



OPERATIONAL PLAN FOR UNWINDING CONTINUOUS COVERAGE AND THE COVID-19 PUBLIC HEALTH EMERGENCY

PART I: MEDICAID RENEWAL – THE RESTART OF NORMAL MEDICAID ELIGIBILITY OPERATIONS

Part II: RETURN TO NORMAL OPERATIONS

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Overview

When the public health emergency caused by the spread of the coronavirus disease 2019 (COVID-19) hit in 2020, the Department of Health Care Finance (DHCF) responded by taking critical steps to ensure District residents had access to health coverage. The agency had three primary roles in response to the public health emergency (PHE):

- Ensure **access to coronavirus testing and treatment** for Medicaid/Alliance and eligible beneficiaries;
- Ensure **ongoing access to care** for beneficiaries in the event of an emergency; and
- Support Medicaid **providers** in providing **testing and treatment** for coronavirus, and in continuing **ongoing care delivery operations**.

DHCF fulfilled its role by utilizing various temporary flexibilities that allowed the District to streamline eligibility and enrollment, increase provider payments, and expand covered services. Since implementing these changes, DHCF has been planning for the end of the PHE and the return to normal operation. The December 2022 enactment of the Consolidated Appropriations Act, 2023 (the Act), set March 31, 2023, as the end date for the Medicaid continuous coverage requirement, decoupling the continuous coverage requirement from the PHE. On January 30, 2023, the Biden Administration announced that the PHE will end on May 11, 2023. These actions created a two-phased approach to returning to normal operations. The first phase is restarting normal Medicaid eligibility operations; the second phase is unwinding program flexibilities.

Returning to normal operations is the most significant undertaking by Medicaid since implementing the Affordable Care Act. Enrollment in the District's Medicaid program grew twenty percent (20%) from February 2020 through December 2022. Current enrollment is approximately 305,000 beneficiaries – representing the highest enrollment in the program's history. DHCF expects enrollment to decline during the unwinding period because some beneficiaries will no longer meet Medicaid eligibility requirements.

DHCF is committed to being prepared, transparent, communicative, and responsive throughout the Medicaid Restart process. This document communicates high-level planning details related to DHCF's operations in anticipation of the return to normal operations. The document is presented in two parts. Part I focuses on the end of the Medicaid continuous coverage requirement and the resumption of normal eligibility operations. Part II focuses on the return to all normal Medicaid programmatic functions outside of eligibility. Part II will be published by March 2023.

Background

Under Section 319 of the Public Health Service Act, the Health and Human Services (HHS) Secretary is authorized to make a determination that a public health emergency exists. On January 31, 2020 the HHS Secretary declared that a public health emergency exists for COVID-19. The

declaration was effective beginning January 27, 2020 and had been extended by the HHS Secretary for subsequent ninety (90) day periods. On January 30, 2023, the Biden Administration announced their intent to let the PHE expire fully on May 11, 2023.

DHCF made changes to the administration of the District of Columbia Medicaid program, the DC Health Care Alliance Program (Alliance), and the Immigrant Children’s Program (ICP) in response to the PHE. The changes include service expansions, rate increases for providers, and changes to eligibility processing for Medicaid beneficiaries. While many of these flexibilities will end with the federal PHE ending, some will continue as temporary or permanent changes to the District’s public health benefits.

The authorities the District utilized include emergency Medicaid state plan amendments (SPA), Section §1915(c) Waiver Appendix K, and Section §1135 Waivers. Details on each type of authority can be found in Chart 1 below:

Chart 1: PHE and Emergency Authorities for the Medicaid Program			
Authority	Effective Date	Termination Date	Example
Medicaid State Plan Amendments	March 1, 2020, or later date selected by the state	End of the federal PHE or any earlier date selected by the state	DC SPA- 20-01 - Temporary 20% increase to nursing facility rates
Appendix K (Home and Community-Based Services Waivers)	January 27, 2020 or any later date elected by the state	Up to 6 months following the conclusion of the federal PHE	§1915 (c) HCBS Waiver Appendix K : Temporary 15% addition to assisted living facility rates
Medicaid §1135 Waivers	March 1, 2020	End of the federal PHE	District §1135 Waiver Request : Temporarily suspend Medicaid fee-for-service prior authorization requirements

Utilization of these authorities is tied to the federal PHE, and DHCF’s ability to utilize them will terminate on or near the end of the federal PHE, as detailed in Part II.

Additional changes to Medicaid programs were authorized through federal legislation. The Families First Coronavirus Response Act (FFCRA), for instance, authorized enhanced federal funding for Medicaid programs conditioned upon Maintenance of Eligibility (MOE) requirements that prohibit beneficiary disenrollment in most circumstances. This requirement is commonly referred to and throughout this document as the Medicaid continuous coverage requirement under FFCRA. Further, the American Rescue Plan Act (ARPA) extended coverage of COVID-19 vaccines and treatment services to limited benefit populations at no cost to states, and provided an enhanced funding opportunity for State Medicaid programs to spend on increasing access to HCBS. More information on DHCF’s ARPA HCBS initiative is available on [DHCFs website](#).

Finally, until the passage of the Consolidated Appropriations Act of 2023 (CAA 2023), signed into law on December 29, 2022, FFCRA's continuous coverage requirements, as well as FFCRA's 6.2% temporary Federal Medical Assistance Percentage (FMAP) increase, were tied directly to the duration of the federal PHE. CAA 2023 sets March 31, 2023, as the definitive end date to the Medicaid continuous coverage requirement; meaning the District will resume the Medicaid eligibility redetermination processes beginning April 1, 2023.

As with the flexibilities granted by CMS through the temporary SPA and waiver pathways, the FFCRA, ARPA, and CAA 2023 requirements also impact planning outlined herein.

DHCF's Approach to Medicaid Restart

DHCF defines Medicaid Restart as the universal return to standard Medicaid operations in response to the end of the Medicaid continuous coverage requirement and the end of the COVID-19 federal PHE. The agency's Medicaid Restart approach has two primary phases: 1) resumption of normal eligibility operations beginning April 1, 2023; and 2) return of standard program operations following the conclusion of the federal PHE and termination of its corresponding flexibilities. During this time, the District's top priorities are to set clear expectations for District stakeholders and maximize continuity of coverage for District beneficiaries throughout the unwinding process.

To support States through this challenging transition, CMS issued guidance to Medicaid programs, providing details and requirements for unwinding each type of federal flexibility. CMS published three State Health Official (SHO) Letters specifically on the topic of unwinding federal flexibilities authorized during the PHE—SHO# 20-004, SHO# 21-002, and SHO# 22-001—in addition to tool kits, presentation slide decks, and other materials. CMS also hosted numerous all-state webinars and made themselves available for individual technical assistance calls. DHCF understand the significant operational impact and has taken every opportunity to partner with CMS on the unwinding efforts. The latest guidance for unwinding the PHE can be found on CMS' website located [here](#).

SHO# 20-004, released on December 22, 2020, contains the majority of guidance related to unwinding Medicaid flexibilities through the Disaster Relief SPA, §1135, §1115, and Appendix K processes.

All DHCF policy guidance specific to the PHE is on [DHCF's website](#).

Part I: Resumption of Normal Eligibility Operations

Under the FFCRA continuous coverage requirement, states are required to maintain enrollment of nearly all Medicaid enrollees through end of the month in which the PHE ends. The Consolidated Appropriations Act, 2023 (CAA), enacted on December 29, 2022, delinked the continuous coverage requirement from the federal PHE. With the passage of the CAA 2023, **the continuous coverage requirements will end on March 31, 2023 and the unwinding of the continuous coverage requirement will begin.**

When continuous coverage requirements expire, the District will conduct full redeterminations for all Medicaid enrolled beneficiaries over the following fourteen (14) months (April 2023 through May 2024).

There are two (2) main pathways to Medicaid eligibility:

- Modified Adjusted Gross Income (MAGI) that primarily applies to adults without dependent children, non-disabled children, pregnant women and parents/caretaker relatives; and
- Non-MAGI, which covers all other eligibility pathways to Medicaid and generally applies to people 65 or older, people who may qualify for Medicaid based on a disability or in need of Long Term Care services, or for people who qualify for Medicaid for reasons other than income.

	Dec. 2022 Enrollment	MCO / FFS Split	Option to Passively Renew
MAGI	242,000	97% MCO 3% FFS	Yes, with exception of those who are only eligible due to continuous coverage requirement
Non-MAGI	63,000	48% MCO 52% FFS	No, with exception of certain Supplemental Security Income and other beneficiaries

There are approximately 305,000 District residents enrolled in Medicaid as of December 2022. This represents approximately 33,000 seniors (65+), 171,000 adults (21-64), and 101,000 children (0-20). Most enrollees fall under the MAGI eligibility definition and will have the opportunity to passively renew. For passive renewal, a beneficiary’s renewal is reviewed using electronic data sources only. If all the data sources match what the beneficiary has attested or declared and the beneficiary continues to meet requirements, the system will automatically renew eligibility for an additional year. **Most Medicaid beneficiaries – approximately two-thirds of the total Medicaid population – will not have to do anything to maintain their Medicaid benefits because of the passive renewal process.**

Anticipated Coverage Loss

During the public health emergency, the District’s Medicaid enrollment has grown by 20 percent, from 254,000 beneficiaries in February 2020 to approximately 305,000 at the end of 2022. The number of individuals in the District’s locally funded Alliance and ICP programs grew by more than half prior to a recent restart of eligibility redeterminations, increasing from approximately 20,000 in February 2020 to more than 30,000 in August 2022. While it is anticipated that a majority of MAGI Medicaid beneficiaries will have their coverage passively renewed, the District recognizes that those who must actively submit information to support a continuation of eligibility are at a greater risk of coverage loss. For some of these individuals, an increase in income or other change in circumstance may mean that they no longer qualify. For others, challenges to maintaining coverage may include non-receipt of renewal notices due to outdated contact information on file with DHCF; lack of familiarity with updated eligibility processes, particularly among non-MAGI beneficiaries who previously renewed through a legacy eligibility system and

will be experiencing District Direct for the first time; and required verifications of income and other eligibility factors, rather than self-attestation. While the District is updating its enrollment projections to incorporate the latest available information (e.g., on timing for the end of Medicaid continuous coverage), previous estimates have assumed that overall Medicaid enrollment will decrease by more than 10 percent during a 12-month unwinding period.

Agency Outreach Campaign

Over the past three years, many beneficiaries have had limited contact with the Medicaid eligibility system due to the continuous coverage requirement. Therefore, many beneficiaries have experienced changes in living arrangements and household circumstances that have not been reported. As the District prepares for unwinding, it is critical to engage with community stakeholders -including Medicaid beneficiaries so the District has up to date information.

To help address this, agency will be conducting advertising to beneficiaries to update their addresses and/or create a District Direct account so they are able to receive accurate notices about their coverage, and to make sure they renew their health coverage. This advertising will be conducted by a contracted vendor and will include digital, traditional, and out-of-home (transit) advertising development and placement that the Contractor will execute according to an Advertising Plan developed through feedback from the agency. The Advertising Plan includes digital media outreach (e.g., website updates, email outreach, and social media, text message scripts and systems for DHCF to send messages to beneficiaries, etc.) that the Contractor will execute. This will include Bus ads in targeted locations of Wards 4, 5, 6, 7, and 8; TV and radio advertising around local news times (WUSA9, NBC4, etc.); agency-specific press releases; a dedicated one-stop website for all pertinent information about the end of the PHE; mailers/handouts/door hanger events, and more.

DHCF is developing a Communication Toolkit to assist stakeholders with understanding the unwinding process and guide them in conducting their own outreach operations. The Toolkit is designed to assist stakeholders and DHCF with outreach to program beneficiaries; residents experiencing homelessness or housing instability; health care providers; internal stakeholders and staff; entities that provide assistance with applications and renewals; advisory groups; community-based organizations and Associations; and anyone else who needs to use the Toolkit. The Communications Toolkit is being developed with the help of a contracted vendor.

Other Stakeholder Outreach

DHCF will utilize its existing stakeholder groups and forums to share unwinding information as it becomes available. As necessary, DHCF will also host new stakeholder events to discuss the unwinding process when existing forums are not sufficient. DHCF is planning to host a series of townhalls in March that will review DHCF's plans as the agency nears the unwinding period and present stakeholders with the opportunity to

pose any operational questions. For April 2023 and forward, DHCF will host a bi-weekly Medicaid community meeting with the goal of providing regular status updates on the resumption of redeterminations.

Role of Medicaid Managed Care Organizations (MCOs) in Beneficiary Engagement

DHCF will require the contracted MCOs to communicate important outreach messaging and materials to their respective enrollees during the period to unwind from the PHE. Currently, MCOs are contractually required to provide assistance with completing renewals for Medicaid eligibility. These efforts will be advanced by a more unified outreach approach, using tools and resources provided by DHCF's contracted communications vendor related to renewal activities, in addition to guidance provided by CMS, [*Strategic Approaches to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations.*](#)

The CMS guidance promotes use of four key strategies for working with MCOs which align with their current contractual requirements:

1. Partnering with MCOs to obtain and update beneficiary contact information.
2. Sharing renewal files with MCOs to conduct outreach and provide support to beneficiaries enrolled in Medicaid during their renewal
3. Enable MCOs to conduct outreach to individuals who have recently lost coverage.
4. Permit MCOs to assist individuals to transition to and enroll in Marketplace coverage if ineligible for Medicaid or CHIP.

DHCF will continue to collaborate with the MCOs to ensure eligible enrollees retain coverage in Medicaid and ease transitions for individuals eligible for coverage through the Marketplace, called DC Health Link. DC Health Link is an online health insurance market enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. The DC Health Link is overseen by the DC Health Benefit Exchange Authority (HBX). HBX was established by the District of Columbia to develop and operate DC Health Link. DC Health Link may be the best place to buy insurance for anyone ineligible for Medicaid and who do not have coverage through their employer.

DHCF's Guiding Principles for the Restart of Normal Eligibility Operations

The District's goal during the Medicaid Restart is to maintain eligibility for individuals who continue to qualify for coverage and mitigate churn for beneficiaries. Upon resumption of normal eligibility operations, DHCF and its District partners will be guided by a few key principles:

- Ensuring limited disruption of access to services for beneficiaries and families who remain eligible for Medicaid benefits;
- Ensuring timely and efficient processing of all pending Medicaid renewals and determinations;
- Keeping beneficiaries within their current recertification period; and
- Planning adequate distribution of eligibility redetermination workload to ensure functioning eligibility processing infrastructure.

Beneficiaries and District stakeholders should expect DHCF to act in accordance with the planned actions and timelines set forth below, as well as in accordance federal guidelines throughout the unwinding period.

DHCF Eligibility Operations Under the Continuous Coverage Requirement

In response to the COVID-19 Emergency, the District implemented several policy changes, programmatic system updates, and flexibilities to ensure District residents retained access to health care coverage through the District Medicaid program. In doing so, the District qualified for additional federal Medicaid funding under section 6008 of FFCRA to ensure continuous enrollment for all Medicaid beneficiaries.

The District implemented the following policy changes and adjustments during the PHE (this list is not exhaustive):

- Continued eligibility for all Medicaid beneficiaries enrolled in coverage as of March 17, 2020;
- Acceptance of self-attestation from applicants and beneficiaries for residency, income, resources via amendment of the District’s Eligibility Verification Plan;
- Conducted long-term services and supports level of care assessments through remote, web-based, or telephonic means; and
- Acceptance of telephonic signatures for individuals and couples submitting a Long-Term Care Medicaid application for the Elderly and Persons with Disabilities Waiver Program

Under the CAA 2023, the continuous coverage condition and receipt of the temporary FMAP increase is no longer linked to the federal PHE declaration. The decoupling of the continuous coverage condition from the PHE allows for certainty of the date to expect the return to normal operations. The date continuous enrollment in Medicaid ends is March 31, 2023. As outlined below, the flexibilities the District adopted during the PHE and period of continuous coverage requirement will expire and standard redetermination processing will resume. The District expects some beneficiaries will lose coverage because they are no longer eligible for the program.

Federal Eligibility-Related Flexibilities During Renewals

The District’s goal during the Medicaid Renewals is to maintain eligibility for individuals who continue to qualify for coverage and mitigate churn for beneficiaries. To accomplish this goal and limit the risk of eligible beneficiaries inappropriately losing coverage, CMS allowed states including the District limited use of section 1902(14)(A) authority of the Social Security Act. This act allows the District to use waivers to promote continuous access to coverage for beneficiaries, navigate challenges with new eligibility systems, and address operational obstacles. CMS approved the following 1(14)(A) waiver submissions on August 8, 2022:

1. Ex Parte Renewal for Individuals with No Income and No Data Returned

For ex-parte renewals, the agency first attempts to redetermine eligibility based electric data sources without requiring information from the individual. This process is known as auto-renewals, passive renewals, or administrative renewals. The District will complete income determination for ex-parte renewals without requesting additional income information if:

- a. The most recent income determination (either at initial application or most recent renewal) was no earlier than 12 months prior to the beginning of the PHE (i.e., March 2019);
- b. The state verified an attestation of \$0 income at such determination; and
- c. The state checks financial data sources in accordance with its verification plan and no information is received.

This authority will assist the District in addressing the expected high volume of renewals and other eligibility and enrollment actions that would need to be conducted during the unwinding period. The goal of this authority is to expedite the processing time for the staff and beneficiaries who experience homeless or housing insecurities.

2. Partnering with Managed Care Plans, Enrollment Broker, and the PACE Organization to Update Beneficiary Contact Information

The District has the authority to accept updated enrollee contact information from managed care plans, the District's enrollment broker, and the PACE Organization without additional confirmation from the beneficiary. Without this waiver authority, the District could not act on updated address from the beneficiaries without issuing a notice to beneficiary's previous address to confirm the address change. This authority allows the District to receive updated contact information from Managed Care Organizations, PACE Organizations, and the Enrollment Broker and immediately make the change. These entities are required to only provide updated contact information if information is received directly from the beneficiary, or the beneficiary's authorized representative recognized by the entity. The District will not accept contact information provided by a third party.

3. Use of National Change of Address (NCOA) Database and U.S. Postal Return Mail in-state forwarding address to update contact information.

This waiver authority allows the District to accept updated enrollee contact information from the National Change of Address (NCOA) Database and U.S. Postal Service (USPS) returned mail that contains an in-state forwarding address without additional confirmation from the individual. The updated contact information is considered reliable and up to date. This waiver would temporarily eliminate the need to send a notice to the beneficiary first at the previous address before updating the newly reported address.

4. Extending Automatic Re-enrollment into Medicaid Managed Care Plans up to 120 Days

If a beneficiary loses coverage and re-applies for Medicaid, the District allows an automatic re-enrollment into their managed care plan if the lapse in time is 60 days or less. Under the waiver authority, the District would extend the automatic re-enrollment from 60 to 90 days which is consistent with our renewal re-instatement period. The extension of automatic enrollment to 90 days promotes provider continuity and access.

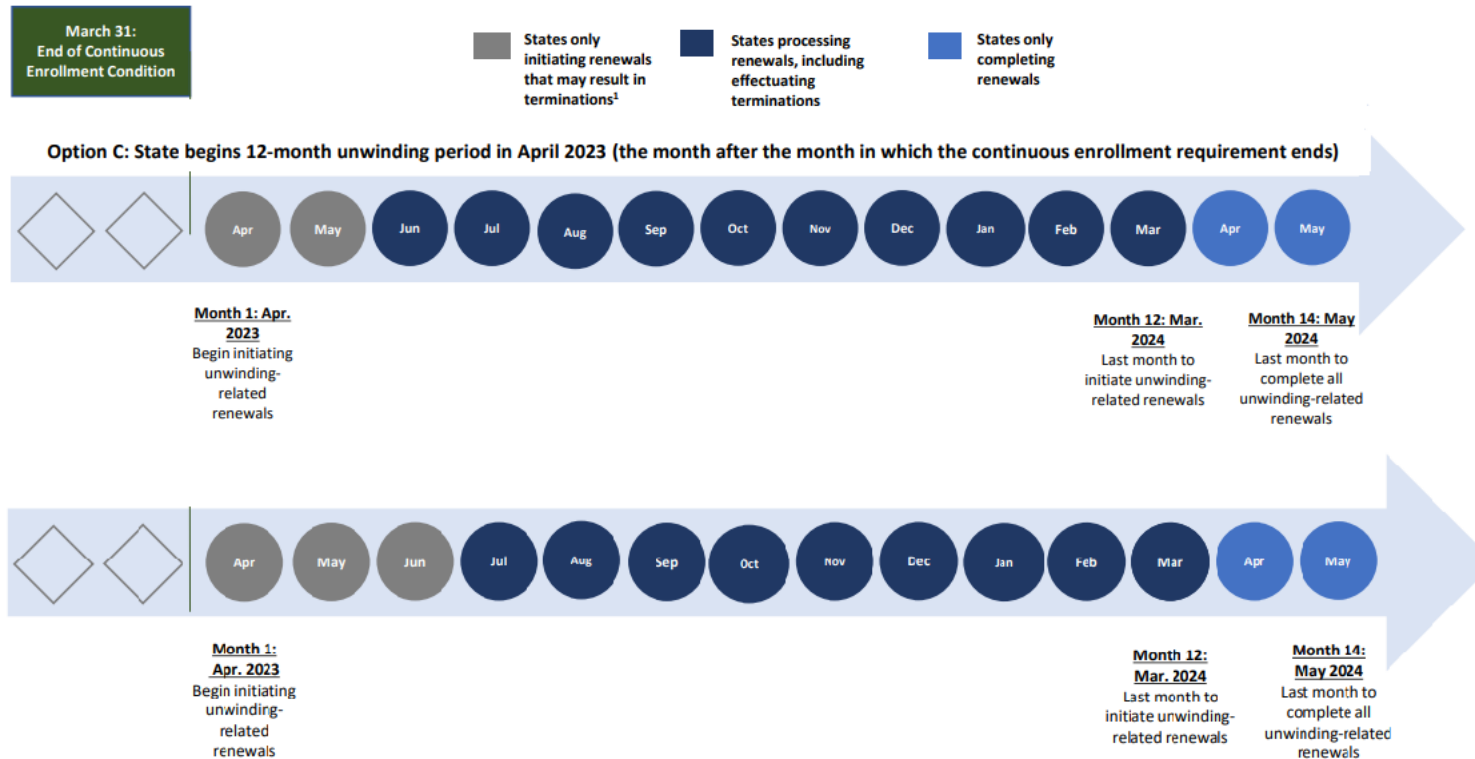
DHCF Eligibility Operations During Renewals and Timeline

CMS required¹ each state to choose a timeline in which they would resume normal processing and begin unwinding from the continuous enrollment condition. The District will have twelve (12) months option to initiate all renewals and other outstanding verification actions and two additional months (14 months total) to complete all pending actions initiated during the first twelve (12) months. The “unwinding period” describes the twelve (12) months the District will utilize to initiate all renewals. The 12-month unwinding period will stagger the Medicaid discountenances that will occur after the continuous coverage condition ends on March 31, 2023. **The District will begin unwinding from the continuous coverage provision beginning April 1, 2023** (see Graphic 1).

MAGI renewals are sent sixty (60) days prior to the renewal end date and Non-MAGI renewals are sent 90 days prior to the renewal end date. The Medicaid continuous coverage condition will end March 31, 2023 and the District will send May 2023 MAGI and June 2023 Non-MAGI renewal packets starting April 1, 2023. This process will continue throughout the unwinding period. The timeline is represented graphically below:

¹ Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency (March 3, 2022). Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf>.

Graphic 1: Unwinding Timeline for States with a 60 & 90-day Renewal Process



As mentioned above, the District implemented several programmatic changes to ensure continuous coverage for beneficiaries. These changes also allowed the District to become more efficient in ways to streamline current Medicaid policies and procedures. Largely, these changes will be sunseting after March 31, 2023.

Applications and Self Attestation

Applicants may apply for District Medicaid via internet, phone, mail, in person or through other electronic means. During the continuous coverage condition, the District did not change processing or timeliness standards for Medicaid applications but allowed beneficiaries to self-attest (declare) their financial and non-financial eligibility information (except for immigrant and citizen status). Effective April 1, 2023, the District will no longer accept self-attestation for income, residency, and resources at application. Residents are required to verify any outstanding eligibility factors such as residency, income, and assets to complete their application.

Reporting Changes of Circumstances

During the continuous enrollment condition, beneficiaries could report changes at any time and the District acted on the change. If the change resulted in negative impact on the beneficiary, the information was updated in the 'District's eligibility system but the change was not effectuated and coverage was maintained. Effective April 1, 2023, the District will return to regular change reporting procedures and will resume taking adverse actions on identified or reported changes in circumstances after renewals are completed. The District will also no longer accept self-attestation for financial and non-financial eligibility factors when a change is reported. However, if the beneficiary reports a change during the continuous coverage unwinding period (12-months) the change will be acted upon during the beneficiary's regular scheduled renewal. This will streamline any initial changes and minimize renewal workload.

Examples:

- *Reported change prior to the renewal certification*

The beneficiary has a May 2023 renewal date. They submit a reported change in February 2023. The change will not be processed until their full renewal determination in May 2023.

- *Reported change after the renewal certification*

The beneficiary has a May 2023 renewal date and submitted documentation to update renewal through May 2024. They submit a reported change in July 2023. The change will be processed in July 2023 according to change reporting guidelines since a full renewal determination was completed in May 2023.

Renewals and Redeterminations

All Medicaid beneficiaries must conduct a renewal during the continuous coverage unwinding period. The District must complete all renewals within fourteen (14) months following the resumption of Medicaid redeterminations. Effective April 1, 2023, the District will no longer accept self-attestation for financial and non-financial eligibility factors during the renewal process. Renewal packets will be sent 60 days in advance for MAGI beneficiaries and ninety (90) days in advance for Non-MAGI beneficiaries.

If a beneficiary does not submit their MAGI Medicaid renewal or verifications in the initial time period given, they will still have a 90-day grace period after their coverage officially expires to recertify their DHCF health coverage. This grace period is designed to give beneficiaries more time to provide the renewal to DHCF. For example, if a beneficiary failed to submit their June 2023 renewal packet or turn in verifications by the end of their certification period (June 30, 2023), they have a grace period from July 1, 2023 through September 30, 2023 to submit that documentation. If no information is submitted by September 30, 2023, the beneficiary will lose coverage and will need to submit a new application to regain it. The grace period for non-MAGI eligibility groups is thirty (30) days.

Types of Renewals:

- Passive Renewals

A beneficiary may qualify for an auto-renewal also known as a passive or ex parte renewal. In this renewal process, a beneficiary renewal is reviewed using electronic data sources only. If all the data sources match what the beneficiary has attested or declared and the beneficiary continues to meet requirements, the system will automatically renew eligibility for an additional year. This auto-renewal process is the most efficient for the beneficiary and the agency because it requires no touch from either party. Currently, mostly MAGI beneficiaries fall into the passive renewal category. The District has a historic average of approximately 80% of MAGI beneficiaries who may passively renew.

- Non-Passive Renewals

A non-passive renewal is a renewal process that is not automatically completed by the eligibility system and requires the District to send the renewal packet to the beneficiary for them to send back to the District. This process may begin as early as 60 to 90 days before the end of the renewal period. If the beneficiary does not return all the information needed to process the renewal, the agency will need to make additional request to the beneficiary and then wait for an additional time for the beneficiary to return documentation. The District's new eligibility system, called District Direct, will not allow passive or auto-renewals during this first round of renewals for Converted Non-MAGI Medicaid cases and requires additional information from the beneficiary to complete the integration process. After this initial cohort of renewals, a portion of Non-MAGI renewals may be able to passively renew.

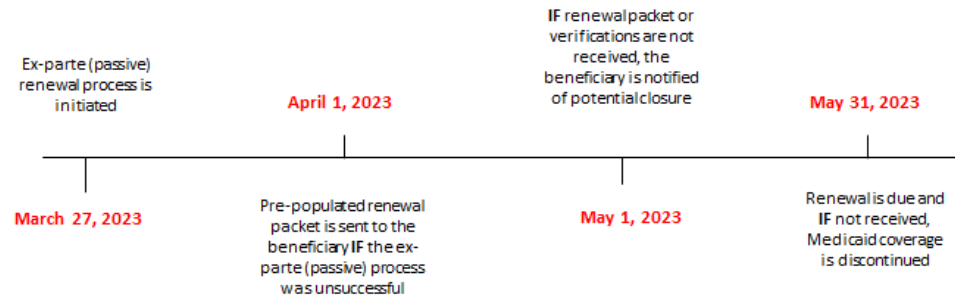
Renewal Cycle Examples (*Medicaid Continuous Enrollment ending March 31, 2023*)

MAGI Household- Certification Month May 2023

- ~65 days prior to end of certification, an ex-parte (passive renewal) process is initiated.
- ~60 days prior to end of certification, a pre-populated renewal packet is sent to the beneficiary **IF** the ex-parte (passive renewal) process was unsuccessful.
- ~30 days prior to end of certification, if pre-populated renewal packet or verifications are not received, the beneficiary will be notified of potential Medicaid closure in 30 days.
- May 31, 2023, renewal is due and if not received, Medicaid coverage is discontinued.

This example timeline is represented visually below:

Example: MAGI Household- Certification Month May 2023

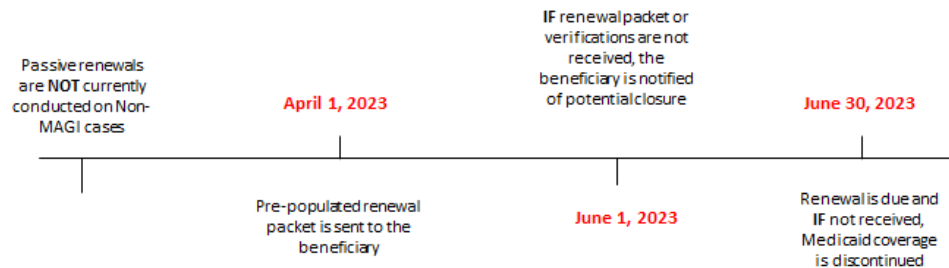


Non-MAGI Household- Certification Month June 2023

- Passive renewals are not currently conducted on Non-MAGI cases (this is a future enhancement).
- ~90 days prior to end of certification, a pre-populated renewal packet is sent to the beneficiary.
- ~30 days prior to end of certification, if pre-populated renewal packet or verifications are not received, the beneficiary will be notified of potential Medicaid closure in 30 days.
- June 30, 2023, renewal is due and if not received, Medicaid coverage is discontinued.

This example timeline is represented visually below:

Example: Non-MAGI Household- Certification Month June 2023



Beneficiaries submitting MAGI or Non-MAGI renewals will be evaluated on whether they meet eligibility under various eligibility categories. During the renewal process, some beneficiaries' program codes may change, which may impact their eligibility for certain services. For example, if a beneficiary is no longer eligible for a waiver program code, they may maintain coverage under a different eligibility code.

District Renewal Distribution Plan

While most beneficiaries will retain their original certification end date, the District will utilize a hybrid approach and redistribute individuals that are only eligible for coverage due to the Medicaid continuous coverage requirement in three to eight months of unwinding, while keeping all other individuals within their current certification period; completing redeterminations for the entire Medicaid population within 14 months of the resumption of eligibility redeterminations. The District is pursuing this option because it will help mitigate additional burden to eligibility staff and lengthens the timeframe before Medicaid beneficiaries need to renew, many of whom have not completed a renewal in over three years or have never completed a renewal. The District is required to [submit a renewal distribution plan](#) to CMS no later than February 15, 2023. The submission will summarize DHCF's plan for initiating renewals for its total caseload within the unwinding period. DHCF will share a copy of its renewal distribution plan following approval by CMS.

System and Coverage Enhancements Under Continuous Coverage and During Unwind

The District transitioned all public benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF) and other programs to a new integrated eligibility system called District Direct. Within District Direct, there have been several system upgrades completed and in progress to assist the District with unwinding efforts. To implement these changes, the District is using a longer, but more comprehensive, application form that asks questions to evaluate the applicants for MAGI and non-MAGI Medicaid eligibility. Therefore, beneficiaries who receive a renewal packet should expect to provide more information on their renewal form than in previous years to ensure information is correct and updated.

Workload Alignment

The District has a variety of different Medicaid eligibility groups. It is not uncommon for a household of beneficiaries to have different Medicaid program groups and/or different renewal certification periods. When there are households with multiple renewal periods, the beneficiaries will receive multiple renewal packets so that all renewals in the household will have the same renewal date. To decrease the burden on the beneficiary, the District will align renewal certifications for MAGI programs starting April 2023. These enhancements will reduce the amount of paperwork sent to the beneficiary's household and promote a streamlined process for the agency.

Workload Distribution

The expected workload distribution is impacted by the District's planned renewal distribution described below. The District expects a high rate of passive renewals (more than three-quarters) among MAGI beneficiaries upon the resumption of Medicaid redeterminations.

Reasonable Compatibility

Reasonable compatibility² is the process in which information obtained through an electronic data source is found to be reasonably compatible with an individual's attestation of income. The District has a threshold in which it measures that reasonable compatibility, which is currently set at 10%. In response to PHE unwinding, the District has permanently raised its compatibility threshold from 10% to 20%. This threshold increase will allow more beneficiaries to successfully complete their renewals through the ex-parte (passive) renewal process which requires no action from the caseworker.

For example, if a beneficiary's attested income is \$18,000 and the electronic records state that the beneficiary's income is \$20,000, DHCF will conduct the eligibility determination using the passive renewal process because the discrepancy is within twenty percent (20%) of the attestation. This will allow for fewer manual reviews of renewals.

Fair Hearings and Appeals Processes

During the federal PHE, DHCF temporarily extended the timeframes for individuals to request Medicaid fair hearings in fee for service and managed care delivery systems using §1135 waiver authority. These flexibilities will expire at the conclusion of the federal PHE and fair hearing timelines will return to the normally outlined procedures.

As a reminder, during the appeals (Fair Hearings and Reconsideration) and complaints/grievances processes, residents have a right to:

- A Fair Hearing and may request a hearing no more than ninety (90) days from the postmark of the letter notifying you of the action taken by the DC Government and/or enrolled providers Beneficiaries enrolled in managed care have 120 calendar days from the date of the MCO's appeal decision to request a Fair Hearing);
- Keep receiving a benefit while your Fair Hearing is being reviewed. To keep your benefit during a Fair Hearing, you must request a Fair Hearing before the 30-day notice ends;
- Request a Reconsideration within 21 days of the date noted on the adverse notice (regarding LOC assessments);
- Have someone from the DC Health Care Ombudsman help you through the grievance process;
- Represent yourself or be represented by your family caregiver, lawyer or other representative of your choice (This person cannot be an employee of District government);

² "Reasonable" Flexibility: Exploring Models to Help States Resolve Inconsistencies in Income for Medicaid, CHIP and Tax Credit Eligibility (June 28, 2012). Available at <https://www.shvs.org/wp-content/uploads/2014/11/State-Network-Reasonable-Compatibility-Webinar.pdf>.

- Have accommodations made for any special healthcare needs you have;
- TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) capabilities and services for the visually impaired,
- Translation services and/or an interpreter; and
- See all documents related to your appeal (Fair Hearing or Reconsideration) or your complaint/grievance.

Beneficiaries have a right to request a Fair Hearing with the DC Office of Administrative Hearings if you believe Medicaid was wrong in denying, reducing suspending, or stopping a service or item. Beneficiaries may call or make your request in writing to:

DC Office of Administrative Hearings
44¹ 4th Street, NW, Suite 450 North
Washington, DC 20001
Telephone Number: 202-442-9094

Other District-Funded Medical Programs

The District's public health emergency ended July 25, 2021. Alliance and the Immigrant Children's Program (ICP) renewals were extended until July 2022. Renewal certifications have re-started for Alliance and ICP, with the first renewal packets sent on July 1, 2022 and will continue moving forward on a month to month basis. Beneficiaries renewing for these state-funded programs are required to verify income and D.C. residency.

To assist the applicants/beneficiaries with a more streamline application and renewal process the District has made the following policy changes for Alliance and ICP;

1. Alliance and ICP follows MAGI methodology;
2. Alliance no longer requires a resource test;
3. Alliance no longer requires a face-to face interview;
4. Effective October 2022, Alliance certifications will change from 6-months to 12-months

August and September 2022 renewals have a 6-months renewal period. At the next renewal scheduled for February and March 2023 renewals, the 12-month recertification period applies. As of November 15, 2021, Alliance and ICP applicants and beneficiaries can complete their application, changes, or renewal on the District Direct website or mobile app. Renewals will be sent to beneficiaries 60 days in advance in alignment with MAGI renewal timelines.

Part II: Return to Normal Operations

While the Omnibus bill provides the District with a definitive end date to the Medicaid continuous coverage requirement on April 1, 2023, the conclusion of the federal PHE is slated for May 11, 2023. As outlined in the background and overview section, DHCF made changes to the administration of the District of Columbia Medicaid program in response to the federal PHE and some of these flexibilities will end with the end of the PHE. Many of the flexibilities will continue as temporary or permanent changes to the District’s health system.

This section provides clear definitions of what flexibilities were granted because of the PHE, and whether and when they expire. It starts with Telehealth; covers Medicaid State Plan benefits related to pharmacy, Health Homes, FQHCs, and COVID-19 Vaccine Testing and Administration; and Home and Community-Based Waiver Services (HCBS) State Plan Long Term Services and Supports. It ends with a chart with all flexibilities continuing past the end of the PHE and sections on Provider Enrollment Flexibilities and contact information.

Continuing Programmatic Flexibilities and Programmatic Services -Chart

A chart summarizing the sum total of the programmatic, frequency, and reimbursement changes that will continue into the future - beyond the conclusion of the federal PHE - is included below:

Chart 2: Continuing Programmatic Flexibilities and Programmatic Services

Service/Program	Continuing Flexibilities and Programmatic Changes	Expiration Timeframe
Pharmacy	Pharmacies may dispense a 90-day supply of maintenance medications.	Permanent Change
COVID-19 Treatment	Coverage of COVID-19 testing and vaccination will continue (A decision on permanent coverage of at-home testing will be made at a later date).	Permanent Change
Nursing Facility Reimbursement	20% reimbursement increase to all facility rate components will be extended for two (2) months following the conclusion of the federal PHE.	11-Jul-23
ICF/IID Reimbursement	15% reimbursement increase to the Direct Service cost center will be extended for two (2) months following the conclusion of the federal PHE.	11-Jul-23
Home Health and PCA	Reimbursement of overtime rates, quarantine rates, and staffing agency rates to Home Health Agencies for Skilled Nursing, Private Duty Nursing, and Personal Care Aide (PCA) will be extended for six (6) months following the conclusion of the federal PHE.	11-Nov-23
Specialty Hospital	The District intends to delay the date of rate rebasing per diem rates for specialty hospital services until October 1, 2025 and plans to rebase every four years thereafter.	Permanent Change
FQHC	The rebasing schedule will be updated to every three years after January 1, 2022.	Permanent Change
<i>My Health GPS</i>	All assessment, reimbursement, and programmatic changes to My Health GPS implemented during the PHE will be incorporated into the permanent State Plan.	Permanent Change
Elderly and Physically Disabled (EPD) §1915(c) HCBS Waiver	Allowance for participant-directed community services to exceed the 16 hours per day limitation; Allowance for reimbursement of participant-directed community services delivered by family members; Allowance for respite services to exceed the 17 hours per day limitation; Addition of coverage for PERS; Increased payment rates to account for higher staffing costs; Allowance of retainer payments to ADHP providers; and DHCF intends to amend the EPD Waiver to make increased assisted living rates permanent until a more comprehensive reimbursement methodology update is established.	11-Nov-23
		Permanent Change

§1915(i) and § 1915(c) Adult Day Health Programs (ADHP)	Expand AHDP services to include wellness checks provided via video conferencing/other electronic modality (e.g., Skype, FaceTime). Expands 1915(i) HCBS ADHP services to include the following services, when delivered via video conferencing/other electronic modality or telephone: remote therapeutic activities conducted individually or in groups by a licensed therapist and remote nursing services conducted individually by a licensed nurse Allows payment for services delivered via telehealth that differ from payments for the same services when provided face to face, for adult day health services. Permit the District Medicaid program to make retainer payments to Adult Day Health Program (ADHP) providers whose operations have been impacted by the PHE.	11-Nov-23
§1915(i) Housing Supportive Services (HSS)	Expansion of case manager supervisor staffing criteria	Permanent Change
§1915(c) IDD & IFS HCBS Waiver	All Appendix K flexibilities will remain in place through six (6) months following the conclusion of the federal PHE	11-Nov-23

Telehealth in the District

Prior to the start of the COVID-19 public health emergency, the District adopted the use of telemedicine to increase access to quality care for beneficiaries, increase beneficiary compliance with treatment plans, and improve beneficiary health outcomes. The D.C. Telehealth Reimbursement Act of 2013 directed that Medicaid cover and reimburse for healthcare services delivered through telemedicine, to the extent the service would be covered by Medicaid for an in-person visit. And since 2016, the District has reimbursed providers for eligible services rendered to Medicaid beneficiaries through telemedicine.

Historically, telemedicine in the District was defined, in rulemaking and in the D.C. Telehealth Reimbursement Act of 2013, as a healthcare treatment service delivered through a two-way, real-time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment. Notably, the definition in the Telehealth Reimbursement Act of 2013 excluded audio-only telemedicine and DHCF rulemaking did not permit a beneficiary's home as an originating site. To ensure the health, safety, and welfare of residents was not threatened by a lapse of in-person access to covered healthcare, the District announced that it would expand the definition of telemedicine to also reimburse for audio-only visits throughout the public health emergency and until 60 days after the end of the public health emergency declared by the Mayor of the District on March 11, 2020 (Mayor's Order 2020-045).

On March 12, 2020, the District also added the beneficiary's home as an eligible originating site for telemedicine through emergency and proposed rulemaking. The rule allowing the beneficiary's home as an eligible originating site was finalized on August 14, 2020. Subsequently, the Telehealth Reimbursement Amendment [Act of 2020](#) made audio-only telemedicine permissible under District statute effective December 3, 2020. Given this new statutory authority, and to ensure the continued access of services after the expiration of the Mayor's public health emergency declaration, (Mayor's Order 2021-096, dated July 24, 2021), on August 18, 2021, DHCF amended rules in the District of Columbia Municipal Regulations (DCMR), on an emergency basis, to permanently expand Medicaid telemedicine services by adding audio-only communication as an allowable method of telemedicine, adding verbal consent as an allowable method for a beneficiary to consent to telemedicine services, and clarifying provider documentation and technology requirements. These changes to the DCMR were adopted as final on November 5, 2021. These changes are reflected in the District's [Telemedicine Provider Billing Guidance](#) document published in January of 2023.

As a reminder, the telemedicine changes were implemented for both providers and participants in the Medicaid fee-for-service, Medicaid managed care, Health Care Alliance, and Immigrant Children's programs. All requirements stipulated in the referenced provider [guidance](#) apply to all programs DHCF administers.

In addition to the allowances for audio-only telemedicine and a beneficiary's home as an originating site, DC Health, the agency in the District with oversight for provider licensing requirements, waived provider licensing requirements to allow for the provision of telehealth by clinicians licensed outside of the District for the duration of the Mayor's Public Health Emergency beginning on March 13, 2020. This waiver allowed providers licensed in their home jurisdiction in their field of expertise to provide care to District of Columbia residents as a temporary agent of the District of Columbia. This waiver was further extended through August 10, 2022 by a [law](#) passed by the Council of the District of Columbia on October 26, 2021.

Importantly, all the flexibilities described above are paired with flexibilities implemented by the federal government to encourage access to telehealth during the PHE. The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) [stated it would not](#) "impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency."

[In new guidance](#), OCR clarified that these flexibilities remain in effect only during the federal PHE. The new guidance expounds the types of technologies, business associate agreements with vendors, and details how to ensure HIPAA compliance when using audio-only technologies. Providers delivering services via audio-only telehealth after the conclusion of the federal PHE should familiarize themselves with OCR guidance to ensure their practices remain HIPAA compliant.

Expiring Flexibilities: As described above, DC Health's licensure waiver order has expired.

Flexibilities Made Permanent: The changes allowing audio-only telemedicine and a beneficiary's home as an originating site have been made permanent and will not expire.

Medicaid State Plan Services

DHCF made changes to the District of Columbia Medicaid program in response to the public health emergency (PHE). The changes include benefit changes, service expansions, provider reimbursement increases, authorization changes, and changes to eligibility processing for Medicaid beneficiaries. These changes were effectuated by a combination of emergency State Plan amendments, §1135 Waivers, and §1915(c) Appendix K's. While many of these flexibilities will end with the federal PHE, some will continue as temporary or permanent changes to the District's public health benefits. The District's plan to continue or unwind from these changes is outlined below for each major covered service category.

Pharmacy

Prior to the start of the COVID-19 PHE, reimbursement was only allowed for the dispensing of a thirty (30)-day supply of medications used to treat conditions that are considered chronic or long-term; commonly known as maintenance medications. During the COVID-19 PHE, the District requested and obtained approval to allow reimbursement for dispensing of a ninety (90)-day supply of maintenance medications. Because beneficiaries using maintenance drugs require regular, daily use of these medications, the District intends to continue this policy beyond the end of the COVID-19 PHE.

Expiring Flexibilities: None

Flexibility Made Permanent: Pharmacies may dispense a 90-day supply of maintenance medications.

COVID-19 Vaccination, Testing, and Administration

Pursuant to the requirements under the American Rescue Plan Act of 2021, effective March 11, 2021 (Pub. L. No. 117-2; 42 U.S.C. § 1396d(a)(4)), DHCF is submitted and received CMS approval for an Emergency Relief SPA to receive time limited authority to reimburse COVID-19 vaccine once the federal government discontinues purchasing the vaccine and COVID-19 vaccine administration at one hundred percent (100%) of Medicare rates, effective from March 11, 2021 through the last day of the first calendar quarter that begins one year after the last day of the federal public health emergency. DHCF received time limited authority from CMS to raise reimbursement rates during the PHE for COVID-19 vaccine administration to one hundred percent (100%) of Medicare rates.

DHCF also temporarily increased Medicaid reimbursement of laboratory services related to the diagnostic testing of COVID-19 from 80% of the Medicare reimbursement rate to 100% of the Medicare rate. This temporary increase in reimbursement will remain in place until the last day of the first calendar quarter that begins one year after the last day of the federal PHE, in accordance with requirements established under ARPA. DHCF additionally reimburses pharmacies for at-home COVID-19 test kits at the reimbursement methodology (the “lesser of” logic) for multiple source drugs under the ARPA SPA authority. This temporary authority will also remain in place during the same time frame after the federal PHE ends.

Reimbursement at 100% of Medicare rates for COVID-19 vaccination and administration are incorporated as permanent changes to the State Plan. Reimbursement at 100% of Medicare rates for COVID-19 laboratory testing are temporary changes. At-home testing will be reimbursed in accordance with the methodology established under the temporary amendment to the District State Plan.

Expiring Flexibilities: DHCF may seek additional authority to ensure at-home testing for COVID-19 is covered on a permanent basis to keep reimbursement for COVID-19 PCR/lab tests at 100% of Medicare. Final decisions will be communicated at a future date.

Medicaid Reimbursement and Rate Changes (State Plan) and Related §1135 Flexibilities

DHCF aims to reimburse providers in line with Medicare and Medicaid general principles of reimbursement, ensuring sufficient provider rates for the efficient delivery of needed health care services. A District priority during the COVID-19 pandemic was ensuring sufficient flexibility in Medicaid authorization requirements so that beneficiaries could maintain access to care. To ensure access and simplify requirements for providers during the COVID-19 PHE, DHCF sought approval for several §1135 Waiver flexibilities that impacted provider reimbursement even though not all of them were ultimately implemented:

- Temporary suspension of Medicaid fee-for-service prior authorization requirements;
- Extension of pre-existing authorizations for which a beneficiary has previously received prior authorization through the end of the PHE;
- Suspension of Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessments for thirty (30) days;
- Reimbursement of otherwise payable claims from out-of-state providers not enrolled in the District of Columbia Medicaid; and
- Reimbursement of services in provided in alternative settings, meaning allowing facilities (including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), hospitals, and NFs) to be fully reimbursed for services rendered to an unlicensed facility.

CMS began sunseting these §1135 flexibilities as early as [June 6, 2022](#). All flexibilities tied to §1135 authority will sunset at the end of the federal PHE on May 11, 2023.

During the COVID-19 pandemic, many providers reported increased costs related to the safe provision of care during the PHE. In response, DHCF increased provider reimbursement and proposed reimbursement changes for several State Plan services:

- Increased reimbursement rates for **Adult Substance Use Rehabilitation Services (ASURS)** by 20% effective March 1, 2020;
- Effective November 30, 2022, the District received CMS approval to the rebasing of per diem **specialty hospital** rates until the expiration of the public health emergency;
- Increased reimbursement **for intermediate care facility services for individuals with intellectual disabilities (ICF/IID)** by a 15% increase to the Direct Service cost center effective March 1, 2020;
- Increase reimbursement to **Nursing Facilities (NF)** by 20% to all facility rate components (i.e., Nursing Care Price, Routine and Support Care Price, and Capital Rate) effective March 1, 2020;
- The District is proposing an emergency State Plan Amendment to permit the District to override the “lesser of” fee schedule logic codified in the State Plan; allowing the District to reimburse providers above the amount billed in the event of retroactive rate changes; and
- Amend and increase reimbursement to **Home Health** Agencies for **Skilled Nursing, Private Duty Nursing, and Personal Care Aide (PCA)** services to establish overtime rates, quarantine rates, and staffing agency rates during the PHE.

Flexibilities Expiring on May 11, 2023:

- **ASURS** reimbursement increases will expire at the conclusion of the PHE, on May 11, 2023; and
- The “lesser of” fee schedule logic override will expire at the conclusion of the federal PHE, on May 11, 2023.

Flexibilities Expiring on July 11, 2023:

- **ICF/IID** and **NF** reimbursement increases will be extended for two (2) months following the conclusion of the federal PHE, or until July 11, 2023.

Flexibilities Expiring on November 11, 2023:

- State Plan **Home Health** and **PCA** rates changes will be temporarily extended for six (6) months after conclusion of the federal PHE, or until November 11, 2023. This temporary extension will ensure State Plan rates are in effect for the same duration as §1915(c) **Home Health** and **PCA** rates.

New Frequency:

- The District intends to delay the date of rate rebasing per diem rates for **specialty hospital** services until October 1, 2025 and plans to rebase every four years thereafter. DHCF intends to permanently incorporate this delay and updated rebasing schedule into the District of Columbia Medicaid State Plan.

Federally Qualified Health Centers (FQHCs)

FQHCs and FQHC look-alikes are a vital part of the District of Columbia health care system. DHCF made several changes to FQHC reimbursement to increase support for FQHCs during the PHE.

Effective March 1, 2020, DHCF temporarily modified the State Plan reimbursement methodology for FQHCs to establish a new alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. The per-member-per-month (PMPM)APM converted the approved FQHC per encounter reimbursement rate into an equivalent PMPM rate using historical beneficiary utilization and expenditures from December 1, 2018 through November 30, 2019.

DHCF established three PMPM APM rates, with one established for each service category of the approved APM in place on February 29, 2020: primary care; behavioral health; and preventive and diagnostic dental, and comprehensive dental. Under the PMPM APM, DHCF reimburses FQHCs a PMPM rate (for each service category) for each attributed beneficiary. DHCF used historical utilization data to establish assignment to an FQHC.

Due to implementation of the PMPM APM, DHCF also delayed the scheduled FQHC rebasing to January 1, 2022. The rebasing schedule will be permanently changed to occur every three years following January 1, 2022.

Expiring Flexibilities: The PMPM APM will expire at the end of May 2023. FQHC services with delivery dates on or after June 1, 2023 will be reimbursed in accordance with the reimbursement methodology in place on February 29, 2020.

New Frequency: The rebasing schedule will be updated to every three years after January 1, 2022, on a permanent basis.

Health Homes: My Health GPS

Effective April 1, 2020, DHCF made temporary changes to the My Health GPS health home program to eliminate acuity tiers, face-to-face requirements, update care team staffing requirements, and modify reimbursement during the public health emergency.

Changes included:

- Enrollment of My Health GPS beneficiaries into a single acuity tier, replacing the currently approved Acuity Levels 1 and 2;
- Changing the My Health GPS acuity-based staffing model set forth under the State Plan to instead allow for the following staff participation ratios per 400 enrolled beneficiaries: Health Home Director (0.5 FTE), Nurse Care Manager (2 FTE), Social Worker (1 FTE), and Community Health Worker (1 FTE);

- Removing the in-person requirements for the initial and annual a biopsychosocial assessment to allow My Health GPS providers to complete the required initial and annual biopsychosocial assessments via video conferencing or other electronic modality or telephone, in accordance with HIPAA requirements;
- Establishment of a new per member per month (PMPM) rate and frequency. In place of the previously approved two PMPM rates based on different acuity levels, DHCF established a single combined rate reimbursable quarterly to providers who provide at least one authorized My Health GPS activity per quarter. The quarterly reimbursement rate to My Health GPS providers is \$304.98; and
- Temporarily delayed implementation of My Health GPS pay-for-performance and quality reporting requirements set forth in the State Plan until fiscal year 2022 in order to decrease the administrative burden on My Health GPS providers due to the public health emergency.

DHCF intends to permanently incorporate these changes to My Health GPS into the District of Columbia Medicaid State Plan with corresponding changes to the DCMR.

Expiring Flexibilities: None

Home and Community Based Waiver Services (HCBS), State Plan Long Term Services and Supports, and Related §1135 Flexibilities

The pandemic’s disproportionate impact on individuals receiving care in congregate care settings highlighted the crucial role of Medicaid home and community-based services in safely and effectively meeting the long-term care needs of older adults and individuals with disabilities. The District used the authorities available under the PHE declaration to offer additional flexibilities and to ensure ongoing access to these critical services. The PHE actions temporarily modified program policies and offered additional resources so that individuals and providers could implement social distancing strategies to mitigate the spread of COVID-19 as well as respond to workforce and supply chain disruptions caused by the pandemic.

The District used the §1135 waiver authority to temporarily waive requirements for signatures from the participant and all providers responsible for implementation of the person-centered service plan prior to service delivery. The §1135 waiver authority was also used to allow for services to be delivered in settings which have not been verified as compliant with home and community-based setting requirements when an individual requires relocation to an alternative setting to ensure service continuity. Finally, the District utilized the §1135 waiver authority to delay initial assessments of need to create a plan of care and reevaluations for §1915(i) and §1915(c) services for up to one (1) year. These flexibilities will sunset on or before the end of the federal PHE.

The American Rescue Plan Act (ARPA) of 2021 was signed into law on March 11, 2021. Section 9817 of ARPA provides states with a temporary ten (10) percentage point increase to the federal medical assistance percentage (FMAP) for Medicaid Home and Community-Based Services

(HCBS). States must use funds equivalent to the amount of federal funds attributable to the increased FMAP to implement activities that enhance, expand, or strengthen Medicaid HCBS.

HCBS is defined broadly in the statute and guidance to include traditional HCBS services (home health, §1915(c) waivers, §1915(i) services, etc.) and services provided under the rehabilitative services option (ASARS, MHRS), regardless of whether those services are delivered under managed care or approved under a Section §1115 demonstration program. Federal guidance also makes clear that Section 9817 creates an opportunity for reinvestment of local savings to draw additional enhanced FMAP.

ARPA Section 9817 imposed maintenance of effort requirements on state's using ARPA 9817 funds to enhance, expand, and strengthen Medicaid HCBS. In order to meet ongoing maintenance of effort requirements, the District must:

- Use federal funds attributable to the increased FMAP to supplement and not supplant existing local funds expended for Medicaid HCBS in effect as of April 1, 2021.
- Use local funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.
- Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021.
- Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Additionally, states are expected to retain temporary changes made under Appendix K or emergency state plan authority for as long as allowable under those authorities but will not be penalized/deemed noncompliant when/if those changes expire.

The ARPA 9817 maintenance of effort requirements are considered in the outline of expiring flexibilities outlined below.

Elderly and Physically Disabled (EPD) §1915(c) HCBS Waiver

The District amended the EPD waiver five times using the Appendix K emergency preparedness and response addendum. These amendments temporarily modified EPD waiver policies to:

- Allow for level of care assessments to be completed remotely.
- Suspend requirement for physician/APRN signature for level of care assessment requests.
- Allow for participant-directed community services to exceed the 16 hours per day limitation.
- Allow for reimbursement of participant-directed community services delivered by family members.

- Suspend CPR and First Aid training and certification renewal requirements for participant-directed service providers.
- Allow for respite services to exceed the 17 hours per day limitation.
- Extend community transition service eligibility to 120 days prior to the facility discharge date.
- Continue coverage for Personal Emergency Response Systems (PERS) during the implementation of state plan DME MADS benefits.
- Allow for limitation of the ability to have visitors at any time for participants who receive services in provider owned or controlled settings.
- Allow for person-centered service plan development and monitoring activities to be conducted remotely.
- Increase payment rates to account for higher staffing costs.
- Provide retainer payments to Adult Day Health Program (ADHP) providers.

Flexibilities That Expired on November 1, 2022:

- On November 1, 2022, Liberty Health Care, DHCF’s assessment partner, resumed face-to-face assessments for long-term services and supports. Many beneficiaries likely had an assessment with Liberty Health Care by phone during the PHE. However, a beneficiary’s next assessment will be conducted in person at a time and location convenient to the beneficiary.

Flexibilities That Expired on March 1, 2023:

- Effective March 1, 2023, required in-person activities by EPD Waiver providers resume, including collection of “wet” signatures (by beneficiaries, physicians, or others) and in-person monthly visits by case managers and in-person visits by support brokers.

Flexibilities Expiring on April 1, 2023:

- On April 1, 2023, DHCF and its partners will resume “adverse actions” related to long-term services beneficiaries may receive as a part of their Medicaid coverage. During the pandemic, even if an assessment determined an individual no longer was eligible to receive certain services, services have continued without any changes. Beginning on April 1, this practice will end, meaning beneficiaries’ services may change based on their assessment.

Flexibilities Expiring on November 11, 2023:

- Due to ARPA 9817 maintenance of effort requirements, authority for service and payment changes will remain in effect until six months following the conclusion of the federal PHE. These include 1) Allowance for participant-directed community services to exceed the 16 hours per day limitation; 2) Allowance for reimbursement of participant-directed community services delivered by family members; 3) Allowance for respite services to exceed the 17 hours per day limitation; 4) Addition of coverage for PERS; 5) Increased payment rates to account for higher staffing costs; 6) and allowance of retainer payments to ADHP providers.

- In addition to increased payments rates remaining in place for six (6) months following the conclusion of the PHE, DHCF intends to amend the EPD Waiver to make increased assisted living rates permanent until a more comprehensive reimbursement methodology update is established.

Persons with Intellectual and Developmental Disabilities (IDD) Waiver

The District amended the IDD waiver six times using the Appendix K emergency preparedness and response addendum. These amendments temporarily modified IDD waiver policies to:

- Extend annual physical exam requirements for up to 180 days.
- Allow for reimbursement of companion services delivered by family members and legally responsible individuals.
- Expand companion service provider qualifications to include supported living, residential habilitation, and host home providers.
- Suspend CPR and First Aid training and pre-employment background check requirements for certification requirements for participant-directed service providers.
- Postpone certification reviews for supported living, residential habilitation, host home, and in-home supports providers.
- Allow for additional flexibility in provider staffing ratio requirements.
- Suspend initial and annual training requirements for direct support professionals and allow for online training as an alternative to in-person training.
- Allow for assistive technology providers to be certified by enabling technologies specialist and accredited technology first organizations.
- Allow for remote delivery of physical therapy; supported employment; occupational therapy; speech, language, and hearing; creative art therapies; day habilitation; individualized day supports; employment readiness; community support; companion; and behavioral support services.
- Allow for supported employment, periodic supported living, and in-home support services to be delivered remotely in excess of the 20% limit.
- Suspend prior authorization requirements for direct support professional, personal care aide, and skilled nursing services supporting participants who are quarantined.
- Expand the settings in which day habilitation, individualized day support, employment readiness, and respite services may be rendered.
- Increase limits on individualized day supports.
- Allow for delivery of select services during acute hospitalization or short-term institutionalization when required to support communication, behavioral stabilization, or intensive personal care needs.
- Allow for person-centered service plan development and monitoring activities to be conducted remotely.
- Modify incident reporting requirements related to staffing deviations.

- Allow for incident report follow-up visits to be waived or conducted remotely.
- Increase payment rates to account for higher staffing costs.
- Increase enhanced reimbursement rate for the RN and LPN components included within the per diem rate for Supported Living Daily with or without Transportation and Residential Habilitation services
- Allow for supplemental payments to providers that increase wages paid to direct support professionals through 9/30/2022.
- Allow for supplemental payments to reimburse providers for increased personal protective equipment costs.
- Provide retainer payments to day program service providers.

Flexibilities Expiring on November 11, 2023: All flexibilities will remain in place through six (6) months following the conclusion of the federal PHE, until November 11, 2023.

Individual and Family Support (IFS) Waiver

The District amended the IFS waiver three times using the Appendix K emergency preparedness and response addendum. These amendments temporarily modified IFS waiver policies to:

- Allow for reimbursement of companion services delivered by family members and legally responsible individuals.
- Allow for additional flexibility in provider staffing ratio requirements.
- Suspend initial and annual training requirements for direct support professionals and allow for online training as an alternative to in-person training.
- Allow for assistive technology providers to be certified by enabling technologies specialist and accredited technology first organizations.
- Allow for remote delivery of physical therapy; supported employment; occupational therapy; speech, language, and hearing; creative art therapies; day habilitation; individualized day supports; and employment readiness services.
- Increase limits on individualized day supports.
- Allow for supplemental payments to providers that increase wages paid to direct support professionals through 9/30/2022.
- Allow for supplemental payments to reimburse providers for increased personal protective equipment costs.

Flexibilities Expiring on November 11, 2023: All flexibilities will remain in place through six (6) months following the conclusion of the federal PHE -November 11, 2023.

§1915(i) and § 1915(c) Adult Day Health Programs (ADHP)

The District submitted two State Plan Amendments to temporarily modify ADHP policies under the §1915(i) HCBS authority.

- Expand ADHP services to include wellness checks provided via video conferencing/other electronic modality (e.g., Skype, FaceTime).

- Expands §1915(i) HCBS ADHP services to include the following services, when delivered via video conferencing/other electronic modality or telephone: remote therapeutic activities conducted individually or in groups by a licensed therapist and remote nursing services conducted individually by a licensed nurse
- Allows §1915(i) eligibility evaluation and §1915(i) face to face independent assessment requirement using telehealth/telemedicine.
- Allows payment for services delivered via telehealth that differ from payments for the same services when provided face to face, for adult day health services.
- Permit the District Medicaid program to make retainer payments to Adult Day Health Program (ADHP) providers whose operations have been impacted by the PHE.

These changes were mirrored under the §1915(c) EPD Waiver’s ADHP.

Flexibilities That Expired on November 1, 2022:

- On November 1, 2022, Liberty Health Care, DHCF’s assessment partner, resumed face-to-face assessments for long-term services and supports. Many beneficiaries likely had an assessment with Liberty Health Care by phone during the PHE. However, a beneficiary’s next assessment will be conducted in person at a time and location convenient to the beneficiary.

Flexibilities Expiring on November 11, 2023: All flexibilities except independent assessments via telehealth will remain in place through six (6) months following the conclusion of the federal PHE - November 11, 2023. DHCF will submit a temporary State Plan amendment to preserve state plan flexibilities set to expire after the conclusion of the federal PHE.

§1915(i) Housing Supportive Services (HSS)

The District submitted an emergency State Plan Amendment to temporarily modify HSS policies operated under the §1915(i) HCBS authority to broaden the criteria and certification requirements for individuals who provide services for the HSS agency as a case manager supervisor. If approved, effective May 1, 2022, (which is retroactive to the effective date of the original SPA) individuals who meet the following criteria may serve as case manager supervisors:

- A master’s degree in a human services field with a minimum of two (2) years of professional experience providing counseling supportive services to individuals experiencing homelessness or other vulnerable populations and certification as a Licensed Independent Clinical Social Worker (LICSW) or Licensed Professional Counselor (LPC); or
- A master’s degree in a human services field with a minimum of two (2) years of professional experience providing counseling supportive services to individuals experiencing homelessness or other vulnerable populations, under the supervision of a LICSW or LPC that is employed by the HSS agency and responsible for the delivery of HSS; or

- A certification as a Social Worker (LGSW) or Licensed Graduate Professional Counselor (LGPC) with a minimum of two (2) years of professional experience providing counseling supporting to individuals experiencing homelessness or other vulnerable populations; or
- A bachelor’s degree with a minimum of four (4) years of experience providing counseling supportive services to individuals experiencing homelessness or other vulnerable populations, and a minimum of two (2) years of supervisory experience.

Expiring Flexibilities: None. DHCF intends to permanently incorporate these changes into the District of Columbia Medicaid State Plan.

Provider Enrollment Flexibilities and Related §1135 Flexibilities

In accordance with D.C. Official Code § 4–131, the Director of DHCF was delegated the authority vested in the Mayor by Section 303 of the COVID-19 Response Emergency Amendment Act of 2020 (D.C. Act 23-247) and renewed in Section 508 of the Coronavirus Support Temporary Amendment Act of 2020 (D.C. Law 23-130) and Section 508 of the Coronavirus Support Temporary Amendment Act of 2021 (D.C. Law 24-9) to take other actions as appropriate to support the continuity of, and access to, benefits provided by any public benefit program. DHCF utilized this authority, along with flexibilities put in place by other District agencies, to make several programmatic changes in response to COVID-19, including increasing flexibilities with regard to provider enrollment.

- Maintaining provider enrollment through expiration of their license, consistent with flexibilities put in place by DC Health; and
- Enrolling Certified Nursing Aides licensed in the District, Maryland, and Virginia to provide Medicaid personal care aide services, consistent with flexibilities put in place by DC Health.

Additionally, DHCF sought authorization of provider enrollment flexibilities authorized [under §1135 waiver authority](#) including enrollment of providers who are enrolled with another State Medicaid agency or Medicare for the duration of the public health emergency.

Although the DHCF received approval of this provision, this change was not implemented during the federal PHE.

Flexibilities Expiring on May 11, 2023: All flexibilities authorized under §1135 expire on or before the end of the PHE on May 11, 2023.

As communicated in [State Medicaid Director Letter #21-03](#), DHCF will continue to adhere to any licensure and clinician certification flexibilities granted by DC Health on a temporary or permanent basis.

Providers Enrolled in Managed Care

The District is currently contracted with five (5) Managed Care Organizations to provide services to DHCF beneficiaries, and they are AmeriHealth Caritas District of Columbia, CareFirst Community Health Plan District of Columbia, Health Services Children with Special Needs, MedStar Family Choice District of Columbia, and UnitedHealthcare ([Dual Choice](#)).

Providers should follow instructions provided by the enrollee's MCO for billing and prior authorizations. Providers should contact the appropriate MCO for more information or any questions:

- AmeriHealth Caritas DC Provider Services: 202-408-2237 or 1-888-656-2383
- CareFirst Community Health Plan DC Provider Services: 202-821-1100
- Health Services for Children with Special Needs (HSCSN) Provider Services: 202- 467- 2737 | Option #2
- MedStar Family Choice DC Provider Services: 855-798-4244
- UnitedHealthcare Provider Services: 888-350-5608

Resources

Additional information and updates for providers and beneficiaries can be found on the DHCF website and elsewhere online:

- [Medicaid Beneficiary COVID-19 Updates](#)
- [Program Updates and Provider Transmittals](#)
- [Informational Bulletins for Long Term Care Providers](#)
- [District of Columbia COVID-19 Updates](#)
- [HHS COVID-19 Updates](#)

Contact Us

General questions about Medicaid Restart (inclusive of eligibility, operations, and authorities related to the PHE) should be directed to Medicaid.Restart@dc.gov.

Questions specific to Medicaid eligibility renewals and the return to normal eligibility operations should be directed to Medicaid.Renewal@dc.gov.

Future Updates

Part I, additional information on the strategies and processes the District will put in place for 1) obtaining up-to-date contact information for beneficiaries and 2) contacting beneficiaries for whom the agency receives returned mail.

Glossary of Commonly Used Terms

Adult Day Health Program (ADHP): Community-based supports that promote community inclusion and offer services in a non-residential group setting, paid through Medicaid and available through the State Plan and EPD Waiver.

Adult Substance Use Rehabilitation Services (ASURS): A community-based substance use treatment services covered under the Rehabilitation benefit of the State Plan.

Alternative Payment Methodology (APM): A payment approach that insurers such as Medicaid gives added incentive payments to health providers to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population/

American Rescue Plan Act (ARPA): The bill, signed into law on March 11, 2021 is a piece of legislation that provides additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

Centers for Medicare and Medicaid Services (CMS): Federal agency that regulates Medicaid and Medicare nation-wide.

DC Health Link: The online marketplace created for individuals, families, and small business owners in the District of Columbia to shop, compare, and select health insurance that meets their health needs and budgets, available online or through a phone call.

Department of Health Care Finance (DHCF): District of Columbia's state Medicaid agency. In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children and the Alliance Program.

District of Columbia Municipal Regulations (DCMR): Official compilation of the permanent rules and regulations promulgated by executive departments, agencies and independent entities of the government of the District of Columbia. The DCMR is divided into titles, of which Title 27 contains the rules for contracts and procurements.

Elderly and Physically Disabled (EPD) Waiver: The home and community-based waiver in the District's Medicaid program that provides services in the homes of individuals who would otherwise need to live in a nursing home. The goal of the program is to help beneficiaries live independently in their own home or community.

Enrollment Broker: Provides each eligible managed care beneficiary information about the health plans provided under the Medicaid program and assist them in selecting a health plan that will meet their health needs. Enrollment Brokers can review and update contact information, assist in comparing health plans or with finding a doctor, and advise on meetings in your area to learn more about the health plans.

Families First Corona Virus Response Act (FFCRA): The Act of Congress meant to respond to the economic impacts of the ongoing COVID-19 pandemic. The act provides funding for free coronavirus testing, 14-day paid leave for American workers affected by the pandemic, and increased funding for food stamps.

Federal Medical Assistance Percentage (FMAP): The percentage rates used to determine the federal matching funds rate allocated annually to Medicaid programs.

Federally Qualified Health Centers (FQHC): A community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Fee-For-Service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits. Also refers to types Medicaid Program, as in those not enrolled in managed care.

Full-Time Equivalent (FTE): The unit of measurement for employees used by measuring the total number of full-time hours worked by all employees in a business and comparing it to what would have been worked if the employees had all been full-time (40 hours a week).

Health and Human Services (HHS): The U.S. Department of Health and Human Services, the federal agency that oversees the Medicaid program and other health-related functions.

Home and Community Based Waiver Services (HCBS): A program of supports and services that enables adults and children with developmental disabilities to live in the community as an alternative to facilities.

Immigrant Children's Program (ICP): The health coverage program in the District that is offered to children under age 21 who are not eligible for Medicaid due to citizenship or immigration status. The ICP includes a range of health care services to include primary care services, doctor visits, prescription drugs, dental services, and wellness programs.

Individual and Family Supports (IFS): A §1915(c) Home and Community-Based Waiver Program that provides person-centered services to enable people with developmental disabilities to live in the community.

Intellectual and Developmental Disabilities (IDD): A diagnosis that includes many severe, chronic conditions that are due to mental and/or physical impairments, which qualify for certain services in Medicaid. Also refers to a §1915(c) Home and Community-Based Waiver Program in the District.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): A facility that serves four (4) or more persons with intellectual disability or persons with related conditions and provides health or rehabilitative services on a regular basis to individuals whose mental and physical conditions require services including room, board, and active treatment for their intellectual disability or related conditions.

Managed Care Organization (MCO): Provide for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services.

Medical Assistance Devices and Services (MADS): Medical equipment which withstands repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, is appropriate for use in the recipient's home

Mental Health Rehabilitation Services (MHRS): Community-based mental health services covered under the Medicaid State Plan.

Modified Gross Adjusted Income (MAGI): The methodology for how income is counted and how household composition and family size are determined for eligibility for Medicaid and other DHCF health programs. MAGI applies to adults without dependent children, non-disabled children, pregnant women and parents/caretaker relatives applying for DHCF health coverage.

National Change of Address (NCOA): System available through the Post Office that makes available current change of address information to forward your mail and provide notification of a change of address.

Nursing Facilities (NF): 24-hour inpatient facilities, primarily engaged in providing professional nursing services, health-related services, and other supportive services needed by the patient/resident.

Office for Civil Rights (OCR): An office within HHS that enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule.

Per Member Per Month (PMPM): Measurement of payments made to providers by Medicaid organizations, done by computing the average cost of a beneficiary per month and paying that to the provider.

Personal Care Aides (PCA): Workers who provide assistance with activities of daily living provided in a person's home or community setting.

Personal Emergency Response System (PERS): Light-weight, battery-powered devices worn around your neck, on a wrist band, on a belt, or in your pocket that let you call for help in an emergency by pushing a button for help.

Program of All-Inclusive Care for the Elderly (PACE): A nationally recognized model of care that integrates Medicare and Medicaid benefits for eligible beneficiaries. Under PACE, beneficiaries are eligible for a broader array of benefits than is typically available under either Medicaid or Medicare programs and their care is managed by a comprehensive, inter-disciplinary team of clinical professionals working to deliver high-quality and highly coordinated care.

Public Health Emergency (PHE): A declaration of an outbreak or disease-related emergency that allow states and federal authorities to access certain funds and authorities to take certain actions in response.

Social Security Administration (SSA): The federal agency which administers both Social Security benefits and the Supplementary Security Income (SSI, often referred to as “disability”) program.

State Health Official (SHO): Named for the leadership of the Medicaid program in the State. In the District, the SHO is the Medicaid Director and Senior Deputy Director.

State Medicaid Agency (SMA): The agencies responsible for administering Medicaid programs -in the District, it’s the Department of Health Care Finance (DHCF),

State Plan Amendment (SPA): A document which makes changes to a Medicaid program’s policies or operational approach that allows it to keep receiving federal funds.

Supplemental Nutritional Assistance Program (SNAP): The SNAP program (formerly known as Food Stamps) helps low-income individuals and families by providing monthly benefits to purchase food. SNAP benefits are provided on an Electronic Benefits Transfer (EBT) card that is used as a debit card.

Teletype/Telecommunications Device for the Deaf (TTY/TDD): Any text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

Temporary Assistance to Needy Families (TANF): A program that provides cash assistance to families in need, so long as they are income eligible and have a child in the home.

United States Postal Service (USPS) The independent federal agency that picks up and delivers the mail.