

## DEPARTMENT OF HEALTH CARE FINANCE

### NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (“DHCF”), pursuant to the authority set forth in Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6)), An Act To enable the District of Columbia to receive Federal financial assistance under title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), and Mayor’s Order 2024-115, dated July 1, 2024, hereby gives notice of his adoption of a new Section 933 to Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (“DCMR”).

DHCF is the single state agency responsible for the administration of the State Medicaid program, under Title XIX of the Social Security Act, in the District. In 1993, Medicaid beneficiaries filed a class action lawsuit, *Salazar v. District of Columbia*, Civil Action No. 93-452 (TSC) (D.D.C.), alleging the District violated the Medicaid statutes by failing to process and decide applications for Medicaid eligibility in a timely manner, failing to provide adequate notice before suspending or terminating benefits, and failing to provide early and periodic screening, diagnostic, and treatment (“EPSDT”) services. In 1999, a settlement order was entered by the Court, and on September 2, 2005, the Court issued a subsequent order clarifying the eligibility requirements for reimbursement to a beneficiary or their family member for expenses of covered Medicaid services and the processing of those reimbursements. DHCF thereafter implemented procedures to implement the Court’s order.

These rules formalize the reimbursement procedures in District regulations and extend the time for seeking reimbursement. A proposed rulemaking was published in the *District of Columbia Register* on October 31, 2025, at 77 DCR 012181. DHCF received comments from one stakeholder during the public comment period. Each of the stakeholder’s comments are addressed below.

Comment: The commenter stated that the cross-reference to 29 DCMR §§ 9501.8 – 9501.12 at section 933.1(a) only captures a subset of the Medicaid population and does not include beneficiaries who qualify for Medicaid under other distinct pathways.

Response: DHCF acknowledges the commenter’s concern, and consistent with DHCF’s originally intent, has amended the language at section 933.1(a) to capture all eligibility categories.

Comment: The commenter stated that while section 933.2(a) provides a list of reimbursable out-of-pocket expenses for medically necessary services, the list does not include a full description of the services available to children through EPSDT. The commenter suggested that a new subparagraph “(5)” be added to section 933.2(a) to describe EPSDT services.

Response: DHCF acknowledges the commenter’s concern and has added language to the proposed rules at section 933.2(a) to clarify that any service included in the Medicaid State Plan is covered. While EPSDT services are not called out specifically, coverage of services under the Medicaid State Plan includes coverage of EPSDT services as required by federal law and assured in the District’s Medicaid State Plan.

Comment: The commenter expressed concern that, without a clear explanation in the rulemaking, beneficiaries with third-party liability and the managed care plans (“MCP”) that cover them, would not understand that Medicaid is the payer of last resort. The commenter also expressed concern that the beneficiary would not receive timely denial of coverage from their third-party insurer, which may impact their ability to timely request reimbursement from the Medicaid program. The commenter suggested that a statement be added to section 933.2(c)(4), explaining that Medicaid is the payer of last resort.

Response: It is well established under section 1905(a)(25) of the Social Security Act that Medicaid is the payor of last resort. The absence of a need to provide further clarification in District regulations on this matter is supported by the absence of a federal regulation as the federal law is unambiguous and speaks for itself. DHCF has made no changes to the regulation based on this comment.

Comment: The commenter noted that the form linked in section 934.4 should be electronic and available in both English and Spanish.

Response: The District acknowledges the need to ensure that the reimbursement request form is easily accessible. The link at section 933.4 has been updated to include an electronic version of the reimbursement form, in English and Spanish.

Comment: The commenter stated that the three (3) scenarios that DHCF identifies as reasonable for not being able to provide a payment receipt, at section 933.4(h), are circumstances solely within the control of the provider and do not account for circumstances that may, otherwise, make obtaining a payment receipt difficult for the beneficiary, such as homelessness.

Response: DHCF acknowledges the commenter’s concern about the list of reasonable explanations contained in the proposed rulemaking including reasons that may only provide a hardship or impossibility for the provider to produce a receipt to the beneficiary. As a result, DHCF has added two (2) additional reasonable explanations at section 933.4(h) to account for instances where producing a receipt may be out of the beneficiary’s control. DHCF notes, however, that homelessness, alone, is not a sufficient reason for failing to produce a receipt or other proof of payment and has not added homelessness to the list of reasonable explanations at section 933.4(h).

Comment: The commenter stated that under orders related to the *Salazar* case, when a beneficiary enrolled in fee-for-service (“FFS”) challenges an adverse decision, the challenge should proceed directly to a fair hearing appeal with the Office of Administrative Hearings (“OAH”). The commenter stated that the option for the beneficiary to avail themselves of an administrative review before a District agency, violates this process for FFS beneficiaries. The commenter also stated that it should be clarified that beneficiaries enrolled with a Medicaid MCP must exhaust the plan’s administrative process prior to having a fair hearing before OAH.

Response: The proposed rule does not require that an administrative review by the agency director occur before a beneficiary is able to request a fair hearing nor is the timing of a fair hearing delayed by this process. On the contrary, the administrative hearing before the agency provides the beneficiary with an additional avenue to resolve an issue. The Department believes that each

beneficiary should have the option to avail themselves of every option that best suits their situation. As such, there are no changes to the language concerning an administrative review.

DHCF, however, has amended language at §933.11 to clarify that when services are received through an MCP, the MCP's appeal process must be exhausted prior to the beneficiary requesting a fair hearing with the Office of Administrative Hearings.

The Director of DHCF took final action to adopt this rulemaking on April 1, 2026, and the rules shall become effective upon publication of this notice in the *District of Columbia Register*.

**Title 29, PUBLIC WELFARE, of the DCMR is amended as follows:**

**Chapter 9, MEDICAID PROGRAM, is amended as follows:**

**A new Section 933, BENEFICIARY REIMBURSEMENT FOR MEDICAID COVERED SERVICES, is added to read as follows:**

- 933.1 Reimbursement to a Medicaid beneficiary, their authorized representative, or their family member may occur if:
- (a) A Medicaid covered expense was incurred and paid by or on behalf of the beneficiary, on a date of service consistent with 29 DCMR 95; and
  - (b) The requirements for reimbursement of a Medicaid covered expense, as described in § 933.2, are met.
- 933.2 When reimbursement is requested, consistent with §§ 933.4 and 933.5, a beneficiary, a family member of a beneficiary, or an authorized representative of a beneficiary shall be reimbursed for covered expenses for medically necessary services under the State Medicaid Plan if:
- (a) The beneficiary, family member of the beneficiary, or authorized representative of the beneficiary paid out-of-pocket for:
    - (1) Prescription drugs;
    - (2) Doctor or clinic visits;
    - (3) Hospitalization expenses;
    - (4) Durable medical equipment, prosthetics, orthotics, or other supplies (DMEPOS); or
    - (5) Other services covered under the Medicaid State Plan, for which the beneficiary is eligible.

- (b) The beneficiary, family member of the beneficiary, or authorized representative of the beneficiary is currently paying an outstanding bill from a pharmacy, clinic, doctor's office, hospital, or DMEPOS supplier; or
- (c) The beneficiary was improperly denied coverage of a Medicaid covered expense. This includes when:
  - (1) The Department of Health Care Finance (the Department) incorrectly determined the beneficiary was no longer eligible for Medicaid at the time of renewal or recertification.
  - (2) A healthcare provider or supplier is holding the beneficiary financially liable for a Medicaid covered expense because the beneficiary was incorrectly identified, by the Department, as ineligible for Medicaid.
  - (3) A beneficiary is under age twenty-one (21) and was required to pay for any Early and Periodic Screening, Diagnostic, and Treatment service.
  - (4) A beneficiary is dually eligible for Medicaid and a third-party insurer (including Medicare) and a healthcare provider or supplier is holding the beneficiary financially liable for any portion of the expenses for a Medicaid covered service not covered by the third-party insurer.

933.3 Request for reimbursement shall be submitted within twelve (12) months of the date the beneficiary incurred the Medicaid covered expense, or within twelve (12) months of the date the beneficiary was determined eligible for Medicaid, whichever is later.

933.4 To receive reimbursement, a beneficiary or their representative shall submit a Medicaid Reimbursement Form, available at <https://dhcf.dc.gov/publication/medicaid-%E2%80%93-reimbursement-form>, or the same information described in paragraphs (a) through (h), to the Department or the Medicaid Managed Care Plan (MCP) in which the beneficiary was enrolled on the date the service was provided. Each Medicaid Reimbursement submission should include:

- (a) The Medicaid beneficiary's name, date of birth, social security number, mailing address, and Medicaid identification number;
- (b) The actual or estimated date of the service was provided;
- (c) The name and address of the provider;
- (d) The amount paid and owed, if applicable;

- (e) The amount paid by any other insurer, including Medicare;
- (f) The amount the beneficiary is requesting that Medicaid reimburse; and
- (g) A receipt(s) for the Medicaid covered service, showing payment to the provider; or
- (h) A signed and dated statement that the information provided is true and accurate, with an explanation of why a receipt from the provider cannot be presented. An inability to produce a receipt would be reasonable when:
  - (1) The provider to whom the bill was paid has ceased operations;
  - (2) The provision of services and payment is beyond the provider's recordkeeping timeframe;
  - (3) The provider no longer has access to the recordkeeping system associated with the service for the incurred expense;
  - (4) The provider refuses to release payment receipt; or
  - (5) The Department, on a case-by-case basis, determines that a reasonable circumstance exist.

933.5

If the Department receives a Medicaid Reimbursement Form, or the same information described in § 933.4, it shall identify whether the beneficiary was enrolled in Medicaid fee-for-service (FFS) or a Medicaid MCP on the date of service for which they are seeking reimbursement.

- (a) If the Department determines that the beneficiary was enrolled in Medicaid FFS on the date of service, the Department shall process the reimbursement claim.
- (b) If the Department determines that the beneficiary was enrolled in a Medicaid MCP on the date of service for which reimbursement is being requested, the Department shall, within thirty (30) calendar days after receiving the claim:
  - (1) Provide written notice to the beneficiary that their claim will be processed by the Medicaid MCP. The notice shall also provide an explanation of the beneficiary's right to appeal and request a fair hearing challenging an adverse determination by the Medicaid MCP; and
  - (2) Forward the claim and notice to the Medicaid MCP.

- 933.6 Medicaid MCPs shall provide a final written determination to a beneficiary within sixty (60) calendar days of receiving the claim from the Department or the beneficiary.
- 933.7 In order for a written determination to be considered final, the MCP or the Department shall ensure:
- (a) The written determination includes:
    - (1) A full payment of the claim;
    - (2) A partial payment of the claim and an explanation of the partial denial; or
    - (3) A denial of the claim and an explanation for the denial.
  - (b) A denial of a reimbursement claim, in whole or in part, shall include a statement of the beneficiary's due process appeal rights.
  - (c) If payment is due in full or in part, the Department or the MCP, as applicable, shall make payment to the beneficiary by the required due date of the final written determination.
- 933.8 If a Medicaid MCP fails to issue a final written determination consistent with § 933.7 within sixty (60) calendar days, the MCP shall pay the full claim within five (5) business days after the expiration of the sixty (60) day deadline.
- 933.9 If the Department fails to submit a claim to an MCP within thirty (30) calendar days, resulting in the MCP not being able to issue a final written determination within ninety (90) calendar days of the claim's initial submission to the Department, the Department shall pay the full claim within fifteen (15) calendar days after the expiration of the ninety (90) day deadline.
- 933.10 If the Department fails to issue a final written determination within ninety (90) calendar days from the date of the submission of the claim from a beneficiary enrolled in Medicaid FFS on the date of service for which reimbursement is requested, the Department shall pay the full claim within fifteen (15) business days after the expiration of the ninety (90) day deadline.
- 933.11 Medicaid FFS enrollees and Medicaid MCP enrollees may appeal the final determination on a claim for reimbursement, pursuant to § 9508 and MCP appeals processes, as applicable.
- 933.12 If a beneficiary is successful during a fair hearing challenging the denial of a claim for reimbursement by an MCP, the MCP cannot appeal that decision.