Perinatal Mental Health Task Force

March 28, 2023

Meeting Overview

- Welcome and Overview
- Observations of Individuals with Lived Experiences
- Perinatal Mental Health Primer, Part II
- Findings from Other States
- Discussion on Proposed Subcommittees
- Medicaid Renewals
- Other Business and Announcements
- Public Comment

PROGRAMS AND RESOURCES

MMH HOTLINE

HRSA Maternal & Child Health

PSI POSTPARTUM SUPPORT INTERNATIONAL

1-833-9-HELP4MOMS
1-833-943-5746

- 24 / 7 / 365; voice and text; English and Spanish
- Staffed by licensed and credentialed mental health, healthcare, and childbirth professionals; certified peer specialists
- Provides education, information, support, brief intervention, resources
- Reciprocal agreements with other hotlines for "hot" hand-offS

POSTPARTUM SUPPORT INTERNATIONAL

SUPPORT TO MOTHERS / FAMILIES

Warmline

Volunteers in all states

Volunteers for special situations

Online provider directory

20+ online support groups

TRAININGS FOR PROVIDERS

Free introductory webinar

Webinar series

2-day Certification Course

Advanced trainings

Annual conference

PSI POSTPARTUM SUPPORT INTERNATIONAL

www.postpartum.net

PREVENTION PROGRAMS

Reach Out, Stay Strong, Essentials for mothers of newborns

An empirically-validated prevention intervention for PPD, ROSE is an educational class provided during pregnancy in settings that provide health care to low-income pregnant women

Mothers and Babies

Mothers & Babies is an evidence-based program that uses cognitive behavioral therapy and attachment theory, and is being scaled throughout the U.S. and internationally

PREPP (Practical Resources for Effective Postpartum Parenting

PPD is viewed as a disorder of the mother–infant dyad, which can be approached through preventive psychological and behavioral changes in the mother — commencing before birth — that affect her and the child

PSYCHIATRY ACCESS PROGRAMS

1

EDUCATION

Trainings and toolkits for frontline providers and staff

2

CONSULTATION

Real-time psychiatric consultation for frontline providers

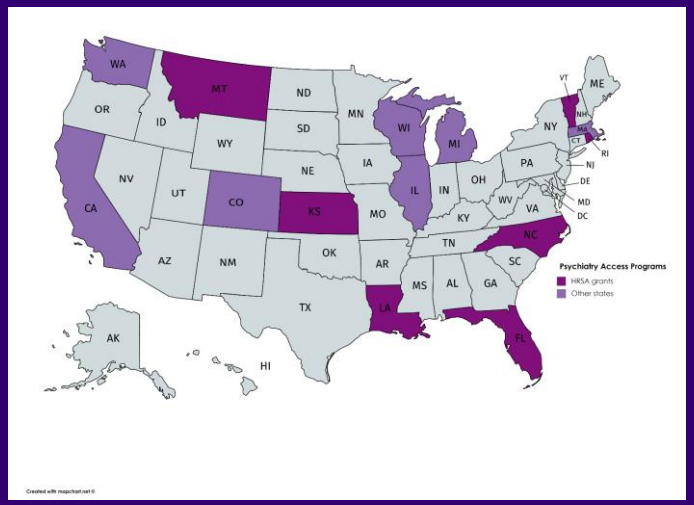
3

RESOURCE & REFERRAL

Linkages with community-based resources

Massachusetts Child Psychiatry Access Program
MCPAP For Moms

Lifeline for moms



STATE POLICIES

Screening Requirements

California
Delaware
Florida
Illinois
New Jersey
Oklahoma
Pennsylvania
Texas
Utah
West Virginia

Education for Providers and/or Parents

California
Delaware
Illinois
Minnesota
Oklahoma
Oregon
Pennsylvania
Tennessee
Utah
Virginia

Public Awareness Campaigns

California
Colorado
Florida
Maryland
Michigan
New York
Oregon
Utah
Washington

Task Forces / Commissions

Arizona
California
Colorado
DC
Florida
Maine
Massachusetts
Maryland
Oregon
Utah

PMH Awareness Proclamations

Arizona
California
Georgia
Illinois
Indiana
Michigan
Minnesota
Montana
New Jersey
North Carolina
North Dakota
Pennsylvania
Texas
Tennessee
Utah
Virginia

SCREENING & EDUCATION

PMH EDUCATION & SCREENING PROJECT

- Multi-hear collaborative effort led by MMHLA and March of Dimes
- Synthesize existing screening recommendations
- Create Framework for PMH Education & Screening
- Address barriers to screening

ROUTINE SCREENING
Conception to full year postpartum

PREGNANCY
At initiation of obstetric care
Each trimester

DELIVERY
Prior to discharge
Within 3 weeks postpartum

POSTPARTUM
All well-baby visits
2 wks, 1, 2, 4, 6, 9, 12 months
Obstetric follow up

Approximately 25 interactions with healthcare providers

WHO SHOULD SCREEN?

Conversation should start with the PROVIDER

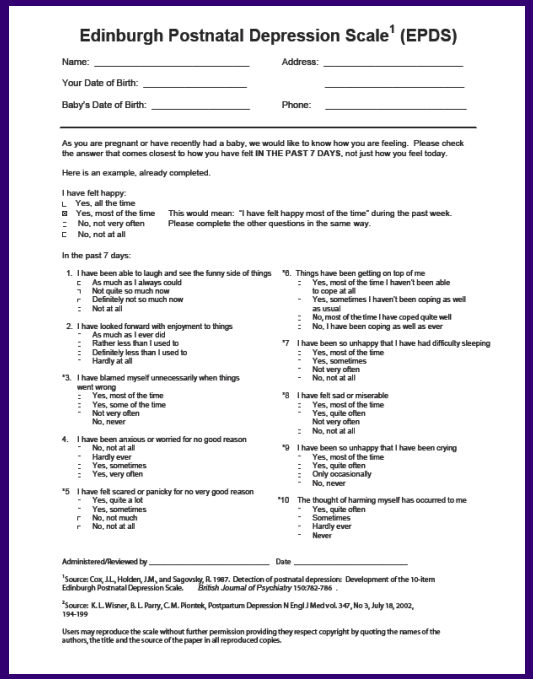
- Mom looks to provider as the expert
- If provider takes it seriously, then mom will take it seriously

Screening can be provided by ANYONE

- Screening must be done thoughtfully
- Moms may be more comfortable talking with nurse

HOT TIP Designate a "PMAD" specialist on staff

WHAT SCREENING TOOL SHOULD BE USED?
Edinburgh Postnatal Depression Scale



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- No, not very often — Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5 I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8 I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10 The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K.L. Wisner, B. L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh postnatal depression scale. Br J Psychiatry. 1987;150(6):782–786.

- Since 1987
- FREE
- Short: 10 questions
- Easy to score
- Validated in pregnancy & postpartum
- Depression, anxiety, & suicidality
- Controls for changes associated with pregnancy & postpartum (sleep, appetite)
- No "test fatigue"
- Not culturally relevant for some ethnic groups

(Cox, Holden, & Sagovsky, 1987; Chen et al., 2021)

WHAT SHOULD WE SAY?

Talk about MMH…early and often!

CONVERSATION STARTERS

- Childbearing women are at increased risk
- #1 complication of pregnancy / childbirth
- Transition to motherhood can be challenge
- Having a baby in the house is stressful
- Many changes taking place:
  - ✓ Physical changes
  - ✓ Lack of sleep
  - ✓ Expectations vs. reality
  - ✓ Role transition

POSSIBLE SCRIPT

Your mental health is as important as your physical health.

Every time I see you, I'm going to ask **"How are *you* doing?"**

We're going to screen you periodically.

Our job is to task.

Your job is to be honest.

The sooner we identify difficulties, the sooner we can address them.

BARRIERS
From the provider's perspective

Training

Reimbursement

Resources

I don't know what to say.

I don't know what to do.

Asking about it will make it worse.

I don't get paid.

I don't have time.

What if she falls apart in my office?

If I ask, then it's my problem.

She's not my patient.

BARRIERS
From the mother's perspective

Shame
Stigma
Cultural issues
Fear of losing baby
Fear of being labeled a "bad mom"

Moms don't know anything is wrong

Moms don't know where to go or what to say

Moms are afraid or ashamed

Time off from work
Transportation
Childcare
Insurance

SOLUTIONS

#1 Mental health must be treated as importantly as physical health

- Mental health parity in insurance
- Stigma around mental health must be decreased
- Mental health should be imbedded with physical health

#2 Resources must be widely available

- Support groups, therapists (social workers, counselors, psychologists), psychiatrists, in-patient programs
- Medications, alternative treatments, prevention programs
- Access to affiliated providers such as doulas, home visitors, etc.

#3 Providers must be educated and trained

- Knowledge is power
- Medical and nursing school
- Residency programs for obstetricians, pediatricians, family physicians
- Fellowship programs for psychiatrists

LEARN MORE

LEARN MORE!

National Curriculum in Reproductive Psychiatry

ncrptraining.org

Learning modules

Online and Classroom

Women's Mental Health Across the Lifespan

Pregnancy & Postpartum

5-hour Essentials

Marce Society

perinatalmentalhealth.com

Research-focused

Bi-ennial Conference

Postpartum Support International

postpartum.net

Support to parents

Provider education

Annual conference

FINAL THOUGHT…

Birth is not only about making babies.

Birth is about making mothers –
strong, competent, capable mothers
who trust themselves and know their inner strength.

-- Barbara K. Rothman

LEARN MORE!


PSI
POSTPARTUM SUPPORT INTERNATIONAL


POSTPARTUM
Action INSTITUTE


GPS
GROUP
PEER
SUPPORT


POSTPARTUM
RESOURCE CENTER
OF NEW YORK


THE POSTPARTUM
STRESS CENTER


PERINATAL
SUPPORT WASHINGTON


SELENI


MGH
CENTER for
Women's Mental Health
Reproductive Psychiatry Resource & Information Center


CE4less


BLOOM
FOUNDATION


Postpartum Support Virginia
Hope and help for new mothers


MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

Findings from Other States

Common Themes

- 11 states have formed a Task Force, Review Program, Commissions or Committee which mentions perinatal mental health and have issued
- Reports span from 2007 (Oregon) to 2022 (Arizona)
- In addition to Task Force meetings:
  - Workgroups
  - Interviews/focus groups
  - Systematic literature reviews
- Areas of focus
  - Screening and Referral
  - Provider Education
  - Policy and Legislation
  - Financing
  - Community Support

California

- The resolution called for the formation of a Task Force to study, review, and identify:
  - Current barriers to screening and diagnosis.
  - Current treatment options for both privately insured and those who receive care through the public health system.
  - Evidence-based and emerging treatment options that are scalable in public and private health settings.
  - The Task Force was also asked to identify the needs of both providers and patients in order to improve diagnosis and treatment.
- Meetings Occurred over a period of 12 months
- Expert presentations exploring:
  - MMH prevalence data
  - Existing research
  - Barriers to care
  - Provider shortage areas
  - Innovative programs
  - Public policies both within and outside of California
- Scope and Limitations: Would have benefited if they included intimate partner violence, substance abuse, mental health of partners, including fathers; and special populations (e.g., military families and incarcerated women).
- Report published 2017; Follow-up report 2019

Work Products

- Provider Core Competencies
  - The competencies were developed to address baseline levels of knowledge to recognize and address MMH disorders, among the different types of providers encountering pregnant and postpartum women
- Continuum of Care Reference
  - Critical time frames when providers in various settings should engage with women to address MMH
- Screening: Score “Cut Offs” and Timing Recommendations
  - As a result of Task Force inquiries, Postpartum Support International (PSI) developed recommended guidelines for uniform “cut-off” scores for the two most popular screening tools identifying maternal depression/anxiety as well as screening frequency and intervals.
- A “Menu” of Prevention and Treatment Options
  - To help Ob/Gyns (the provider type who the Task Force deemed should be the “home base” for education, detection, and treatment of mental health disorders) facilitate treatment, the Task Force adapted from the Massachusetts Child Psychiatry Access Program for Moms (“MCPAP for Moms”) toolkit, a “Menu” of prevention and treatment options. This range of options should be presented and discussed with women, so they have the opportunity to select interventions that are the most appealing given personal preferences and needs.
- An explicit Call-to-Action for Individual Stakeholder Groups
  - detailed framework is meant to provide all critical players with a detailed road map or starting point for change.

Barriers and Recommendations

- **Providers lack guidelines, referral pathways, capacity, and support to screen and treat.**

- **Recommendations:**

1. California Ob/Gyns and other obstetric providers should be prepared to serve as the 'home base' for MMH and should immediately adopt the screening and treatment guidelines of ACOG and the Council on Patient Safety in Women's Health Care.
2. Though Ob/Gyns and other obstetric providers must serve as the "home base" for education, screening, treatment and referral, all health care providers must be in a position to screen and detect MMH disorders and when needed, refer women back to their Ob/Gyns or other local treatment programs.
3. Leaders from boards and/or education and advocacy organizations should develop certification boards for mental health providers who wish to be recognized as MMH specialists by the year 2021
4. Provider-to-provider reproductive consult program(s) should be piloted immediately and the results reported to the legislature in order to promulgate a new statewide provider resource to be implemented by the year 2021
5. Insurers should develop MMH case management programs to oversee women's treatment access, reporting back to the Ob/Gyn.

Barriers and Recommendations

Medical and mental health insurance and health delivery systems and providers are not integrated.

Recommendation:

- In order to lay the groundwork for provider behavioral health integration, medical insurers should first bring mental health in-house, include mental health benefits in all medical care benefit contracts, and expand medical provider contracts to reimburse for MMH services.

Ob/Gyn screening rates are not measured and reported.

Recommendation:

- National accrediting and measurement bodies should develop and adopt HEDIS measure(s) for screening and treatment of MMH disorders by the year 2021

Stakeholder groups lack a framework or road-map for coordinated change.

Recommendation:

- Stakeholder groups, such as state agencies, the insurance community, the hospital community, the employer community, funders and health care provider trade associations, should use the framework developed by the Task Force to guide efforts to close gaps in MMH care.

Barriers and Recommendations

Women don't receive adequate MMH support and education.

Recommendations:

1. The California Department of Public Health (CDPH) should develop a culturally and linguistically appropriate statewide public awareness campaign to normalize and destigmatize MMH disorders after treatment shortages have been addressed, and before the year 2022.
2. Local communities should form new or employ existing coalitions to address MMH, including correcting local treatment shortages/referral pathways, disseminating educational materials and awareness campaigns, and improving support resources for mothers.
3. Family-friendly policies and resources which aim to reduce maternal stress should be considered by employers, communities, and the state legislature.
4. Churches, community centers, business and others serving women who are pregnant or in the postpartum period should be aware of MMH disorders, their prevalence and symptoms, and be prepared to assess for trouble and refer to an Ob/Gyn or another community resource.

Louisiana

- Resolution enacted the formation of the Louisiana Maternal Mental Health Task Force, stipulating representation from specified agencies, advocacy organizations, and service providers.
- Led: the Bureau of Family Health and Institute of Women and Ethnic Studies (IWES), a community-based public health organization based in New Orleans.
- Task Force assessed formal clinical services and upstream factors related to perinatal mental health, including:
  - Acknowledging the role of cultural oppression in mental illness
  - Centering at the margins and giving voice and power to those who are voiceless or disempowered by current systems of care
  - Being innovative to build on the strengths of individuals and their communities to emphasize the extent to which oppressed peoples have survived under oppressive conditions
  - Working to resist and interrupt the intergenerational transmission of racist narratives of Black and Brown people, migrants, and people who are seeking asylum in the US

Patient Barriers and Solutions

- Personal Time
  - Patients insured by Medicaid are often hourly workers. Long wait time or multiple appointments in order to access treatment can be a deterrent to accessing care due to the impact on employment, child care, and other demands on the lives of mothers/birthing people.
    - Solutions: Conduct Screening at pediatric visits; utilize telemedicine
- Lack of Providers/Accessibility
  - Services are not available during routine healthcare visits for mothers/birthing people.
  - Disjointed services negatively influence patient motivation to reach out for help.
    - Solutions: Implement the Collaborative Care Model; Provider network meets referrals; create a directory of PMH providers
- Affordability
  - The inability to pay for additional services not deemed medically necessary by insurers deters patients from seeking treatment for perinatal mental health issues and discussing symptoms of PMADs with providers.
    - Solution: Mandate screenings in certain settings
- Lack of Awareness/Stigma
  - Patients may ignore their symptoms and not recognize their importance if they are unaware of the implications of what they are experiencing.
    - Solution: Educate patients, family & friends, and the general public about perinatal mood disorders
- Trust
  - Patients may not want to admit to mental concerns due to long standing distrust of health systems and pervasive stigmas around mental health in poor and/or minority communities.
    - Solution: Use a behavioral health care manager (BHCM) to allow patients to experience consistent treatment of care and management of care

Provider Barriers and Solutions

- Provider Time and Service Payment
  - Provider appointment time is often tightly linked to insurance reimbursements.
    - Solution: Fund the use of alternative communication methods and referral systems for treatment, consultations, and referrals such as telemedicine to allow providers to offer services with an appropriate demand on their time. Increase funding for PMH resources, Fund referrals.
- Relevant Training
  - Practitioners may have inadequate training to know what symptoms to look for and how to screen for PMH issues.
  - Practitioners have inadequate training on trauma-informed care.
    - Solution: Mandate/implement training for primary care providers on proper PMH screening techniques and procedures to be implemented in their practice
- Integrated Care
  - Providers need to have similar processes, screening tools and databases for shared results in order to optimize their ability to communicate in similar ways, to access patient history, and share in care plan recommendations.
    - Solutions: Utilize the Collaborative Care Model; Establish referral system

System Barriers and Solutions

- Funding
  - Mandate standardized coverage of basic PMH care.
    - Solution: Close the gap for provider reimbursement rates; Fund Collaborative Care Model
- Number of Qualified/Trained Providers
  - Enable/mandate provider education on how to incorporate PMH screening and care as standard practice.
    - Solutions: Utilize TANF/SNAP as a possible checkpoint and opportunity for PMH screening; Establish Community Health Workers
- Policy
  - Without statewide policy, many of the options for education, funding and service will remain siloed and insufficient to cover the demographic in need.
    - Solutions: Collaborative Care Model; Patient passports to allow patient to play active role, Management algorithm to provide more objective system

Recommendations

- Incorporate universal PMAD screening into key care systems for pregnant and postpartum persons
- Expand direct access to mental health services for birthing people in need of perinatal mental health services by integrating primary care and mental health
- Optimize and expand the care coordination system for birthing people in need of perinatal mental health services
- Require LDH to ensure Louisiana's mental health and substance use provider network can meet and address in a timely manner the mental health needs of pregnant and postpartum persons, with a focus on the needs of black and brown women

Subcommittees

- Navigation and Access
- Resources and Data
- Screening, Referral, and Workforce Development
- Public Awareness and Systems Capacity

Navigation and Access

a. What barriers do birthing persons, caregivers and families from diverse populations (including but not limited to Black birthing people, Hispanic birthing people, pregnant and postpartum people of color, perinatal immigrant populations, adolescents who are pregnant and parenting, LGBTQIA+) encounter accessing needed resources? What stressors/triggers need to be identified and addressed?

b. What changes need to be made to overcome identified barriers? Can telehealth or other modalities be used or better utilized?

c. What is the best standard of care for each of these populations?

d. How can the District focus on being trustworthy? If the care within the system improves for the identified populations, then the trust should grow.

e. What community-based, peer-based, or multi-generational supports can help birthing persons, caregivers and families?

Resources and Data

a. What are the available resources, including programs, treatments, and services, addressing perinatal mental health needs in the District including hospital-based, community-based, peer-based, and multi-generational supports?

   i. Please delineate grant/foundation-funded programs, treatments, and services from those that are fee-for-service or in-network with Medicaid and/or commercial insurance

   ii. Are these resources over/under-utilized? If so, why?

   iii. What is the organizational capacity to address needs (i.e., waiting lists, wait times, application process, etc.)?

   iv. What gaps exist in addressing the full spectrum of perinatal mental health needs in the District?

b. What needs assessment, research, and program evaluation must be in place to create a robust data collection system to monitor and evaluate progress on addressing perinatal mental and anxiety disorders?

c. What organization or agency could oversee collection and dissemination of surveillance data?

a. What quality metrics are needed to improve accountability and utilization of case management, care navigation, social work, peer support, and doula services to ensure continuity of care?

b. What currently non-billable services (care coordination, home visiting, preventative interventions, integrated behavioral health care in obstetrics) could become reimbursable by Medicaid to support perinatal population?

Screening, Referral and Workforce Development

Screening:

a. How does the District integrate screening and referral into a broad range of public health and early childhood programs? Which screening tools need to be implemented and into which programs?

b. Review national models for perinatal mental health screening implementation. What barriers exists in the District to move towards universal, multi-timepoint screening and referral across all healthcare settings?

c. How is screening currently integrated in the primary care, obstetric and pediatric settings in across the health systems in the District?

d. What is needed to improve rates of screening and referral across all settings?

Workforce Development:

a. What education/training do providers need on perinatal mental health? Which providers should be targeted? What strategies would increase provider participation in training initiatives?

b. What education/training do providers need to be culturally humble and be aware of implicit bias? Which providers should be targeted? What strategies would increase provider participation in training initiatives?

c. How does the District increase the number of providers with expertise in perinatal mental health and reproductive psychiatry who reflect the populations that are being targeted for services and who participate with Medicaid and commercial insurance? (i.e. language access, cultural awareness)

d. What currently non-billable services (care coordination, home visiting, preventative interventions, integrated behavioral health care in obstetrics) could become reimbursable by Medicaid to support perinatal population?

e. What initiatives would promote the training, recruitment and retention of perinatal behavioral health providers? What is creating current behavioral health staffing trends/turnover?

   i. How to create sustainable funding opportunities to strengthen salaries for behavioral health providers and care coordination providers (home visitors, case managers, care navigators, etc.)?

Public Awareness and Systems Capacity

a. How does the District raise awareness among the public and reduce stigma to encourage help-seeking behavior?

b. What systems need to be created or connected to assist both birthing persons and providers?

c. What program funding, reimbursement strategies, and policy development must be implemented for perinatal mental health initiatives?

d. What systems, program funding, reimbursement strategies, and policy development has occurred in other states that we could use to model our recommendations?

e. How does the District build on the existing network of partners to strengthen mental health in pregnancy and post-partum?

f. What organization or agency in the District could oversee future Perinatal Mental Health Initiatives that include program funding, reimbursement strategies, and policy development?

Discussion Questions

- Are we satisfied with the subcommittees?
- How do we incorporate a human-centered design approach?
- How do we ensure we create a space for sharing for birthing persons with lived experiences?
- What community groups/organizations should we reach out to for involvement
- When/where/how shall we conduct subcommittee meetings?
- What materials and resources will subcommittees need to advance work?
- Should subcommittees have a subcommittee chair? Staff liaison?

Medicaid Renewal

Presentation Overview

- Background on Medicaid Renewals
- Key Messages for Beneficiaries and Stakeholders
- Communication and Notices on Medicaid Renewal
- Next Steps
- Q&A

For Official Government Use Only

Medicaid Beneficiaries Will Have to Renew Their Coverage for the First Time in 3+ Years

- In March 2020, CMS temporarily waived the need to renew Medicaid coverage and states received a 6.2% financial boost to accommodate the increased enrollment.

- Medicaid enrollment has increased ~20% since the start of the public health emergency – just over 300,000 District residents are now enrolled in Medicaid.

- At the end of 2022, Congress passed legislation ending the continuous eligibility requirement on March 31, 2023.

- The District is required to restart Medicaid eligibility **renewals beginning April 1, 2023.** (Alliance and Immigrant Children's Program renewals started in July 2022).

States Are Required To Conduct A Renewal Of Every Beneficiary Enrolled In Medicaid Before Taking Any Adverse Action On Medicaid Eligibility

- **DHCFs guiding principles focus on maintaining coverage and minimizing administrative workload**
  - Maintaining enrollment and limited disruption of access to service for beneficiaries who remain eligible for Medicaid
  - Timely and efficient processing of all pending Medicaid renewals and determinations
  - Keeping beneficiaries within their current recertification period; and
  - Adequate distribution of eligibility redetermination workload to ensure functioning eligibility processing infrastructure

- **Several federal requirements guide the Medicaid renewal process**
  - States must submit a report to summarize their plans for initiating the renewals for the total caseload throughout the 14-month period.
  - No single month have more than 1/9th of their caseload up for renewal without explanation.

DHCF Will Start The Recertification Process For Medicaid In April 2023 With Coverage Potentially Ending for Some Beneficiaries on May 31st

- The first set of notices will go out at the end of March with the first disenrollments taking place on May 31.
- By the end of the unwinding process, roughly 112,000 of 145,000 MAGI cases (77%) are expected to passively renew.
- Most Non-Magi beneficiaries cannot passively review for their initial recertifications.

Unwinding month number	Initiation month (notices mailed by 1st of month)	MAGI renewal month due	Non-MAGI renewal month due	Cases				
				Total	MAGI			Non-MAGI*
					Total	Passive	Non-passive	Total
1	2023-04	2023-05	2023-06	12,102	9,347	7,032	2,315	2,755
2	2023-05	2023-06	2023-07	14,263	11,383	10,465	918	2,880
3	2023-06	2023-07	2023-08	19,530	16,001	10,451	5,550	3,529
4	2023-07	2023-08	2023-09	17,632	14,179	8,734	5,445	3,453
5	2023-08	2023-09	2023-10	20,467	9,105	7,834	1,271	11,362
6	2023-09	2023-10	2023-11	19,281	12,448	6,721	5,727	6,833
7	2023-10	2023-11	2023-12	15,237	13,280	7,832	5,448	1,957
8	2023-11	2023-12	2024-01	20,614	19,620	17,821	1,799	994
9	2023-12	2024-01	2024-02	13,050	9,956	9,003	953	3,094
10	2024-01	2024-02	2024-03	13,443	10,143	8,921	1,222	3,300
11	2024-02	2024-03	2024-04	13,887	10,783	9,439	1,344	3,104
12	2024-03	2024-04	2024-05	12,266	9,173	7,812	1,361	3,093
Total				191,772	145,419	112,065	33,354	46,353
Average monthly				15,981	12,118	9,339	2,780	3,863

Stakeholders are Needed to Assist with Outreach and Beneficiary Engagement

1. Share our materials on your website, social media, centers, and at community meetings.

2. Encourage beneficiaries to update their information and support people who have difficulty creating an account or accessing districtdirect.dc.gov to ensure that they receive the necessary paperwork.

3. Identify individuals you serve who may be at risk for not renewing their coverage and encourage them to access and use our resources.

4. Train existing staff to assist beneficiaries with the renewal process, including completing and submitting all forms and required documents to avoid a break in coverage.

5. Assist individuals who lost eligibility due to non-submission of renewal forms to promptly begin the reinstatement process – there is a 90-day reinstatement period.

What Can Stakeholders Say to Beneficiaries? *Don't Wait to Update! Then Check Mail for Important Information!*

What Beneficiaries Can Do Right Now

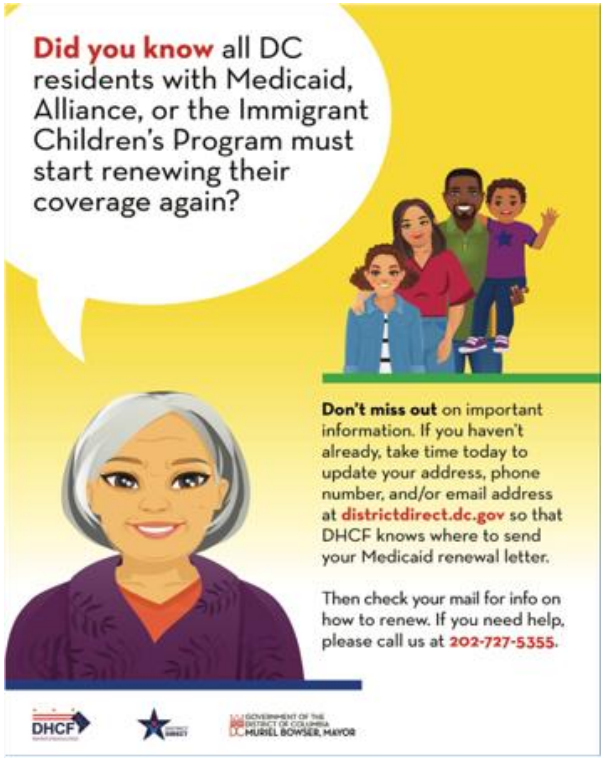
- Don't Wait to Update!: Update your contact information by logging into District Direct. If DHCF does not have the proper contact information, you will not receive notice of the need to renew your coverage through the mail or other means!

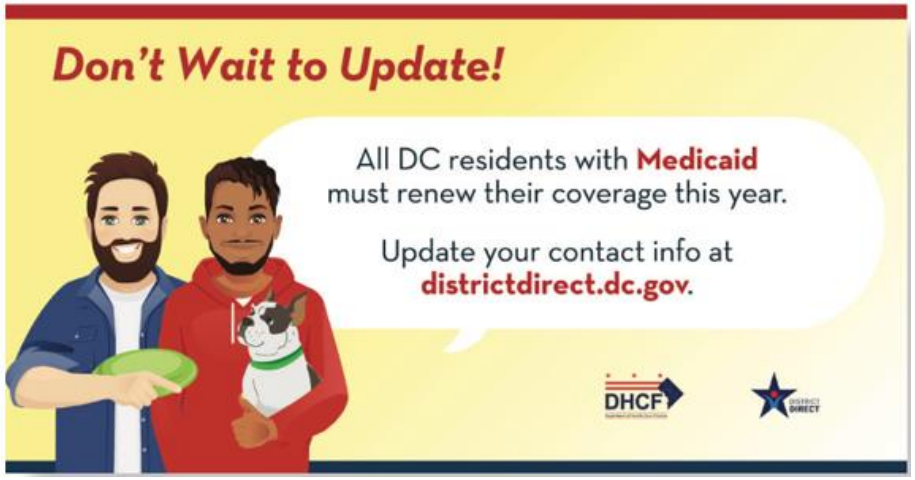
- Check Your Mail: DHCF will mail you a letter about your Medicaid, Alliance, or ICP coverage. This letter will also let you know when it's time to complete your renewal.

What To Do After Receiving Your Renewal Notice

- Complete your renewal by using districtdirect.dc.gov or fill out the form and mail/fax/drop at Service Center immediately to help avoid a gap in your coverage.

Visual Advertisements – Don’t Wait to Update!





Next Steps

- Advertisements will start this month.
- Per Federal guidance, renewals will start on April 1, 2023. People will renew for the next 14 months.
- DHCF will host trainings on District Direct and how to complete Medicaid renewal form. *If you'd like to request a training let us know. Training videos will also be available.*
- Meetings on Medicaid Renewal will begin on March 29, 2023 @ 2:30 PM and continue every 2 weeks.
- Please contact Medicaid.renewal@dc.gov for more information or to get connected to the meetings and trainings.

Q&A

Learn more about DC Medicaid Renewals:
https://dhcf.dc.gov/page/medicaid-renewal-information-dc-medicaid-beneficiaries-and-stakeholders

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