stakeholders in Mississippi and Alabama to discuss the redeterminations process in their respective states (6/15)
- Region 4 Director spoke to the North Georgia Labor Council around Medicaid Redeterminations (6/16)
- HHS meeting with behavioral health stakeholders on redeterminations (6/16)10 new community groups added to the roster of over 1,000 local community partners getting critical messaging out to Medicaid/CHIP beneficiaries
    - New partners include the African Americans Reach & Teach Health Ministry in Seattle; Rural Legal Assistance in Pine Bluff, Arkansas; and the Granite State Organizing Project, New Hampshire's largest faith-based, grass-roots coalition.
- 60 outreach events this past week to spread redetermination messaging. Two examples:
    - CMS Seattle participated in the African Americans Reach & Teach Health Ministry (AARTH) Health Fair, providing information on the Medicaid continuous enrollment unwinding to over 50 participants
    - CMS Dallas met with Arkansas Legal Aid to understand their latest concerns relating to the redetermination process in Arkansas.

Hill/other Departmental Engagement

Rollout of Medicaid unwinding materials to the hill, including a letter from the Secretary to Governors (6/12).

Look Ahead

Upcoming Key Dates/Events

- June 17: HHS Region 4 staff will attend the Don't Lose Your Medicaid Coverage event with Georgia State Rep. Glaize to provide attendees with informational materials to assist those who need to confirm their coverage, or who have lost Medicaid or CHIP coverage
- June 18: HHS Region 3 Acting Regional Director will provide remarks on Medicaid Redetermination and IRA at Celebrate Healthcare in Hampton, Virginia for a Juneteenth celebration and health care education event
- Week of 6/19:
    - Issuing sample "Dear Colleague" letter to all departments' use with stakeholders
    - Drafting Secretary authored blog for SSA
    - Release of Tri-Departments letter to ESI community.
        - HHS will do engagement around this letter when it goes out.
    - Meeting with trusted external partners and CMS leadership
    - Meeting with Choose Health Life
    - Meeting with AMA on supporting engagement/getting the word out
    - Meeting with AAFP on supporting engagement/getting the word out
    - Meeting with Families USA local partners and stakeholders
    - Calls for Regional Directors and Regional Administrators to hear from CMCS about redeterminations work of states in their regions.
- June 20: HHS Region 1 Regional Director will provide opening remarks on PHE Unwinding at the CMS/SSA New England Congressional Briefing
- June 20: Kitchen cabinet calls with advocates in Florida, Mississippi, and North Carolina
- June 21-23: HHS Region 7 Tribal consultation in Kansas City, MO
- June 22: Virtual pen and pads with reporters from Georgia, South Carolina, Virginia
- June 25: "Through the Cracks" segment featuring Dan Tsai interview scheduled to run on This Week, will post later on streaming

Weekly Medicaid Unwinding Report: June 9

Look Back

First Cohort of Renewals Effective	Number of States
April	4
May	15
June	20
July	11
October	1

Top Headlines *(full clips package attached)*
HuffPost: As Ron DeSantis Barnstorms New Hampshire, Thousands Of Floridians Lose Health Insurance (6/4)
Washington Post: States find there's more than one way to unwind Medicaid (6/6)

Earned Media
Secretary Becerra redeterminations event in Minnesota
- Star Tribune
- Minnesota Public Radio
- KARE 11 (Minneapolis NBC affiliate)

Dan Tsai interview with WTEN (Albany ABC affiliate) on what New Yorkers need to know to renew their Medicaid coverage 6/7 https://www.news10.com/news/officials-urge-new-yorkers-to-renew-medicaid-eligibility/
Dan Tsai interview with Megan Messerly (Politico), who has been on the ground in Arkansas reporting on their efforts 6/9. Story to run next week.
Dan Tsai virtual pen and pads with reporters from Arkansas, Arizona, North Carolina, Iowa in anticipation of data releases 6/9
ONGOING (working on written responses)—ProPublica (Cheryl Clark) on national chart for addressing appeals process for Medicaid redeterminations
ONGOING (working on written responses)—Michigan Radio (Ronia Cabansag) on proposal in Michigan to set up passive enrollment in a marketplace health insurance plan for Michiganders who lose their Medicaid eligibility

Social
@SecBecerra: https://twitter.com/SecBecerra/status/1666870551049129991
@BrooksLaSureCMS: https://twitter.com/BrooksLaSureCMS/status/1667212151952486402
@HealthCare.gov: https://twitter.com/HealthCareGov/status/1666448684240850945

Engagement with External Partners
- May 30: IEA and OPOLE held a "Kitchen Cabinet" call with stakeholders in Nevada, urging them to employ and disseminate the Unwinding Communications Toolkit.
- June 5: Dan Tsai speaks at Medicaid Health Plans of America (MHPA) board meeting on unwinding.
- June 6: IEA Center for Faith-Based and Neighborhood Partnerships hosted the Youth Mental Health Symposium that included youth, faith, and community leaders with more than 60 in-person attendees and more than 100 online. Redeterminations and action steps related to supporting community members in securing coverage was presented and the CMS Unwinding toolkits distributed.

- June 7: IEA Director Marvin Figueroa provided keynote remarks focused on redeterminations at the first Idaho Hispanic & American Indian Health Conference in Twin Falls, ID.
- June 7: IEA Center for Faith-Based and Neighborhood Partnerships Director Dr. Rev. Que English attended the 109th Hampton University Ministers Conference where she addressed attendees from Black churches from across the country. Director presented on redeterminations, mental health, and other HHS priorities.
- June 8: Secretary Becerra took part in an event focused on Medicaid redeterminations at the NorthPoint Health & Wellness Center in Minneapolis. He was joined by the Chair of the Minnesota House Human Services Committee, the CEO of the Health & Wellness Center, and the Board Chair of the Hennepin County Commissioners.
- June 8: Dan Tsai meets with NAACP's monthly Health Leads Forum to discuss unwinding.
- Dan Tsai and Rachel Pryor meeting with Walmart and Sam's Club
- OPOLE added nine new community groups to the roster of the over 1,000 local community partners that we've already enlisted to get critical messaging out to Medicaid/CHIP beneficiaries; this includes partners like the Community Health Center Association of Mississippi, the University of Nevada-Las Vegas Minority Health & Equity Coalition, and various statewide disability/disease organizations.
- In addition to the Kitchen Cabinet call above, OPOLE engaged in 40 outreach events this past week to spread redetermination messaging. Two examples: (1) we trained community health and HIV coordinators who work for the Community Health Center Association of Mississippi, and (2) conducted in-person outreach about Medicaid redeterminations to 125 individuals at the Big Tigger Beltline Bikefest in Atlanta, Georgia.

Hill/other Departmental Engagement

- June 8: Letter received from Pallone/Wyden regarding unwinding
- June 9: Briefing with Dan Tsai and Reps. Frankel, Wasserman Schultz, Cherfilus-McCormick

Look Ahead

Upcoming Key Dates/Events

- Week of June 12: Calls with reporters from California, Florida, Maine, Nevada
- June 12: Unwinding Package Rollout
    - Rollout Products:
        - Secretary letter to Governors
        - CMS Fact Sheet
        - CMS Call-to-Action Document
        - State Strategies to Prevent Procedural Terminations
        - Public Reporting on Data and State Activity Related to the End of the Medicaid Continuous Enrollment Condition
    - Letter shared under embargo with select reporters Monday 11 AM
    - Embargo comes off and press release goes out, Monday 2 PM
    - Administrator Brooks-LaSure, Rachel Pryor and Dan Tsai to hold call with national reporters Tuesday 1pm
- June 12: LIS fact sheet with language urging stakeholders to remember about larger redeterminations as we encourage enrollment in LIS.
- June 12: IEA and OPOLE will host a Medicaid Redeterminations "Kitchen Cabinet" call with advocates in Idaho.

- June 13: IEA will host a briefing for intergovernmental stakeholders (NGA, NACo, etc.). Dan Tsai and Rachel Pryor will speak.
- June 14: Secretary Becerra will join Nevada Attorney General Aaron Ford and leadership from the Silver State Health Insurance Exchange for an event focused on Medicaid redeterminations at the University of Nevada Las Vegas (UNLV).
- June 14: IEA and OPOLE will host a Medicaid Redeterminations "Kitchen Cabinet" call with advocates in Georgia.
- June 14: IEA Center for Faith-Based and Neighborhood Partnerships Director Dr. Rev. Que English will discuss redeterminations during her address to faith leaders at the Suicide and Black Church conference in Memphis, TN.
- June 15: Roundtable with insurers hosted by Sean McCluskie, Dan Tsai, Ellen Montz, and Rachel Pryor.
- June 15: IEA Center for Faith-Based and Neighborhood Partnerships will include a presentation on unwinding and the CMS toolkit when they host the inaugural Men's Mental Health Summit at HHS with faith leaders from around the country.
- June 18: "Through the Cracks" segment featuring Dan Tsai interview scheduled to run on This Week, will post later on streaming

Weekly Medicaid Unwinding Report: June 2

Look Back

18 States/districts Began Procedural Terminations June 1

Alabama, Alaska, Colorado, Georgia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Montana, Nevada, North Dakota, Rhode Island, South Carolina, Tennessee, Vermont, Washington, Wisconsin

District of Columbia

NOTE: Most of these states will be releasing total enrollment data publicly anywhere between June 1 and mid-June. Some (not all) will report on the results of their renewals publicly. CMS is responding to data drops with proactive tweets.

Top Headlines (full clips package attached)

Politico: 'A huge investment': Providers race to keep Medicaid patients covered amid unwinding (6/1)

also attached

Inside Health Policy: CMS, Medicaid Advocates Brief States On Unwinding Messaging

Media Engagement

Interview with Dan Tsai on 6/1 for ABC News "Through the Cracks" scheduled to air on This Week 6/12 and on streaming after

Virtual pen and pad with Dan Tsai and 13 reporters from both local and national outlets, held 5/30

Interview with Dan Tsai and Kaiser on 5/26 (article in attached clips package)

Social

CMS: https://twitter.com/CMSGov/status/1664379124108910594

CBL: https://twitter.com/BrooksLaSureCMS/status/1664374982196035592

HealthCare.gov: https://twitter.com/HealthCareGov/status/1663895357720260608

Medicaid: https://twitter.com/MedicaidGov/status/1664391267055173633

Engagement in the States

- Regional directors and regional administrators facilitated "Kitchen cabinet" calls with stakeholders in Arkansas, Illinois, Louisiana, Missouri, Nevada, Ohio, Pennsylvania, Texas, and Utah. Calls with stakeholders in Florida, Georgia, Idaho, Mississippi, and North Carolina scheduled in the coming weeks.

Hill/other Departmental Engagement

- Briefing for SFC Majority / E&C Minority Committee staff

Paid Media

- Phase II "Lost Medicaid/CHIP? Go to HealthCare.gov" paid outreach expanded to the following states on June 1: Alaska, Alabama, Georgia, Hawaii, Mississippi, Montana, North Dakota, South Carolina, Tennessee, Texas, Wisconsin

Look Ahead

Upcoming Key Dates/Events

- TENTATIVE June 6: Secretary letter to Governors
  - Press release
  - CMS-led pen and pad
  - Other proactive press TBD depending on timing and availability of principals
- June 7: IEA Director Marvin Figueroa will provide keynote remarks focused on redeterminations at the first Idaho Hispanic & American Indian Health Conference in Twin Falls, ID.
- June 8: Secretary Becerra and Region 5 Director will participate in a redeterminations event at NorthPoint Health & Wellness Center in Minneapolis, MN.

- June 8: CMS principal speak on NAACP Health Leads Monthly Forum
    - Press plan to be circulated early week of 6/5
- June 12: briefing for intergovernmental stakeholders (NGA, NACo, etc.)
- June 12: LIS fact sheet

From: Georgetown Center for Children and Families <childhealth@georgetown.edu>
To: Albrecht, Sarah B. (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=usera956839a <Sarah.Albrecht@hhs.gov>
Subject: This Week At CCF...
Date: 2024/01/12 13:00:11
Priority: Normal
Type: Note

View this email in your browser

Georgetown University
McCourt School *of* Public Policy
CENTER FOR CHILDREN
AND FAMILIES

Weekly Roundup

The Biden Administration shared the great news that marketplace enrollment had hit a record-breaking 20 million people during this open enrollment period that ends on January 16. While some of these marketplace enrollment increases are due to people losing Medicaid as part of unwinding transitioning to the marketplace, CCF analysis of the latest monthly unwinding data released by CMS shows only a slight increase in the rate of marketplace enrollment - only up to 13.4% - among those losing coverage through the Medicaid redetermination process. Read Edwin Park's blog to learn more.

While all eyes are on the Congressional funding debate, we are also keeping an eye on Medicaid and CHIP provisions related to mental and behavioral health. Anne Dwyer writes that while there are differences between a House-passed bill and provisions recently marked up by

two Senate committees, there is clear bipartisan interest in policies related to mental and behavioral health.

States have approached the Medicaid unwinding process with varied strategies and moved at far different paces with several failing to take the time to get it right. Curious how your state is doing? Check out the guide to CCF's unwinding and enrollment trackers by researchers Ella Mathews, Allie Gardner and Edwin Park then dive into the data.

Read More on Our 'Say Ahhh!' Blog

Upcoming Webinars

Interested in the delays in expansion of Florida's KidCare program? Join CCF, Florida Policy Institute, and Florida Health Justice Project for a webinar discussing this topic. This webinar will include a discussion on the delay in the context of the federal Medicaid unwinding process, what federal processes and regulations require for implementation, and how the delay will impact Florida's children and families. The webinar speakers include:

- • **Erica Monet Li,** health policy analyst, Florida Policy Institute
- • **Joan Alker**, executive director and co-founder, Center for Children and Families in the Georgetown McCourt School of Public Policy
- • **Lynn Hearn**, senior attorney, Florida Health Justice Project

Register for the Webinar

Unwinding Updates

Data is critical to making informed decisions and improving how government works. That is why CCF continues to track as much data as possible to help shed light on how states are performing and how the unwinding is impacting people enrolled in Medicaid. Here is what is new this week on our 50-state unwinding resource tracker:

- • November reports for Maine and Idaho
- • December reports for Georgia, Idaho, Indiana, Iowa, Nebraska, New Hampshire, North Dakota, Ohio, Texas, Utah, Vermont, and West Virginia
- • Dashboard updates for Virginia

As always, we also have a comparison of state unwinding renewal data updated on a rolling basis available here.

View the Latest Unwinding Data

Featured News Clips

Opinion | Hey, What Happened to My Health Insurance?

The New York Times - Bryce Covert - December 20, 2023

Tamikka Burks was in an Arkansas emergency room when she found out she had lost her Medicaid coverage. In mid-September, she went in to deal with a cyst in her toe, and someone at the hospital informed her that the state's Department of Human Services had cut off her coverage on Sept. 1. Ms. Burks hadn't even heard of the Medicaid unwinding until she was caught up in it. But she's among nearly 427,500 people in Arkansas who have been disenrolled from Medicaid since April. The Biden administration has given states 12 months to

go through the unwinding process, but Republican lawmakers in Arkansas decided to get it done in six months — the shortest timeline announced by any state — to reduce, in Gov. Sarah Huckabee Sanders' words, "government dependency." Some states have tried to move more slowly and carefully to find ways to keep people enrolled. But "there are some states," **Joan Alker**, the executive director of **Georgetown University's Center for Children and Families**, said, "where the politics are just about kicking people off quickly."

Hundreds of millions are being siphoned out of Oregon Health Plan

The Lund Report - Christian Wihtol - December 19, 2023

It happened much as the critics had feared and without any headlines. Last December, a giant for-profit health insurance company pulled nearly $29 million of accumulated Oregon Health Plan profits and reserves out of Oregon, public records show. With state regulators' approval, the Missouri-based company, Centene Corp., moved the money from its Lane County subsidiary to the coffers of the publicly traded parent company. That came atop nearly $6 million Centene had quietly pulled out its Oregon Health Plan operations a year earlier. "The role of dividends in Medicaid is an issue on which reasonable people can disagree. That conversation starts with transparency about those dividends," said **Andy Schneider, a research professor at Georgetown University's school of public policy**, and formerly a Medicaid official in the Obama administration. "Beneficiaries, providers, and the public have a right to know how Medicaid dollars are being spent by organizations that are the stewards of healthcare for their enrollees."

Tax Cuts Don't Pay For Themselves. A New Paper Says Medicaid Might.

HuffPost - Jonathon Nicholson - December 31, 2023

In a paper published last month, the CBO said Medicaid and other programs that provide a long-term boost for the recipients' economic prospects may be far cheaper than their initial price tags, once those long-term effects are included in the calculus. "The CBO analysis is another important contribution to the research literature about the long-term benefits of Medicaid coverage during childhood and pregnancy," wrote **Edwin Park**, research professor at **Georgetown University's Center for Children and Families**, in a blog post.

Visit Our Kids' Health Care Data Hub

Twitter

Website

Email

Copyright © 2023 Georgetown University Center for Children and Families, All rights reserved.

Our mailing address is:

500 First Street NW, Third Floor Washington, DC 20001

Want to change how you receive these emails?

You can update your preferences or unsubscribe from this list.

Sender:	Georgetown Center for Children and Families <childhealth@georgetown.edu>
Recipient:	Albrecht, Sarah B. (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=usera956839a <Sarah.Albrecht@hhs.gov>
Sent Date:	2024/01/12 12:59:59
Delivered Date:	2024/01/12 13:00:11
Message Flags:	Unread