FY 2027 Medicaid Advisory Committee (MAC) Meeting

October 28, 2026| 5:30 PM – 7:30 PM ET

Hybrid Meeting

Housekeeping

- **Introduce yourself in the chat:**
  - Name
  - Organization (if applicable)
  - MAC member or non-member
- **Keep yourself muted unless speaking**
- **You can add questions to the chat or use the "Raise Hand" function**
- **This meeting will be recorded**
  - DHCF will post a recording of the meeting on the MAC webpage after the meeting

Agenda

- **Welcome**
  - Introduction of FY 2027 MAC Members
- **DHCF Updates and Discussion**
  - DHCF Report Q&A
  - Enrollment Update
  - 1115 Waiver Renewal Update
  - Digital Health Roadmap
  - Program Integrity
  - One Big Beautiful Bill Act (OB3) Medicaid Eligibility Changes
  - DHCF Grant Opportunities
- **Subcommittee Report Out**
- **Public Announcements**
- **Next MAC Meeting**

Welcome

Welcome to Our New MAC Members!

- **Aisha Saint Fleur,** Community Member and BAC Member
- **Anjie Shelby,** Chair of the DC Developmental Disabilities Council, Vice-Chair of the DC Commission on Persons with Disabilities, and BAC Member
- **Brandon Whren,** Abrams Assisted Living
- **Damien Cabezas,** Community Connections
- **Donna Anthony,** Health Services for Children with Special Needs, Inc. (HSCSN)
- **Jerome Schorr,** AmeriHealth Caritas DC
- **Jessica Althaus,** Community Member and BAC Member
- **Katherine Saavedra,** Mary's Center
- **Leslie Lyles Smith,** UnitedHealthcare
- **Nathaniel Ellis,** Community Member and BAC Member
- **Pamela Henderson,** Public Defender Service for DC

DHCF Updates and Discussion

DHCF Report Q&A / Enrollment Update

Managed Care Plan (MCP) Transition

1115 Waiver Renewal Update

Program Integrity

Digital Health Roadmap

One Big Beautiful Bill Act (OB3) Medicaid Eligibility Changes

DHCF Report Q&A

SPA/Waiver/Rule Report

Eligibility and Enrollment Update

Enrollment Update

- Medicaid enrollment saw a substantial decrease in January 2026.
  - This is largely due to the transition of childless adults and parent/caretaker relatives with incomes above 138% FPL to HBX eligibility.
  - While the most recent months show a decrease, numbers will be higher when run in the future due to retroactive eligibility.
- The Alliance program, which is now inclusive of adults and children under age 21 formerly under the former Immigrant Children's Program (ICP), has seen enrollment decreases since early 2025.
  - This is due in part to fewer applications and more individuals who must respond to a renewal notice to retain coverage.
  - For October 2025 and beyond, it also reflects a reduction in adult eligibility to 138% FPL. In addition, there was a moratorium on enrollment of new adults age 26 and older from October 2025 through September 2026.
  - For comparison to current figures, FY 2019 (pre-PHE) average monthly enrollment for Alliance children was approximately 3,500 and for Alliance adults it was approximately 15,700.

Program	FY 2025	FY 2026											
	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06	2026-07 (preliminary)	2026-08 (preliminary)	2026-09 (preliminary)
Total	**307,078**	**304,200**	**301,505**	**299,886**	**280,518**	**280,619**	**277,939**	**275,801**	**274,473**	**273,368**	**271,620**	**268,176**	**264,643**
Medicaid	276,803	277,272	276,606	276,454	259,041	260,318	259,170	258,281	257,496	256,948	255,846	253,156	250,193
Alliance children	5,316	5,105	4,864	4,615	4,285	4,079	3,814	3,598	3,499	3,400	3,279	3,170	3,087
Alliance adults	24,959	21,823	20,035	18,817	17,192	16,222	14,955	13,922	13,478	13,020	12,495	11,850	11,363

1115 Waiver Renewal Update

CMS Approved DC's Whole Person Care Transformation 1115 Waiver; Includes Continuation of IMD Services and New Reentry Services

- On September 23, 2026, CMS issued approved DHCF's Whole Person Care Transformation 1115 Waiver. The waiver authority will begin on October 1, 2026 and run through September 30, 2031.
- Approved services include:
  - A continuation of coverage for stays in residential treatment facility (Institution for Mental Disease, IMD) for substance use disorder (SUD) and severe mental illness (SMI) for less than 60 days for individuals 21-64;
  - Justice-involved reentry services for 60 days prior to expected date of release for adult facilities and 90 days prior to release for juvenile facilities including:

Approved reentry services	
• Reentry case management • 30-day medication supply upon release • All forms of medication assisted treatment (MAT) for SUD	• Behavioral health counseling/therapy • Peer support services • Intensive, family-based services for youth • Physical and behavioral health screening & diagnostic • All prescription drugs during pre-release time-frame

- CMS did not approve DHCF's request for health-related social needs (HRSN) services.
- The removal of the $1 copay for medication-assisted treatment (MAT) drugs will move to state plan authority beginning October 1, 2026.

DHCF Will Work With Partners Over The Next Year to Support Implementation of the Waiver

- Beginning on October 1, 2026, IMD services will be fully carved in to managed care for managed care beneficiaries. This creates a simplified authorization process and reduces administrative burden on providers.
  - This change was detailed in Transmittal 26-26.
- DHCF is planning to submit a state plan amendment that will eliminate MAT cost-sharing with an effective date of October 1, 2026.
- To prepare for October 1, 2027 implementation of reentry services, DHCF is:
  - Coordinating with DOC and DYRS on policy development and operational readiness
  - Developing implementation and reinvestment plans
  - Creating operational documents and guidance to support implementation
  - Leveraging the Integrated Care Technical Assistance program to support providers
  - Working with community stakeholders to gather additional input on integrate previously gathered feedback on new reentry services
- DHCF will provide a comprehensive update on past and upcoming waiver implementation activities at the December MAC meeting, which will serve as our 1115 Demonstration Annual Post-Award Stakeholder Forum.

1115 HRSN Concept Paper

- To continue DHCF's efforts to advance access to HRSN services, we are now focusing on housing services that:
  - Are more clinically-focused and targeted (e.g., population- or service-specific) to the needs of District residents.
  - Align with current CMS priorities.
- DHCF is developing a concept paper to receive initial feedback and align with CMS on a more focused HRSN approach, using input from the Health System Redesign (HSR) Subcommittee.
  - DHCF will share the concept paper with HSR Subcommittee members for review and input prior to finalization.

2027–2031 DC Digital Health Strategic Plan and Roadmap

Efforts Have Been Underway To Refresh The District's Digital Health Roadmap

- The District's Digital Health Roadmap establishes long-term priorities for improving how health information is shared, accessed, and used across the District.
- Previous roadmap iterations were completed in:
  - 2018
  - 2022
- The roadmap establishes long-term priorities for:
  - Health Information Exchange (HIE)
  - Digital health infrastructure
  - Interoperability and data sharing
  - Provider and resident access to health information
- Designed as a "living" document that is regularly updated to remain responsive to community and system needs

DHCF is Working with DCPCA and Public Consulting Group (PCG) to Update our Roadmap in 2026!

- Build on the District's existing digital health investments to support better coordinated, more effective, and person-centered care.
  - **Assess progress since 2022:** Understand how the District's digital health capabilities and use of health information exchange have evolved.
  - **Identify current needs and gaps:** Examine where existing technology, data sharing, and services can be improved.
  - **Reflect stakeholder priorities:** Incorporate feedback from providers, community organizations, government agencies, and other partners.
  - **Set priorities for the next five years:** Identify strategic goals and actions to improve access to, sharing of, and use of health information.

What We Heard From Stakeholders

- DHCF and its partners conducted 43 stakeholder interviews and 8 focus groups to better understand current digital health needs and priorities.
- Stakeholders consistently emphasized that expanding access to health information is important, but access alone is not enough.
- Cross-cutting needs included:
  - Stronger data quality and standardization.
  - Improved interoperability across systems and sectors.
  - Clear governance, consent, and privacy frameworks.
  - Better integration of information into existing workflows.
  - Role-specific technical assistance and adoption support.
  - Analytics that help stakeholders identify gaps and take action.

What's Included in the Updated Roadmap?

- The 2027–2031 Digital Health Strategic Plan and Roadmap outlines where the District stands today, what improvements are needed, and how the District plans to advance digital health over the next five years.
- The document includes 3 key components:

1. Current Digital Health Landscape
   - Reviews progress since 2022, including expanded HIE participation, new capabilities, and how health information is being used across the District.
2. Stakeholder Feedback and Emerging Needs
   - Summarizes stakeholder priorities, existing challenges, and the policy and program developments shaping future digital health investments.
3. Strategic Goals, Recommended Actions, and Implementation
   - Establishes seven goals and identifies actions to strengthen digital health capabilities, information sharing, care coordination, and health outcomes.

The Roadmap Identifies Seven Strategic Goals

1. **Enhance Whole Person Care for District Priority Domains**: Invest in digital health enhancements that enable seamless, actionable data exchange to support comprehensive, person-centered care and improved outcomes across District-wide priority domains, including behavioral health care, chronic disease prevention, maternal health care, and health-related social needs.
2. **Expand Digital Health Technical Assistance:** Expand technical assistance, training, and communication to provide sustained, workflow-integrated use of digital health tools and services.
3. **Enable Public Health Data Exchange:** Enable multidirectional exchange of public health data through the HIE to enhance disease surveillance, program administration, reporting capabilities, and delivery of actionable information back to care teams.
4. **Improve Foundational HIE Data Quality:** Improve foundational HIE data quality and availability to ensure accurate, complete, and timely information for care coordination and decision making.
5. **Enhance Transitions of Care:** Enhance transitions of care with actionable information exchange, timely event notification, and relevant alerts that support coordination and follow up across care settings.
6. **Strengthen Advanced Population Health Analytics, VBC, and Quality Improvement:** Improve and expand advanced analytics capabilities to support population health management, value-based care, quality improvement, and data-informed clinical decision making.
7. **Bolster Interagency Collaboration, Governance, and Sustainability:** Deepen interagency collaboration and investment to drive coordinated innovation, strengthen data governance and stewardship, and support long-term sustainability of the District's HIE.

DC Wants to Hear From You!

- DHCF invites providers, community organizations, residents, and other stakeholders to review the draft roadmap and share feedback before the plan is finalized.
- We are especially interested in feedback on:
  - Whether there are additional challenges, priorities, or opportunities that should be addressed.
  - How the District can best support implementation and ensure digital health investments benefit providers and residents.
- A copy of the Roadmap will be published on the DHCF website in mid-November with instructions for how to submit public comments.
- Your feedback will help inform the final roadmap and guide the District's digital health priorities for 2027–2031.

Program Integrity Overview

DPI Mission Statement

The mission of the Division of Program Integrity is to provide a reasonable and consistent system of oversight of the Medicaid program which effectively encourages:

- Compliance
- Accountability
- Protection of public funds
- Awareness and responsibility
- Providers meeting participation requirements
- Services being medically necessary
- Payments in the correct amount for covered services

The goal is to reduce and eliminate fraud, waste, and abuse in the Medicaid Program.

The duties of Program Integrity include prevention, investigation, education, auditing, and the recovery of improper payments in cooperation with the Medicaid Fraud Control Unit (MFCU) and other federal/local law enforcement agencies.

Introduction: The Importance of Program Integrity

Medicaid is a vital program providing essential healthcare services.

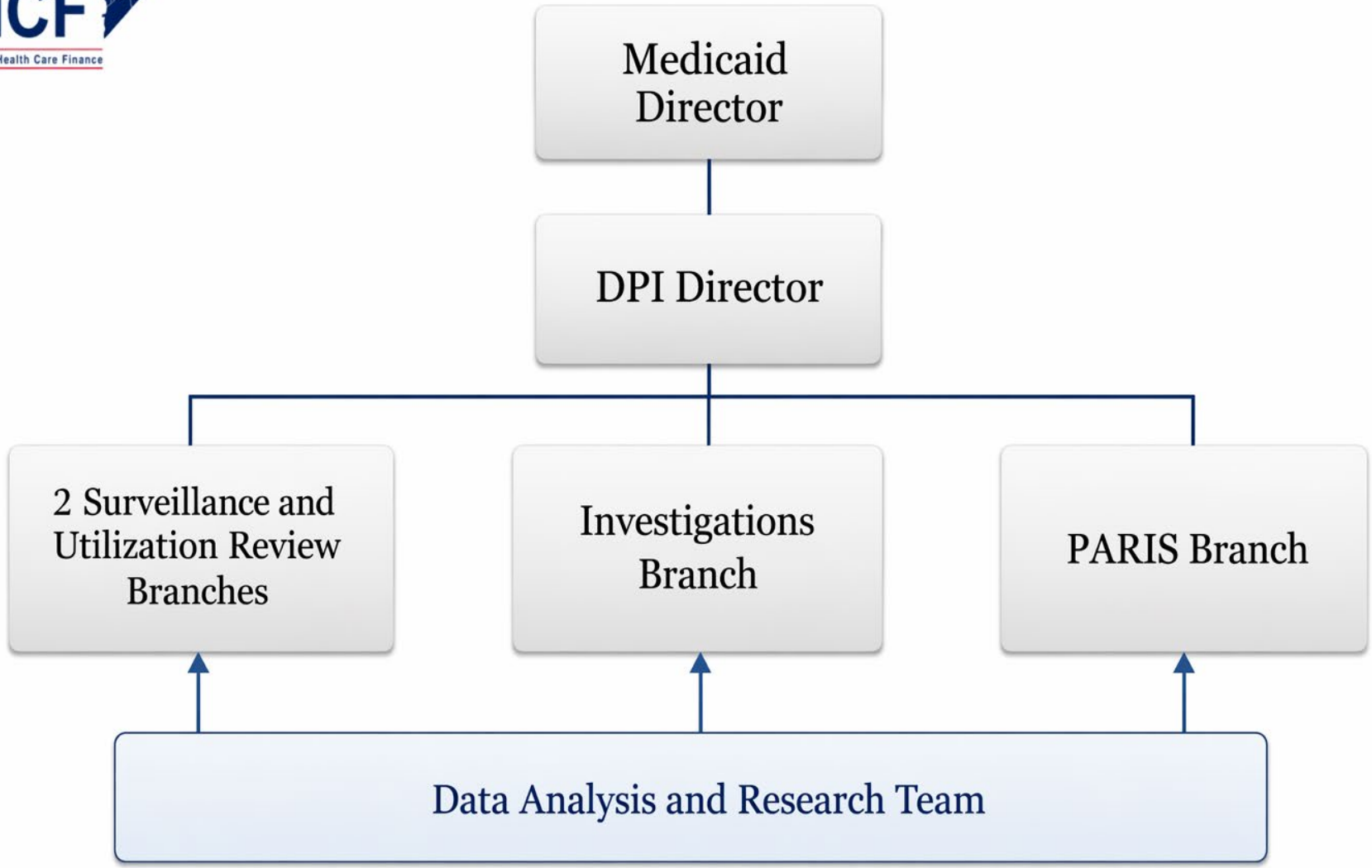
Program integrity safeguards these resources for eligible beneficiaries.

It ensures appropriate and accurate payments to providers for services rendered.

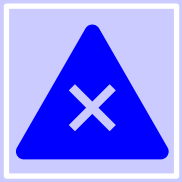
Strong program integrity fosters trust and accountability within the healthcare system.

How DC Medicaid Organizes Its PI Team

- The Division of Program Integrity (DPI) is responsible for detecting, preventing, and correcting fraud, waste, and abuse (FWA).
- DPI includes:
  - SURS Branch (MCO/FFS)
  - Investigations
  - Data Analytics (DART)
  - PARIS
- SURS Branches function as the **front-line surveillance unit**, reviewing billing, utilization, and provider activity.
- Investigations Branch investigates allegations of fraud.
- DART supports all DPI activities, including providing data to DHCF's law enforcement partners for investigations and criminal prosecution.
- PARIS Branch reviews cross-state Medicaid beneficiary eligibility.


Medicaid Director
DPI Director
2 Surveillance and Utilization Review Branches
Investigations Branch
PARIS Branch
Data Analysis and Research Team

Fraud, Waste, and Abuse (FWA): Understanding the Differences



Fraud: Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.

Example: Billing for services not rendered, falsifying diagnoses to justify unnecessary services, kickbacks for referrals.

Federal Citation: 42 U.S.C. § 1320a-7b (Criminal penalties for acts involving Federal health care programs)

Waste: Practices that, directly or indirectly, result in unnecessary costs to the Medicare and Medicaid programs. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

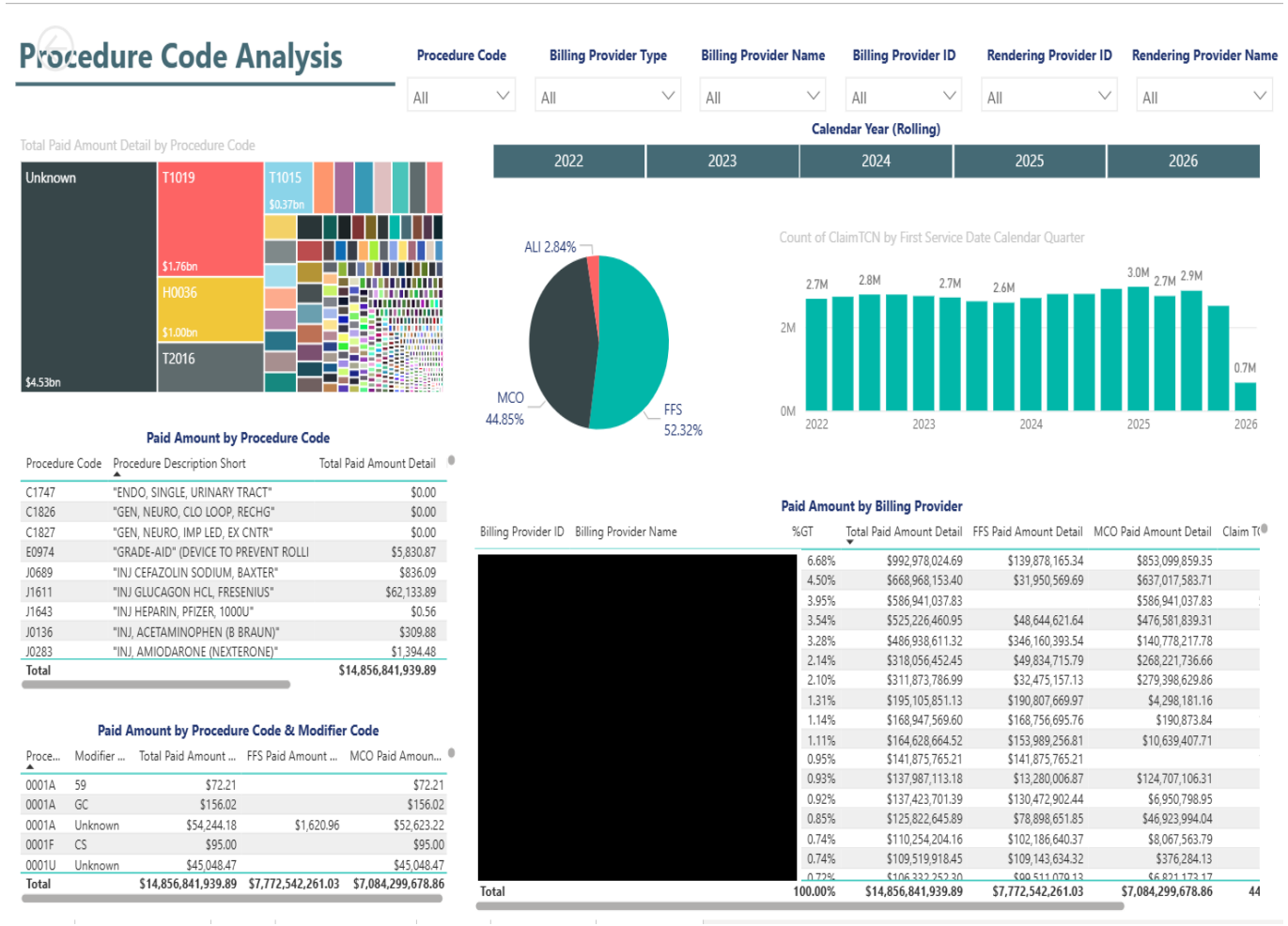
Example: Ordering excessive tests or services, inefficient administrative practices.

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare and Medicaid programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

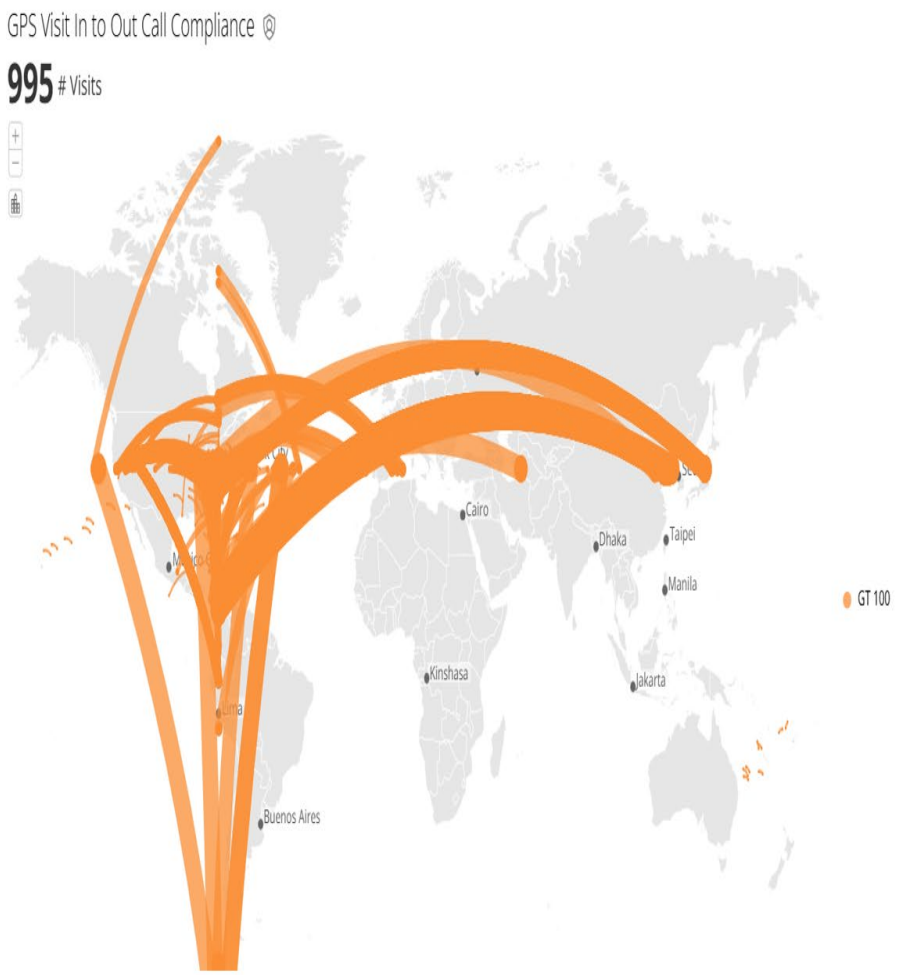
Example: Billing for services that do not meet medical necessity criteria, upcoding services (billing for a more expensive service than provided).

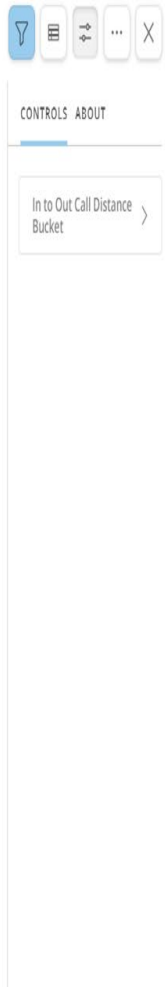
Combating Fraud, Waste, and Abuse

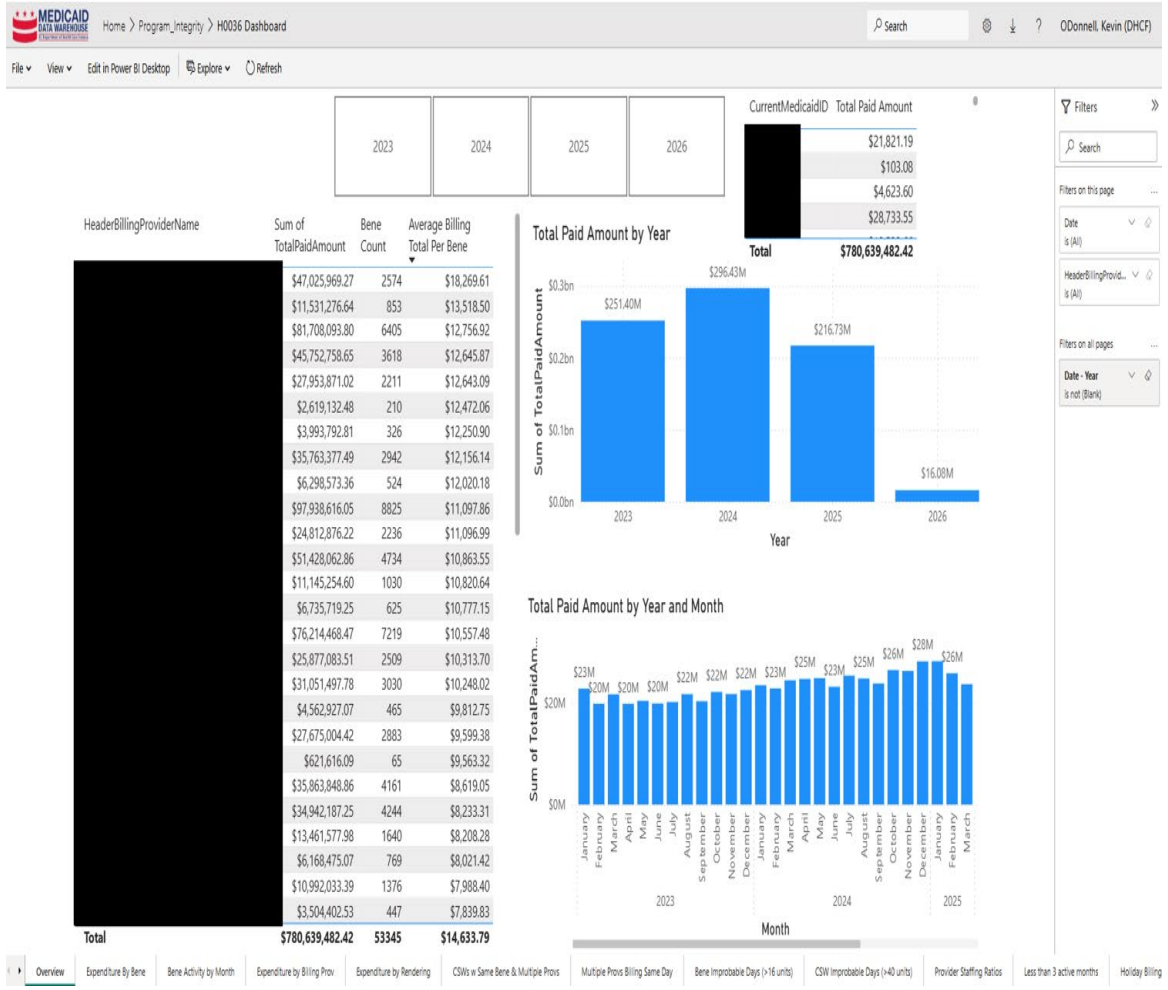
- Data analytics and surveillance
- Provider screening and risk categorization performed at enrollment
- Ongoing FWA education for new and existing providers, including targeted training with DBH and MFCU
- Required CMS “Documentation Matters” training for audited providers
- Post-payment audits of high-risk providers using federal data sources
- Collaborative audits with PBM and UPIC to broaden oversight
- Provider Awareness Letters and self-audit initiative based on analytic findings
- Coordination with MCOs on recoupments and investigation referrals



Data Analytics: Visualizing Vulnerabilities







Criminal Investigation Referral Process

42 CFR Section 455.23

- 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.

Payment Suspension Committee

- MFCU/Law Enforcement Coordination: GCE?
- SME Participation: State Medicaid Director, Division of Program Integrity staff, Health Care Operations Administration, and subject matter experts in the areas relevant to the service modalities at issue.
- Do the facts support a "credible allegation of fraud" determination?
- Do any relevant GCEs apply?

Law Enforcement Referral

- Note that the referral occurs regardless of whether or not a GCE has been granted.

Payment Suspensions: What is a CAF?

Payment Suspensions Due to the Presence of Credible Allegations of Fraud

- Examples of Credible Allegations of Fraud that formed the basis for recent payment suspensions include, but are not limited to, the following:
  - Billing for services not rendered;
  - Impossible day billing;
  - Paying inducements to beneficiaries;
  - Billing for in person services to hospitalized beneficiaries;
  - Missing or falsified documentation;
  - Billing for in office services on days when the office was closed (holidays/weekends);
  - Documentation signed prior to the service start-/stop-time;
  - Conflicting/overlapping services (by the provider or for the beneficiary);
  - Cloning (in treatment notes or in plans of care);
  - Wrong names seen in documentation;
  - Duplicate billing

Key Relationships In Medicaid DPI Work

- **Law Enforcement**
  - DC OIG: Medicaid Fraud Control Unit
  - Federal Bureau of Investigations
- **Federal Agency Partners**
  - HHS/CMS
  - Unified Program Integrity Contractors (UPIC)
  - Payment Error Rate Measurement (PERM) Audits
- **Sister Agencies**
  - DBH
  - DDS
  - DHS/ESA
  - DOH
- **Managed Care Organizations (MCOs)**

DPI: Looking Ahead

- Strengthened Federal/District partnerships
- With the recent rollout of a new MMIS and a FWA data analytics tool from Alivia, DHCF-DPI continues to advance and build a more automated, predictive, and robust analytical framework while streamlining our investigatory workflows.
- Moving from Pay-and-Chase to Caught-and-Stopped

Forthcoming Proposed Rulemaking on Beneficiaries' Role and Responsibility in Program Integrity

- Past investigations showed that some personal care aides (PCAs) and Medicaid beneficiaries worked together to submit false timesheets.
  - PCAs were paid for hours they could not have worked, including times when they were out of the country or claimed to be in two places at once.
  - Some beneficiaries signed off on hours that PCAs did not work and received cash or gift cards in return.
  - DHCF was able to take action against the PCAs but not the beneficiaries involved in fraud at the time because the agency did not have a way to do so.
- DHCF is preparing to release a proposed rule that clarifies Medicaid beneficiaries' responsibilities in program integrity, and the potential consequences if they engage in fraud or abuse.
- Initial presentations and feedback from the BAC and legal advocacy groups.

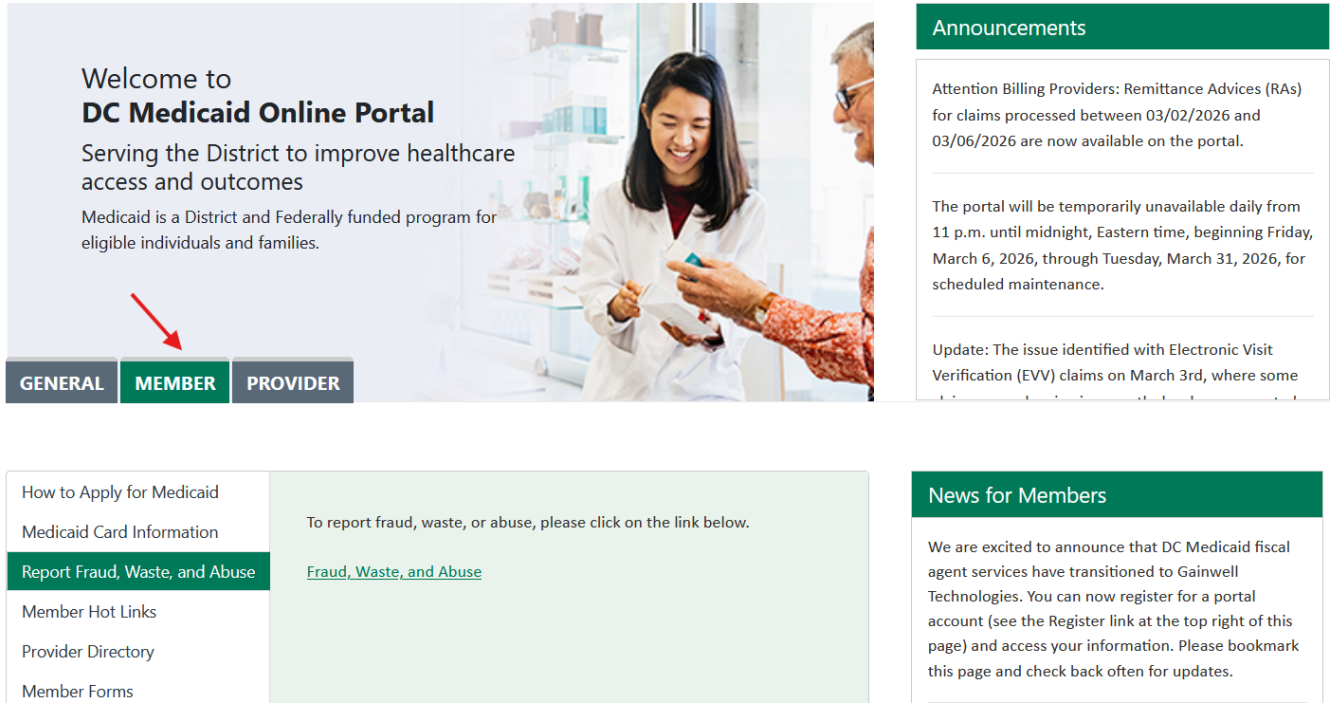
WAYS TO REPORT FRAUD, WASTE OR ABUSE

Fraud Hotline: 1-877-632-2873 (Monday - Friday, 8:00 a.m. - 4:30 p.m.)

Web Address: https://dhcf.i-sight.com/external/case/new

Mail Address: 441 4th Street NW, 900 S.
Washington, DC 20001

Phone: (202) 698-2000



Questions?

One Big Beautiful Bill Act (OB3)
Medicaid Eligibility Changes

Changes to Medicaid Will Roll-Out Over the End of 2026 and Beginning of 2027

- **October 1, 2026:** Some persons with legal immigration statuses lost Medicaid coverage, but most were able to transition to other programs
- **January 1, 2027:**
  - Some adults will have to show work, volunteer or school hours (the “work requirement”) to be eligible for Medicaid
  - Some adults will have to recertify their eligibility every 6 months to keep Medicaid
  - Medicaid retroactive coverage will change from 3 months to either 2 months or 1 month
  - DHCF will allow for the deduction of moving expenses for eligibility for some people
  - DHCF will be required to take action to reduce duplicate or deceased enrollment
- **January 1, 2028:**
  - DHCF will cap the home equity allowed for eligibility from long term services and supports at $1 million

Important Reminder: Work Rules Do Not Apply to Everyone!

Most People Are **Not** Affected: Nearly 8 Out of 10 People will not encounter new eligibility rules!

Medicaid work requirements do not apply to:

1. Children under 19
2. Adults 65 and over
3. Enrolled in Waiver Programs (EPD, Services My Way, IDD, IFS)
4. Individuals Receiving Long Term Care in Nursing Homes
5. Enrolled in PACE Program
6. Individuals with Disabilities or serious health conditions (Non-Magi)
7. Parents and Caretakers of minor children

A Small Group **Is** Affected: About 2 Out of 10 People Will Have to Follow the New Rules!

Medicaid work requirements do apply to:

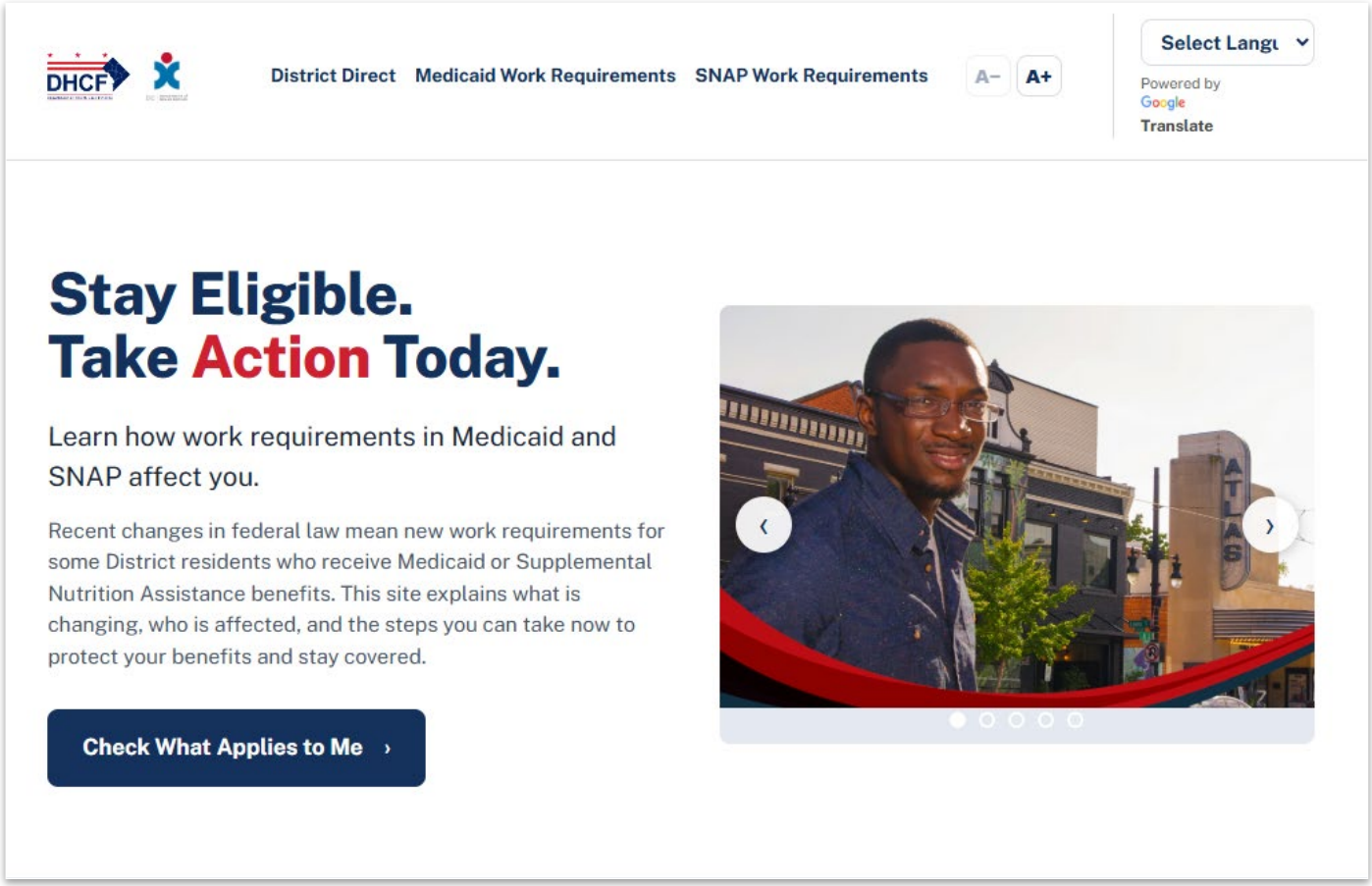
1. Adults aged 19-64
+ 2. No Dependent Children
+ 3. Not disabled or pregnant
= 4. Medicaid Expansion Population (Childless Adults)

Reminder: Some Individuals Will Meet an Exclusion or Exception for Medicaid Work Requirements

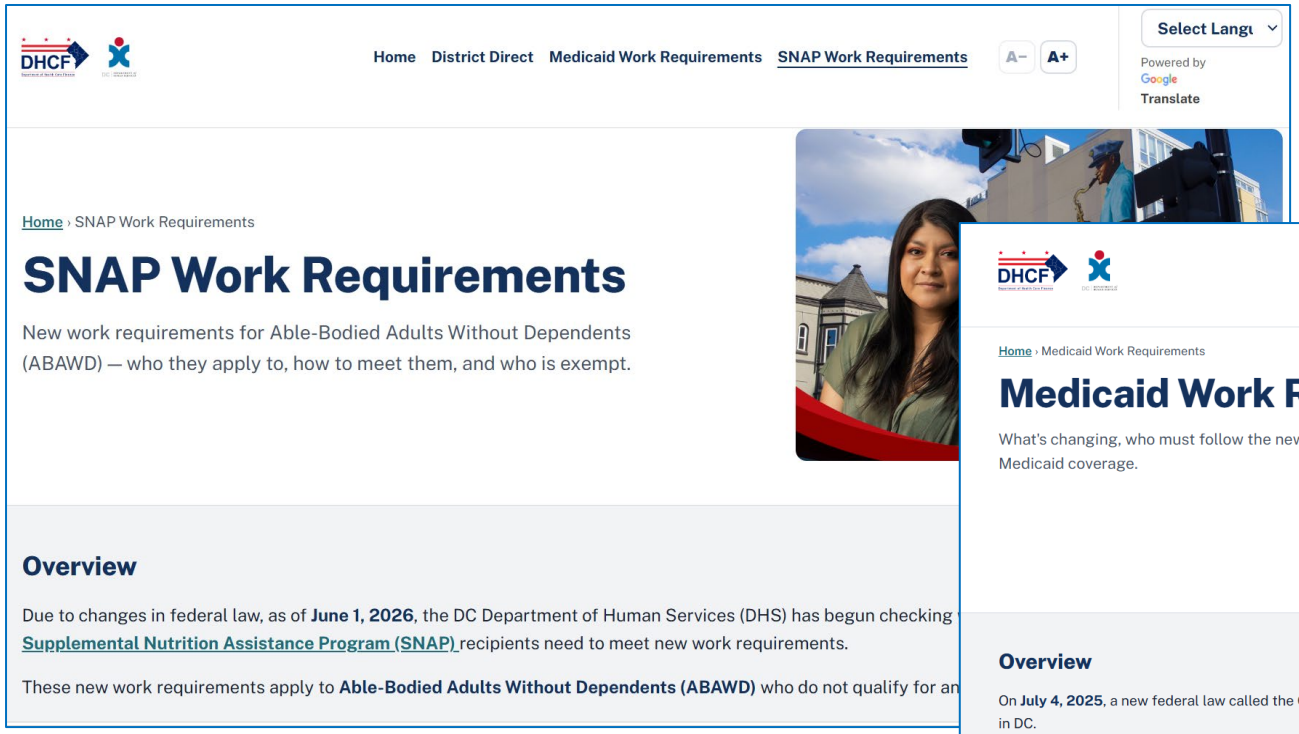
Exclusions	Exceptions
•Former Foster Child	•Under 19 or over 65
•American Indian or Alaska Native	•Entitled to or enrolled in Medicare Part A and B
•Parent, Guardian, Caretaker Relative or Family caregiver of dependent child who is 13 years or under or of a disabled individual.	•Mandatory Categorically Needy Eligibility group (SSI, aged, blind, disabled, children, foster care/adopted children, pregnant and low-income parents and caretaker relatives.
•Veteran 100% rating	•An inmate released within 3 months before they are subject to work requirements
•Medically Frail (blind, disabled, chronic substance use order, disabling mental disorder, physical, intellectual or development disability that significantly impairs daily living or serious or complex medical conditions.	•Short Term Hardship- States have the option to implement •Inpatient hospital, nursing facility, intermediate care for individuals with intellectual disabilities, inpatient psychiatric hospital or similar acuity •Emergency disaster declared by the President •Unemployment rate is above or 1.5 times national unemployment •Travel outside of community for an extended period to receive medical services.
•SNAP and TANF compliant	
•Drug Addiction or Alcoholic treatment or rehabilitation	
•Inmate of public institution	
•Pregnant or entitled to postpartum	

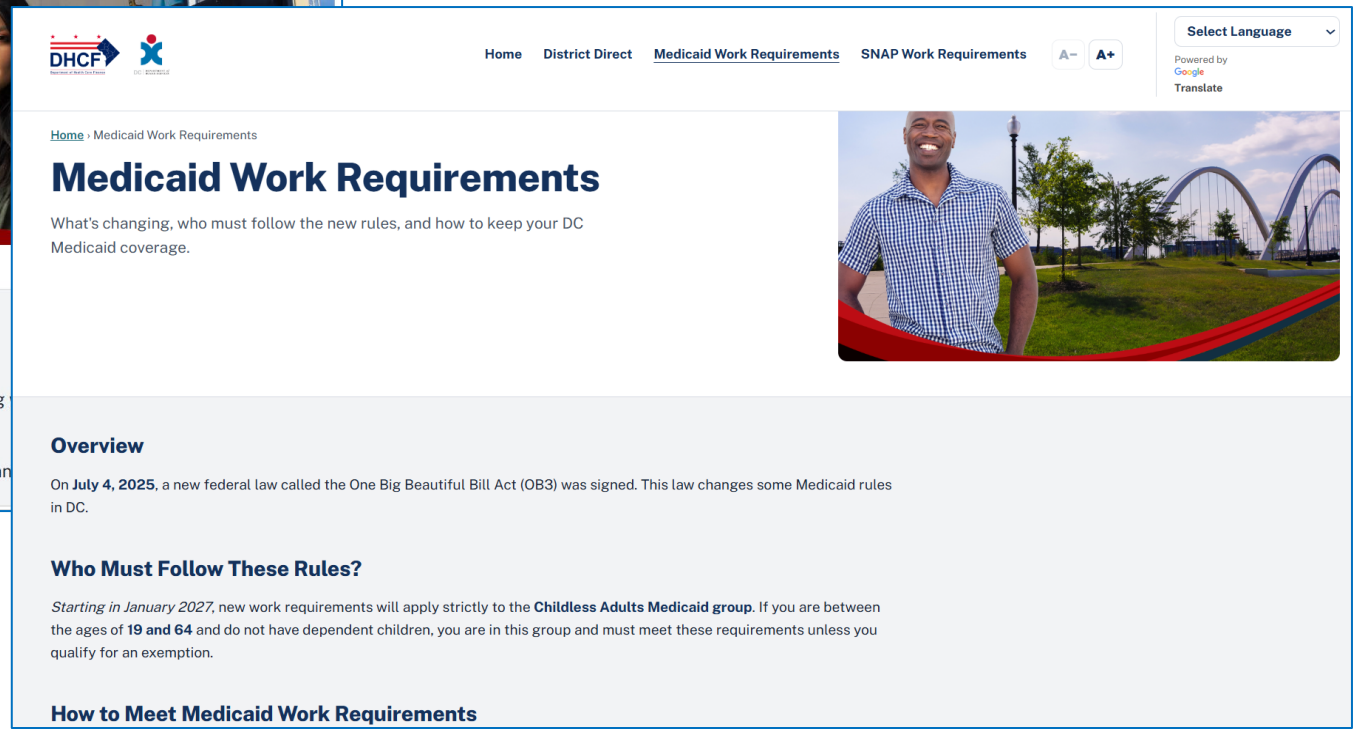
Now Live: Work Requirements Screener for Residents and More Information on the Joint DHCF-DHS Work Requirements Website

- The screening tool lets residents with Medicaid, SNAP, and/or TANF get a sense if work requirements will apply to them.
- Visit: https://workrequirements.dc.gov/



Now Live: Joint Work Requirements Website Features Medicaid and SNAP Sub-Pages with Detailed Info and FAQs





Now Live: New Information Will Be Added, Including a Communications Toolkit

- Questions in programmatic screener were developed and tested with support of The Lab @ DC.
- Website will be enhanced with additional materials over time, including **outreach materials** and additional resources for residents seeking **workforce and community engagement support**
- If you have feedback on the website, feel free to reach out to medicaid.renewal@dc.gov

DHCF Submitted a Short-Term Hardship Request on Work Requirements for Affected Residents Living in Wards 7 and 8

- OB3 permits states to deem applicable individuals compliant with work requirements during a short-term hardship, including residence in a county or equivalent unit of local government with high unemployment.
- *The District applied for a Short-Term Hardship Request Based on High Unemployment for Wards 7 and 8 on October 16, 2026.*
- Based on data published by DOES, both areas have unemployment rates at or above the lesser of 8 percent, or 1.5 times the national unemployment rate (the threshold in the legislation).
- We will share any responses from CMS at future meetings.

CMS Recently Released Additional Guidance on Medical Frailty and DHCF's Work Is Ongoing

- Interim final rule (IFR) from CMS requires states to develop a list of diseases, diagnoses, disorders, or other health conditions to identify individuals who are medically frail.
  - Must be auditable, justifiable, and consistent with the IFR definition of medically frail.
  - Must be revised on a regular basis to add or remove conditions based on the state's experience applying medically frail exemptions.

- DHCF is taking a variety of steps to operationalize this requirement.
  - Identified an initial list of specific codes (diagnosis, procedure, etc.) that indicate a condition consistent with medical frailty, which was developed using external sources with documented methodologies (e.g., Harvard School of Public Health definition; clinical risk group codes from Solventum/3M; Healthcare Effectiveness Data and Information Set values referenced by CMS).
  - State workgroup calls on medical frailty have highlighted that refinement will need to be ongoing.
  - Before DHCF releases condition list details externally, additional internal review and discussion is needed.

Similar to Other States, DHCF Is Using a Tiered Approach for Assessing Medical Frailty

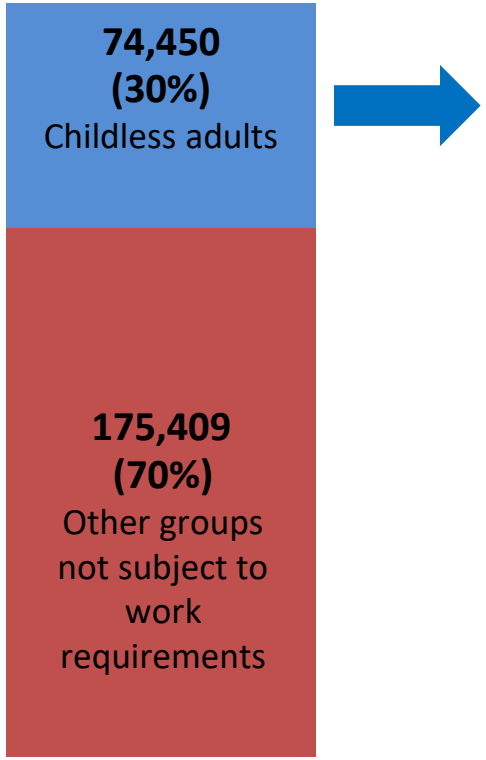
- Consistent with a model outlined by CMS in a document released on September 8, DHCF's medical frailty condition code list reflects a tiered approach.
  - Some codes (largely reflecting diagnoses) are sufficient on their own to indicate medical frailty and are included on a standalone list.
  - Other codes indicate potential medical frailty but need additional support and must be paired with a second code.
  - DHCF's initial list requires the two codes to be present on the same claim; for example, a single medical visit with a diagnosis that indicates potential medical frailty and a service/procedure during the visit that supports severity of the condition.
- The tiered approach is intended to address a provision in the Interim Final Rule form CMS that indicates an individual is considered medically frail **only if their physical, mental, or other behavioral health condition significantly impairs their ability to comply** with the Medicaid work requirement.

DHCF Will Verify Medical Frailty Using Both Electronic Data and Information Provided by Beneficiaries

- Electronic data includes sources such as:
  - Medicaid claims adjudicated in prior 12 months from MMIS (will be in use for January 2027 go-live)
  - Electronic health record data from CRISP DC, the District's Health Information Exchange (HIE) entity, which reflects real-time information from providers (to be added in 2027, timing to be determined)
- When electronic information is not available, other sources will be used, including:
  - Self-attestation (permitted any time in 2027 and limited to once per enrollment period in 2028 and beyond)
  - Manual review of documents submitted by or on behalf of a beneficiary/applicant (process under development)
  - Forms submitted by providers (e.g., facilitated by an electronic version under development in CRISP)

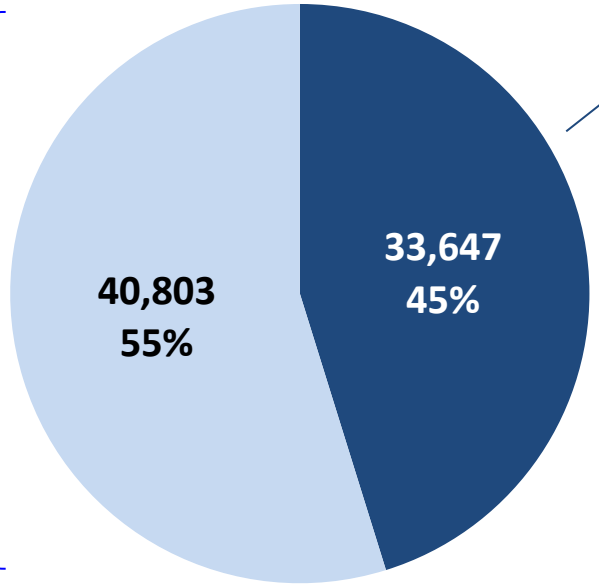
For Medicaid Childless Adults Subject to Work Requirements in the District, 55% Appear Compliant or Exempt Based on Currently Available Data

September 2026 Medicaid Population Breakdown



Childless Adult Breakdown

55% are projected as compliant based on income or exempt based on medical frailty; no additional work or exemption evidence required



45% require additional work or exemption evidence because income data does not show compliance (at least $580 in a month or 44% FPL) and claims data does not indicate a medical frailty exemption; currently unclear what proportion will ultimately maintain coverage

Source: Data extracted from DHCF's Medicaid Management Information System (MMIS) on 10/13/2026. **Notes:** Enrollment is point in time as of 9/30/2026 and medical frailty is based on claims extracted for the prior 12 months. Income in compliant range is at least $580 in a month (approximately 44% FPL).

Next Steps on Medical Frailty

- DHCF will make the medical frailty code set publicly available and we will seek comment / input.
  - Expect release between late November and early December.
  - DHCF will use this initial code set when work requirements go live 1/1/27.
  - DHCF wants to allow time for public review and comment and will aim to finalize the code set by June 2027. From November to June, DHCF will revise the code set as needed.
  - Webpage will be devoted to medical frailty and include:
    - Code set
    - Process for determining medical frailty
    - Other relevant information
- Reminder: Self-attestation is allowable in 2027.

Eligibility Screener – Medical Frailty Self-Attestation

Section 4: Disability or Caregiving

4	*Choose any of the activities below that you currently do. (Check all that apply and fill in the blanks or mark as "N/A").*
	
	☐ ***I provide care for a person with a disability and/or a child under 13.***
	• If yes, do you live with this person?
	  ○ ☐Yes
	  ○ ☐No
	• Next, is this person a member of your family (relative)?
	  ○ ☐Yes, they are family
	  ○ ☐No, they are not family
	(Only answer if you picked, "no they are not my family "in question above)
	• How many hours a month do you help this person? # of hours: _____
	☐ This does not apply to me.
	
	☐ ***I am medically frail or have a special medical need that is listed below.***
	• Blind or disabled
	• Substance Abuse Disorder (SUD)
	• Disabling Mental Disorder
	• Body, mind or learning problem that makes it hard to take care of yourself every day or a serious illness.
	  ○ If yes, does this condition keep you from working, looking for a job, going to school, or volunteering? ☐Yes ☐No
	
	☐ This does not apply to me.

DHCF Grant Opportunities

DHCF Grant Opportunities

- DHCF has recently released Notice of Funding Availability (NOFA) and Requests for Applications for several grant programs.
- Below is an overview of the grant opportunities, and information is also available on the DHCF Grant Opportunities webpage.

Public Notices	Summary	Application Packet	Submission Deadline
FY27 Diaper Bank Grant Program	NOFA	RFA Attachments	4 pm, November 23, 2026
FY27 Medical Respite Care Program	NOFA	*Forthcoming*	4 pm, December 7, 2026
FY27 Produce Prescription (Rx) Program	NOFA	*Forthcoming*	4 pm, December 7, 2026
FY27 FQHC Services for Uninsured DC Residents Grant	NOFA	*Forthcoming*	4 pm, December 7, 2026

Subcommittee Report Out

Health System Redesign (HSR) Subcommittee

Long-Term Care (LTC) Subcommittee

Child Health Subcommittee

For Official Government Use Only

Seeking Members for Child Health Subcommittee

- The first meeting of the Child Health Subcommittee will take place on **Wednesday, November 18 from 10:30am – 12:00pm.**
  - The Child Health Subcommittee will meet bimonthly thereafter.
- DHCF is seeking members to participate in the Child Health Subcommittee, including:
  - Individuals with lived experience in Medicaid, including current and former Medicaid members and family members/caregivers of Medicaid members
  - Providers with a focus on children's health care
  - Community-based organizations that serve children and families
  - Other community partners
- If you are interested in participating in the Child Health Subcommittee, please email: colleen.sonosky@dc.gov.

Public Announcements

Get Involved and Make Sure You're Getting Updates

- The next MAC meeting is scheduled for **Wednesday, December 9 from 5:30 – 7:30 PM.**
- If you (or other community members and partners) are not already receiving MAC meeting invites, you can email dhcfMACandBAC@dc.gov and we will add you to the list.
- **If you are already receiving MAC invites and emails, no action is needed.**