



December FY26 Medical Care Advisory Committee (MCAC) Meeting

February 25, 2026 | 5:30 PM – 7:30 PM ET

Virtual Meeting



Common Terms & Acronyms



- **CMS:** Centers for Medicare & Medicaid Services (federal regulator)
- **DHCF:** DC Department of Health Care Finance (state Medicaid agency)
- **FFS:** Fee for Service [Medicaid pays for a single service (DHCF pays for a doctor's visit)]
- **LTC / LTSS / LTCSS** (on-going care, like personal care aide or nursing facility care)
 - LTC: Long-Term Care
 - LTSS: Long-Term Services and Supports
 - LTCSS: Long-Term Care Services and Supports
- **MCO / MCP** (Medicaid pays a monthly payment per person to a managed care company to administer all Medicaid benefits / services)
 - MCO: Managed Care Organization
 - MCP: Managed Care Plan



Housekeeping

▶ **Introduce yourself in the chat:**

- Name
- Organization (if applicable)
- MCAC member or non-member

▶ **Keep yourself muted unless speaking**

▶ **You can add questions to the chat or use the “Raise Hand” function**

▶ **This meeting will be recorded**

- DHCF will post a recording of the meeting on the [MCAC webpage](#) after the meeting



Agenda

- ▶ **Welcome**
- ▶ **DHCF Updates and Discussion**
 - DHCF Report Q&A
 - Eligibility and Enrollment Update
 - DHCF VBP Strategy Overview
- ▶ **MCAC FY26 Planning**
 - Proposed Bylaw Changes
 - Vote on Bylaw Changes
- ▶ **BAC and Subcommittee Report Out and Recommendations**
 - Health-System Redesign – Cross-cutting Recommendations for MCAC Vote
 - Access Subcommittee
 - LTC Subcommittee
 - BAC
- ▶ **Public Announcements**
- ▶ **Next Meeting**



DHCF Updates and Discussion

DHCF Report Q&A

Enrollment Update

VBP Strategy Overview



DHCF Report Q&A

SPA/Waiver/Rule Report

MTM Report

MMIS Transition MDL

Medicaid Eligibility Changes

Medicaid Changes in OB3



MMIS Transition



DHCF will be Transitioning to a New Fiscal Agent – Gainwell Technologies – Effective March 2, 2026



- ▶ On March 2, 2026, DHCF will transition fiscal agent and claims payment responsibilities from **Conduent (DHCF's current fiscal agent)**, to **Gainwell Technologies**
- ▶ **Gainwell will be responsible for the following functions:**
 - Adjudication and payment of valid health care claims;
 - Operation of provider inquiry and EDI technical support call centers; and
 - Operation of the provider, beneficiary, and general inquiry web portal.

Key Definitions:

Fiscal Agent: DHCF's Fiscal Agent refers to the contracted vendor responsible for administering D.C. medical assistance claims processing, payments, and related operational support services.

Electronic Data Interchange: The electronic exchange of health care claims and related transactions.

Provider Portal: The web-based system used by providers to register, submit claims, access training materials, and obtain support-available at <https://medicaid.dc.gov>



Key Information on the MMIS Transition was shared in Medicaid Director Letter [\(MDL\) #26-01](#)



- ▶ **Provider Payment:** there will be a one-week delay in payments during the system cutover
 - No provider payments will be issued on Friday, March 6, 2026.
 - The first payments issued from the Gainwell system will occur on Friday, March 13, 2026.

- ▶ **Provider Portal:** The new Gainwell provider portal is live and accessible
 - Provider portal link – <https://medicaid.dc.gov/>
 - registration, transition resources, and training can be found under the “Provider” tab

- ▶ **Provider Training:** provider training sessions began on January 6, 2026, and will continue throughout the transition period
 - Registration information for training and session schedules are available through the new Gainwell Provider Portal



DHCF Continues to Work with Medicaid Providers to Support the Transition to the New Fiscal Agent



▶ Key Dates for the New Fiscal Agent:

- January 6, 2026 – Provider training sessions begin
- January 20, 2026 – Gainwell provider portal goes live
- February 2, 2026 – Provider registration opens
- **March 2, 2026 – Gainwell system go-live**
- March 6, 2026 – No provider payments issued
- March 13, 2026 – First provider payments issued from the Gainwell system

If you have questions regarding the fiscal agent transition, please contact Donald Shearer, Director of the DHCF Health Care Operations Administration, at Donald.Shearer@dc.gov, or by telephone at (202) 698-2007



Enrollment Update:



Medicaid and Alliance Decreases Reflect Changes in Adult Eligibility

- ▶ Medicaid enrollment saw a substantial decrease in January 2026.
 - This is largely due to the transition of childless adults and parent/caretaker relatives with incomes above 138% FPL to HBX eligibility.
 - Non-response to renewals due in December (which are still in their 90-day grace period for reinstatement of coverage) and termination of coverage for individuals flagged as living outside of the District account for most of the remaining decrease.
- ▶ The Alliance program, which is now inclusive of adults and children formerly under the former Immigrant Children’s Program (ICP), has seen enrollment decreases since February 2025.
 - This is due in part to fewer applications and more individuals who must respond to a renewal notice to retain coverage.
 - For October 2025 and beyond, it also reflects a reduction in adult eligibility to 138% FPL and a moratorium on enrollment of new adults age 26 and older.
- ▶ The most recent monthly data is linked at: <https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports>.

District of Columbia Department of Health Care Finance Monthly Enrollment Report - February 2026, Reflecting Period of January 2025-January 2026



By Program

Fiscal Year YTD	FY 2025									FY 2026 to date			
Year Month Number YYYY MM	2025-01	2025-02	2025-03	2025-04	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01
Program											(preliminary)	(preliminary)	(preliminary)
Total	310,456	310,192	311,493	311,443	310,218	308,727	308,100	306,372	305,321	301,893	298,396	295,845	273,722
Medicaid	276,981	278,044	279,188	278,839	278,022	276,898	276,625	275,506	275,195	275,263	273,933	272,980	253,148
ICP	6,120	5,843	5,863	5,887	5,776	5,677	5,615	5,454	5,288	5,046	4,759	4,487	4,063
Alliance	27,355	26,305	26,442	26,717	26,420	26,152	25,860	25,412	24,838	21,584	19,704	18,378	16,511



Medicaid Eligibility Changes



As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid



- Eligibility changes made effective January 1, 2026:
 - **No** changes to financial eligibility for Children (0-20), pregnant individuals, SSI individuals, those in the Aged, Blind and Disabled (ABD) group, or participating in long term care.
 - Effective January 1, 2026, the eligibility threshold for Parent/Caretaker Relatives and Childless Adults decreased to 138% FPL.
 - **Adults over this threshold have been disenrolled** from Medicaid effective December 31, 2025.
 - **These adults were sent an adverse action notice** in early December. An informational notice went to impacted individuals in early September.
 - Healthy DC Plan enrollment notices were sent to many transitioning adults on November 1.

Category	Current Childless Adult (Ending 12/31/2025)	Current Parent or Caretaker (Ending 12/31/2025)	**New** Childless Adult and Parent/ Caretaker (Effective 1/1/2026)
Threshold in Federal Poverty Level (FPL)	210% + 5% disregard	216% + 5% disregard	133% + 5% disregard
1 person household, monthly	\$2,806	\$2,884	\$1,800
2-person household, monthly	\$3,790	\$3,896	\$2,432
3-person household, monthly	\$4,775	\$4,908	\$3,065
4-person household, monthly	\$5,762	\$5,923	\$3,697



As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid



- Generally, adults (without dependent children in a household of one) with incomes around \$1,800 / month or more are no longer eligible for Medicaid based solely on their income
- Parents and Caretaker Relatives (in a household with two adults & two children) making around \$3,700 / month or more are no longer eligible
- Single Adults and Parents above these limits with Medicare can still have Medicaid pay monthly Medicare premiums and cost sharing under QMB program but lost their eligibility for full Medicaid benefits.
 - DHCF automatically transitioned these individuals to QMB-Only coverage on January 1, 2026.
- These Medicaid changes also have an impact on Emergency Medicaid coverage in the District:
 - After January 1, 2026, the majority of adults (21+) only qualify for Emergency Medicaid coverage if they are at or below 138% of the federal poverty level.
- DHCF has worked with DCHBX to automatically transition currently enrolled Medicaid enrollees who will be losing coverage to alternative coverage options.



As of January 1, 2026, Many Adults Are No Longer Eligible for Medicaid...And Most Became Eligible for the New Healthy DC Plan



- Options for coverage are available through the DC Health Benefit Exchange (DCHBX)
 - Most adults no longer eligible for Medicaid will qualify for the Healthy DC Plan
 - The remaining adults will be eligible for a Qualified Health Plan
- The Healthy DC Plan is a new option administered by DCHBX and offers no cost coverage to eligible adults
 - Many services covered by Medicaid are included except for non-emergency transportation, dental and vision coverage, long-term services and supports, and some community-based mental health and SUD services
 - About 15,000 Residents disenrolled from Medicaid and eligible for Healthy DC Plan were automatically enrolled for coverage starting January 1
- Residents can find more information regarding the Healthy DC Plan at:
www.HealthyDCPlan.com



Medicaid Changes in the One Big Beautiful Bill Act (OB3)



Changes to Medicaid as a Result of Federal Legislation Will Roll-Out Over the End of 2026 and Beginning of 2027



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



DHCF Aims to Implement Eligibility Changes as a Result of Federal Legislation in a Customer Forward and Transparent Way



- Forthcoming changes we cover below as a result of federal legislation in the One Big Beautiful Bill Act (OB3) are significant – spanning policy, operations, and outreach
- DHCF recognizes there are other program changes occurring as a result of federal legislation this year (e.g. SNAP) and we are collaborating with our sister agencies
- Limited guidance to date from CMS, which means what may not have answers to all your questions and there may be changes to what we expect
 - We will highlight changes in this meeting as we learn of them
- DHCF intends to provide outreach and engagement materials like we did for the Public Health Emergency Unwinding/Medicaid Renewal
 - Communications Toolkit
 - Advertising campaign
 - On the ground outreach (participation in health fairs, other city events, etc.)
 - Attend your event or train your team



OB3 Imposes Restrictions on Some Non-Citizens Eligible for Medicaid, Pending Federal Guidance and Injunctions



- Non-Citizen Eligibility - Effective 10/1/26
 - Definition of “Qualified Alien” eligible for Medicaid benefits and ACA Tax Credits amended to only include Lawful Permanent Residents (LPRs), certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants.
 - What to Know:
 - CMS promised but not has yet provided written guidance clarifying whether eligibility ends for certain populations such as refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, people granted conditional entry prior to 1980, individuals granted withholding of Deportation, and Amerasian entrants
 - A Preliminary Injunction was issued related to this provision, suspending implementation of this OB3 provision, pending litigation in Federal court.



OB3 Imposes 6 Month Certification Periods and Restrictions on Retroactive Coverage After a Successful Initial Applications



- 6 Month Certification Period for Renewals for Expansion Adults - Effective 1/1/27
 - A provision in OB3 shortens certification periods for expansion adults, requiring renewals every 6 months.
 - Previous: Every 12 months
 - This will be the same group subject to Work Requirements
- Retroactive Coverage - Effective 1/1/27
 - Shortens retroactive coverage (currently up to 3 months preceding month of application) to:
 - 1 month for adults in the Expansion category; and
 - 2 months for all other Medicaid and CHIP eligibility groups.



OB3 Imposes Cap on Deductible Home Equity and Allows for Moving Expenses to Be Deductible if Military or Intelligence Related



▶ MAGI Moving Expense Income Deduction - Effective tax year 2026

- ▶ Extends the MAGI qualified moving expense income deduction (applicable to active-duty members in the U.S. Armed Forces/military who are ordered to move or change duty stations) to members of the intelligence community who move pursuant to a change in assignment which requires relocation.

▶ LTCSS Home Equity Cap - Effective 1/1/2028

- ▶ Imposes cap to \$1,000,000 on home equity for LTSS eligibility determinations; Cap is not waivable via asset disregards.
- ▶ The minimum will only continue to increase based on CPI-U increases until it reaches \$1,000,000.



Medicaid Work Requirements are Required to Be in Place no Later than January 1, 2027



- *“Beginning not later than January 1, 2027, states must, as a condition of eligibility, require that applicable individuals (eligible or enrolled in a state Medicaid expansion program or state waiver program that provides Minimum Essential Coverage, ages 19-64, and not an inmate of a public institution during the three months prior) demonstrate community engagement.”*
- This means work requirements must be in place for applications received on or after January 1, 2027 and renewals initiated on or after January 1, 2027.



Individuals Can Demonstrate Compliance With Work Requirements Through 80 Hours of Work or Community Service in a Month, Half Time Educational Enrollment, More



The new Law requires states to condition Medicaid eligibility for adults in the Affordable Care Act (ACA) Medicaid expansion group at application and following enrollment on meeting work requirements starting January 1, 2027

An individual can demonstrate compliance with work requirements for a month if they meet one or more of the following criteria:

- Work at least 80 hours
- Complete at least 80 hours of community service
- Participate in a work program for at least 80 hours
- Is enrolled in an educational program at least half-time
- Engage in any combination of the above for at a total of at least 80 hours
- The individual has a monthly income that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours.
 - *For a household of one, someone earning near the District Living Wage could work ~33 hours a month and earn this amount*
 - This amount is equal to roughly 44% of the FPL for a household of one
- The individual had an average monthly income over the preceding 6 months that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938 multiplied by 80 hours, **and** is a seasonal worker



Compliance With Work Requirements Must Be for One Month of the Eligibility Verification Period for Those Enrolled or Applying



For currently enrolled applicable individuals:

- The District will require that currently enrolled individuals subject to work requirements meet them for **one** month during the individual's most recent eligibility determination and redetermination of eligibility.

For new applicants:

- The District will “look back” **one** month prior to the month of application Medicaid to see if they met work requirements:
 - CMS directs states to use reliable information available to them (e.g. payroll data, payments, Medicaid claims, and encounter data) for verifying community engagement and exemptions



Enrollees Found Not to Meet Work Requirements Get a Notice of Noncompliance and 30 Days to Address Before Termination



- If the District is unable to verify that an applicable individual has met the requirement to demonstrate community engagement, we will:
 - Provide the individual with the notice of noncompliance and give them 30 calendar days from to demonstrate compliance or that the requirement does not apply to them.
 - During this 30-day period, if the individual is already enrolled in Medicaid, they will continue to be enrolled.
 - If the individual cannot demonstrate compliance:
 - The District will deny their application; OR
 - Terminate current enrollment, no later than the end of the month following the month in which the 30-day period ends (two months after noncompliance notice).
 - Prior to termination the state must determine if the individual is eligible for medical assistance under the State plan (or waiver of such plan) or for another insurance affordability program.



Certain Groups Are Not Subject to Work Requirements and Exemptions Will Be Available to Those With Short-Term Hardships

- Many Medicaid populations are not subject to Medicaid Work Requirements:
- Exempted Individuals will include (more detail in following slides):
 - QMB Enrollees
 - Foster Care or Former Foster Youth
 - Individuals who are **Medically Frail**
 - Individuals who are Pregnant or Postpartum
 - Individuals who are already compliant with SNAP/TANF Work Requirements
 - Parent/Caretaker Relatives
- Many Medicaid enrollees may be exempt (more detail in following slides) from having to demonstrate compliance with work requirements during application or renewal based on temporary hardship:
 - Those that received inpatient treatment (NF, ICF, IMD) or treatment of similar acuity in an outpatient setting;
 - Those individuals who resided in a county with an emergency or disaster declared by the President OR reside in a county with a high local unemployment rate;
 - Those who had to travel for treatment of a serious medical condition



Exempted Individuals Include Medicare, Foster Care, American Indians, Disabled Veterans, Medically Frail Individuals



- Many Medicaid populations are not subject to Medicaid Work Requirements through exemptions
- Exempted Individuals:
 - Enrolled in or entitled to Medicare Part A benefits, or enrolled in Medicare Part B
 - Enrolled or eligible for Medicaid as a current or former foster care youth
 - American Indians and Alaskan Natives who are eligible to receive services via the Indian Health Service
 - Veterans with a disability rated as total under section 1155 of title 38, United States Code
 - Individuals who are medically frail or otherwise have special medical needs (as defined by the Secretary), including an individual:
 - ✓ Who is blind or disabled (as defined in section 1614);
 - ✓ With a substance use disorder;
 - ✓ With a disabling mental disorder;
 - ✓ With a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
 - ✓ With a serious or complex medical condition



Other Exemptions Include Those Meeting SNAP/TANF Work Requirements, Those in Rehab, Pregnant Individuals, Parents or Caretakers



- Other Individuals who are Exempted from Medicaid Work Requirements:
 - Individuals who are in compliance with work requirements from SNAP or TANF
 - Individuals participating in a drug addiction or alcoholic treatment and rehabilitation program
 - ✓ Any such program conducted by a private nonprofit organization or institution, or a publicly operated community mental health center, under part B of title XIX of the Public Health Service Act to provide treatment that can lead to the rehabilitation of drug addicts or alcoholics
 - Individuals who are inmates of a public institution or released in past 90 days
 - Individuals who are pregnant or entitled to postpartum Medicaid coverage
 - Parent, guardian, caretaker relative, or family caregivers (as defined in the RAISE Family Caregivers Act) of (1) a dependent child or (2) a disabled individual
 - ✓ In many other states, this only pertains to caregivers of children 13 years or younger, DC is special in this circumstance:
 - ✓ *For states that covered parents up to 138% FPL pre-expansion (CT, DC, MA, MN) none of the parents, guardians, or caretaker relatives are considered “expansion” so none of them would be subject to work requirements.*



Exceptions are Available for Short Term Hardships that Include Inpatient Stays, Disaster Declarations, or Travel for Health



- States *may allow for individuals who request such an exception* to be considered as having met the community engagement requirement for a month if they have experienced a short-term hardship event.
- These events include:
 - The individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including outpatient care relating to other services specified in this subclause), as the Secretary determines appropriate
 - The individual resides in a county with an emergency or disaster declared by the President or a high local unemployment rate:
 - ✓ Permits states to request exemptions for individuals who reside in counties that have unemployment rates at or above 8% or below 8% but 1.5 or more times the national average unemployment rate.
 - The individual or their dependent must travel ***outside of their community*** for an extended period of time to receive medical services necessary to treat a serious or complex medical condition that are not available within their community of residence.



Outreach Standards Include Notices to Beneficiaries with Specific Standards on How to Complete Engagement Requirements



- Prior to the implementation of the community engagement requirement (and periodically thereafter) states must notify applicable individuals enrolled in Medicaid expansion about the requirement, including:
 - How to comply with the requirement, including an explanation of the exemptions
 - The consequences of noncompliance with such requirement; and
 - How to report to the state any change in the individual's status that could result in exceptions or the end of a previously established exception.
- States must notify individuals:
 - By regular mail (or, if elected by the individual, in an electronic format); and
 - In one or more additional forms, which may include telephone, text message, an internet website, other commonly available electronic means, and such other forms as the Secretary determines appropriate;
 - States must begin outreach to notify individuals of the new requirements at least three months before the start of the first compliance "look-back"
 - ✓ States must perform outreach by October 2026 according to preliminary guidance



DHCF VBP Framework



Value-Based Purchasing (VBP) Framework

Five-Year Overview (CY 2026–CY 2030)



Agenda

I. VBP Framework Overview

II. Q&A

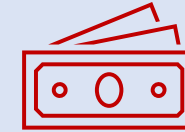


VBP/APMs Overview



Value-Based Payment (VBP)

Under VBP arrangements, providers are **reimbursed based on their ability to improve quality of care** in a cost-effective manner, or to lower costs while maintaining standards of care, **rather than the volume** of care they provide.



Alternative Payment Models (APMs)

APMs refer to **payment approaches that incentivize providers for delivering high-quality, cost-efficient care**, such as bonuses for achieving specified quality and cost benchmarks, or shared savings for delivering services at a lower cost.

- APMs can apply to a provider type, clinical condition, care episode, or population.
- APMs vary by complexity and risk.



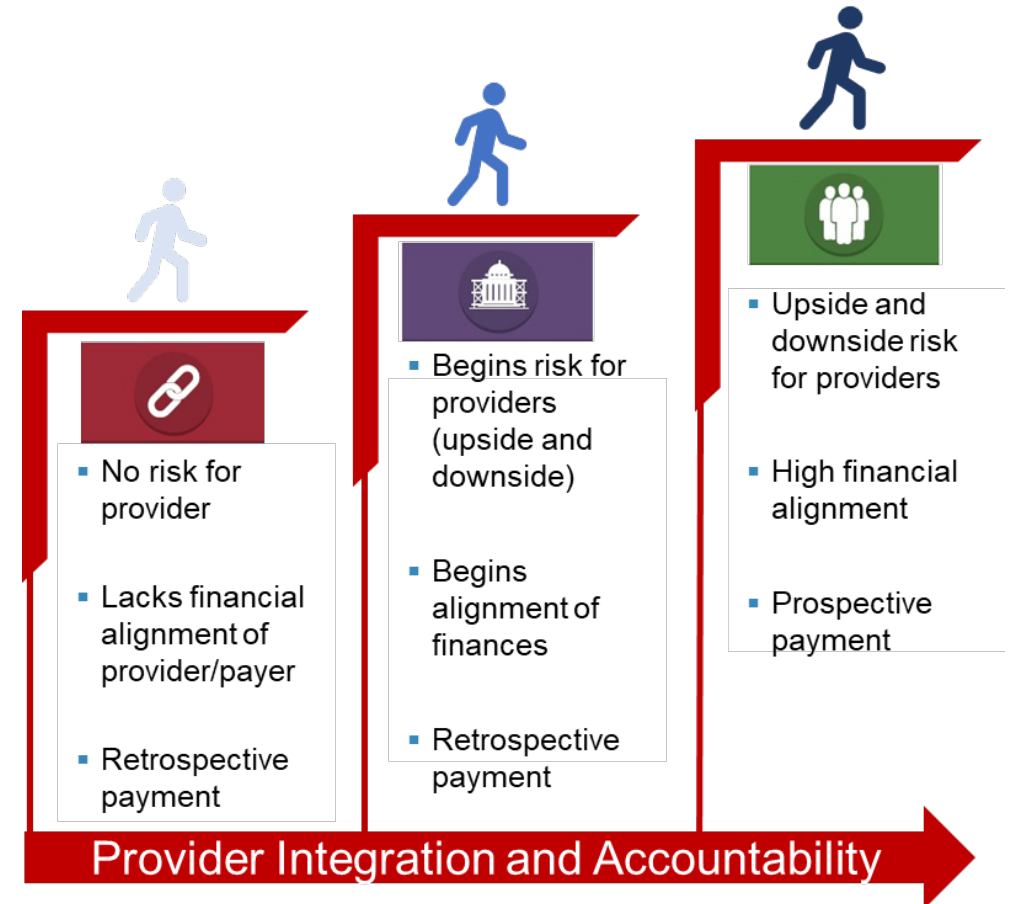
Health Care Payment Learning & Action Network (LAN) Provides Standard Definitions and Categories for APMs



LAN APM Framework

CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Key Characteristics of APM Framework





Objectives



1. Establish Clear Quality Priorities
2. Standardize Key Processes and Measures
3. Clarify Performance Expectations
4. Reward High Quality, Patient-Centered Care
5. Incentivize System and Plan Performance
6. Support the Triple Aim (improved patient experience, improved health outcomes, and reduced costs)



Goals

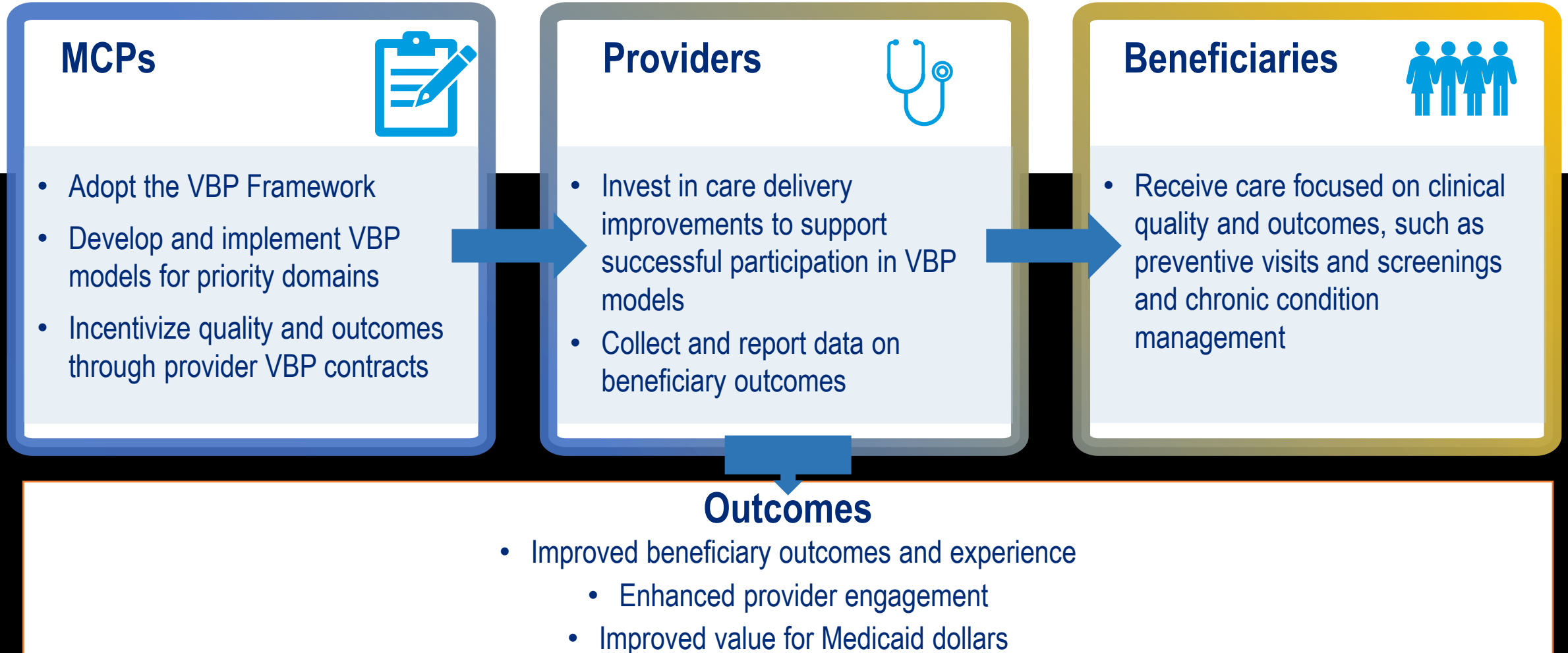


The goal of the Framework is to:

1. Outline DHCF's commitment to care delivery transformation through VBP
2. Transparently outline DHCF's plans to grow value-based efforts in Medicaid to MCPs, providers, and other stakeholders
3. Improve outcomes for Medicaid beneficiaries



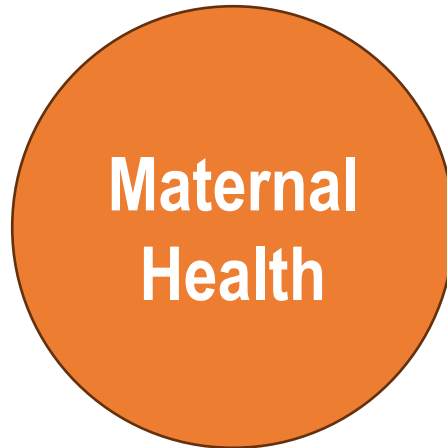
VBP Framework Theory of Change





Domains

Three priority domains for quality improvement for the next five years:





Five-Year Overview

2026	2027	2028	2029-2030
<p>Standardize Quality</p> <ul style="list-style-type: none"> • Domains: Set priority domains for quality improvement (i.e, pediatrics, maternal health, and primary/preventative care) • Quality: Establish quality goals and standardize measures via a preferred measures list • Baseline: Re-establish MCP baseline performance • Support: Aid MCP and provider success through technical assistance and digital health support 	<p>Rapid Evaluation + Continuous Improvement</p> <ul style="list-style-type: none"> • Quality: Refine quality goals and measures, based on 2026 experience • Monitoring: Track adoption and type of VBP arrangements, monitor for increased financial accountability • Support: Refine technical assistance offerings for MCPs and providers 	<p>Increased Accountability + Directed Models</p> <ul style="list-style-type: none"> • Quality: Assess performance toward quality goals, using complete data from 2026 • Monitoring: Continue to track adoption and type of VBP arrangements • Accountability: Consider increasing accountability (e.g., new maternal health directed payment under TMaH) based on complete 2026 data • Support: Refine technical assistance offerings for MCPs and providers 	<p>Refine, Evaluate, and Expand</p> <ul style="list-style-type: none"> • Quality: Assess performance toward quality goals • Domains: Review priority populations and assess future priority areas for Year 6 and beyond • Iterate: Revise and release a renewed 5-year Framework by the end of 2030 • Support: Refine technical assistance offerings for MCPs and providers



CY2025 Vs. CY2026



	CY 2025	CY 2026
VBP Targets	<p>40% of total medical expenditures in LAN categories 2 - 4</p> <ul style="list-style-type: none">No targets in LAN categories 3-4No clinical domain targets	<p>50% of total medical expenditures in LAN categories 2C - 4</p> <ul style="list-style-type: none">At least one-half (25%) of those medical expenditures are through models in LAN categories 3–4At least one-quarter (12.5%) of those medical expenditures are associated with a VBP arrangement in the maternal, pediatric, OR primary/preventive care domain
Quality Measures	<p>MCPs select specific quality measures</p> <ul style="list-style-type: none">No “preferred measures”	<p>MCPs select specific quality measures</p> <ul style="list-style-type: none">Must include at least one “preferred measure” from each sub-category, for the arrangement to count towards the domain target
Reporting	<p>MCPs submit two annual APM assessments via spreadsheet (one prospective and one retrospective)</p>	<p>Exploring methods/tools for more efficient, precise, and effective data collection</p>



CY2026 Vs. CY2027



	CY 2026	CY 2027
VBP Targets	<p>50% of total medical expenditures in LAN categories 2C - 4</p> <ul style="list-style-type: none"> At least one-half (25%) of those medical expenditures are through models in LAN categories 3–4 At least one-quarter (12.5%) of those medical expenditures are associated with a VBP arrangement in the maternal, pediatric, or primary/preventive care domain 	<p>60% of total medical expenditures in LAN categories 2C - 4</p> <ul style="list-style-type: none"> At least one-half (30%) of those medical expenditures are through models in LAN categories 3–4 At least one-quarter (15%) of those medical expenditures are associated with a VBP arrangement in the maternal, pediatric, OR primary/preventive care domain
Quality Measures	<p>MCPs select specific quality measures</p> <ul style="list-style-type: none"> Must include at least one “preferred measure” from each sub-category, for the arrangement to count towards the domain target 	No changes
Reporting	Exploring methods/tools for more efficient, precise, and effective data collection	Implementing new methods/tools for more efficient, precise, and effective data collection (if not already implemented)



Goals by Domain: Pediatrics

Objective	Goal
1. Lead Screening	Screen all children for lead exposure.
2. Asthma Management	Improve management of persistent asthma in children and adolescents.
3. Preventive Pediatric Care (Bundled)	Increase comprehensive preventive care for children.



Goals by Domain: Maternal Health

Objective	Goal
4. Severe Maternal Morbidity and Mortality	Reduce severe maternal morbidity and mortality through early intervention and coordinated care.
5. Timely Engagement in Maternal Care	Increase timely and sustained access to prenatal and postpartum care.
6. Behavioral Health Screening (Perinatal)	Improve identification and treatment of perinatal behavioral health needs.



Goals by Domain: Primary Care

Objective	Goal
7. Preventive Visits and Screenings	Improve performance on preventive and screening measures to close care gaps and detect conditions early.
8. Behavioral Health and Substance Use Care	Strengthen continuity and engagement in behavioral health and substance use treatment to improve outcomes and reduce acute care utilization.
9. Avoidable Emergency Department Utilization	Reduce emergency department use for low-acuity and non-emergent conditions through timely, coordinated care in a primary, outpatient, or community-based setting.



DHCF Preferred Measures List for VBP

Preferred Quality Measures List		
Domain	Measure Steward	Select at least one measure from each subcategory below:
PEDIATRIC		
Well-Child Visits in the First 30 Months of Life	National Committee for Quality Assurance (NCQA)	Developmental Screening *
Child and Adolescent Well-Care Visits (3-21)	NCQA	Developmental Screening *
Developmental Screening in First 3 Years of Life	NCQA	Developmental Screening *
Childhood Immunization Status (CIS-CH)	NCQA	Preventative Screening *
Lead Screening in Children (LSC-CH)	NCQA	Preventative Screening *
Immunizations for Adolescents (IMACH)	NCQA	Preventative Screening *
Social Needs Screening & Intervention	NCQA	Preventative Screening **
Asthma Medication Ratio: Ages 5 years- 18 years (AMR-CH)	NCQA	Preventative Screening ***
Oral Evaluation, Dental Services	DQA	Dental Screening *
Topical Fluoride for Children: Ages 1 through 20	DQA	Dental Screening *
Sealant Receipt on Permanent First Molars (SFM-CH)	DQA	Dental Screening *

*Measures currently available in CRISP- Population Health Dashboard
 **Measures in development/planned by CY2027
 ***Measures planned for development in CY2027 and beyond



DHCF Preferred Measures List for VBP



MATERNAL HEALTH	
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Prenatal/Pre-conception Care *
Contraceptive Care – All Women Ages 15-20 LARC Method of Contraception	Prenatal/Pre-conception Care **
Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception	Prenatal/Pre-conception Care **
Prenatal Immunization Status	Prenatal/Pre-conception Care **
Prenatal Depression Screening and Follow-Up	Prenatal/Pre-conception Care***
Social Needs Screening and Intervention Measure	Prenatal/Pre-conception Care ***
Oral Evaluation During Pregnancy	Prenatal/Pre-conception Care **
Prenatal and Postpartum Care: Age 21 and Older	Prenatal/Pre-conception Care **
Contraceptive Care – All Women Ages 21 to 44	Prenatal/Pre-conception Care*
Low-Risk Cesarean Delivery	Delivery **
Live Births Weighing Less Than 2,500 Grams	Delivery ***
Severe Obstetric Complications	Delivery**
Prenatal Depression Screening and Follow-Up on positive screening	Postpartum Care ***
Postpartum Depression Screening and Follow-Up	Postpartum Care ***
Contraceptive Care – Postpartum Women Ages 15 to 20 - LARC Method of Contraception 3 Days	Postpartum Care *
Contraceptive Care – Postpartum Women Ages 21 to 44	Postpartum Care *

*Measures currently available in CRISP- Population Health Dashboard
 **Measures in development/planned by CY2027
 ***Measures planned for development in CY2027 and beyond



DHCF Preferred Measures List for VBP



PRIMARY/PREVENTIVE CARE	
Breast Cancer Screening	Preventive Visits/Screenings *
Cervical Cancer Screening	Preventive Visits/Screenings *
Colorectal Cancer Screening: Ages 45 to 75	Preventive Visits/Screenings *
Adult Access to Preventive/Ambulatory Care	Preventive Visits/Screenings *
Oral Evaluation - Patients with Diabetes	Dental *
Comprehensive Oral Evaluation	Dental *
Non-traumatic Dental ED Visits per 100,000 member months	Dental
Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)	Behavioral Health *
Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Behavioral Health *
Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)	Behavioral Health *
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Behavioral Health *

*Measures currently available in CRISP- Population Health Dashboard

**Measures in development/planned by CY2027

***Measures planned for development in CY2027 and beyond



Targets

Calendar Year	Required Percentage of Total Medical Expenditures Through VBP Arrangements (2C or Above)
2026	50%*

*For purposes of satisfying the requirement that 50% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must:

- Ensure at least one-half (25%) of qualifying total medical expenditures are through models in LAN categories 3–4
- Ensure at least one-quarter (12.5%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, OR primary/preventive care domain
- Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)

2027	60%**
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**For purposes of satisfying the requirement that 60% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must:

- Ensure at least one-half (30%) of qualifying total medical expenditures are through models in LAN categories 3–4
- Ensure at least one-quarter (15%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, OR primary/preventive care domain
- Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)



Timeline to Review Data to Inform & Establish Targets for CY2028-CY2030

Calendar Year	Phase	Targets Based On	Target Release Date (for following year)	Notes
2026	Data Collection	—	—	Baseline & data quality
2027	Data Collection	—	—	Baseline & data quality
2028	Target Setting	CY2026 data	Fall 2027 (for CY2028)	Publish targets informed by CY2026 data
2029	Target Setting	CY2027 data	Fall 2028 (for CY2029)	Publish targets informed by CY2027 data
2030	Target Setting	CY2028 data	Fall 2029 (for CY2030)	Publish targets informed by CY2028 data



Rate Setting and Financial Impacts

- At this time, the VBP framework and forthcoming contract changes do not direct the expenditures of MCPs (i.e., no VBP state directed payments). All VBP activity remains at the discretion of the MCPs to negotiate and implement among their provider network.
- As such, there are no anticipated considerations for FFY 2026 rate setting.



Evaluation and Continuous Improvement

- Request for feedback annually stakeholders to assess implementation progress, identify barriers, and gather input to inform potential framework updates and identify additional areas for technical assistance.



Setting Expectations for Results

- True outcome improvement takes time; impact typically appears after multiple performance cycles
- Early years focus on infrastructure, reporting, compliance, and alignment
- Year 1 establishes baselines; measurable trends emerge in later cycles



What Success Looks Like

- ✓ Clear quality priorities
- ✓ Increased provider participation in VBP
- ✓ Measurable performance improvement
- ✓ Transparent reporting and accountability



For questions or comments about the VBP Framework, please contact:

Tadessa Harper-Nichols, Project Manager

Email: Tadessa.Harper-Nichols@dc.gov



MCAC Bylaw Changes for MAC Transition

Proposed Bylaw Changes

Vote on Bylaw Changes



The Medicaid Access Rule Required DHCF to Transition from the MCAC to a Medicaid Advisory Committee (MAC)



- ▶ DHCF is transitioning the MCAC to the MAC in order to meet new requirements in the *Ensuring Access and Eligibility in Medicaid* [Final Rule](#) (Medicaid Access Rule).
- ▶ Though the District's current MCAC bylaws largely align with CMS requirements, key changes will be required to come into full compliance with the Medicaid Access Rule. In addition to these changes, we included some additional updates to improve administrative operations of the MAC.
- ▶ Proposed changes fall into three broad categories:
 - Updates to replace old regulatory language with new regulatory language
 - Updates to align MAC structure with new regulatory requirements (not direct regulatory language, but needed to meet new requirements)
 - Administrative updates



Proposed Changes That Include New Regulatory Language



Current Language	Proposed Language
Name of committee: Medical Care Advisory Committee (MCAC)	Name of committee: Medicaid Advisory Committee (MAC)
<p>“The requirement for the MCAC from Section 1902(a)(22) of the Social Security Act states in part: “A State plan for medical assistance must include descriptions of (a) the kinds of professional personnel and supporting staff that will be used in the administration of the plan and the responsibilities they will have; (b) other standards and methods that the state will use to assure that medical or remedial care and services provided for recipients of medical assistance are of high quality.”</p>	<p>“The requirement for the MAC is based on Section 1902 (a)(4)(B) of the Social Security Act states in part: "A State plan for medical assistance must provide for the training and effective use of nonpaid or partially paid volunteers in assisting any advisory committees established by the State agency.”</p>
<p>“The present policy on State Medical Care Advisory Committees is set forth in the Federal Regulations at 42 CFR 431.12:</p>	<p>“The present policy on State Medicaid Advisory Committees is set forth in the Federal Regulations at 42 CFR 431.12(b):</p>
<p>(a) State plan requirements: A State plan for medical assistance under Title XIX of the Social Security Act must provide that:</p> <p>1. There will be an advisory committee to the State agency director on health and medical care services, appointed by the director of the State agency or a higher State authority."</p>	<p>(b) State plan requirements: A State plan for medical assistance under Title XIX of the Social Security Act must provide for a Medicaid Advisory Committee (MAC) that will advise the director of the single State Agency for the Medicaid program on matters of concern related to policy development and matters related to the effective administration of the Medicaid program.”</p>
N/A - new language proposed	<p>“Enhancing coordination of care across providers and care settings to improve patient outcomes</p> <p>Reviewing and advising on eligibility enrollment and renewal processes to ensure efficiency and accessibility for beneficiaries</p> <p>Promoting cultural competency and language access in Medicaid services to meet the diverse needs of the people served.</p> <p>Evaluating any other systemic issues that impact the provision or outcomes of health and medical care services, as determined by the MAC”</p>



Proposed Changes to Align MAC Structure with New Regulatory Requirements



Current Language	Proposed Language
<p>“The MCAC shall consist of no more than fifteen (15) voting members.”</p>	<p>“The MAC shall consist of no more than twenty-one (21) voting members.”</p>
<p>“No more than 49% of the MCAC members (i.e., seven (7) members) shall be classified as health care providers who are familiar with both the medical needs of low-income population groups and the resources available and required for their care. At least one MCAC member must be a board-certified physician.”</p>	<p>“No more than 34% of the MAC members (i.e., seven (7) members) shall be classified as clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries and with the resources available and required for their care. This includes providers or administrators of primary care, specialty care, and long-term care. At least one MAC member must be a board-certified physician.”</p>
<p>“At least 51% of the MCAC members (i.e., eight (8) members) shall be beneficiaries and beneficiary advocates and may represent the following interests:</p> <ul style="list-style-type: none"> • Medicaid beneficiaries; • Individuals legally responsible for a Medicaid beneficiary; • Family members of Medicaid beneficiaries; • Non-governmental social service agencies; and/or • Beneficiary advocate groups.” 	<p>“No more than 24% of the MAC (i.e., five (5) members) shall be classified as state or local consumer advocacy groups or other community-based organizations that represent the interests of, or provide direct service, to Medicaid beneficiaries.”</p> <p>“At least 25% of the MAC members (i.e., six (6) members) shall be members also represented on the Beneficiary Advisory Council (BAC). These may represent the following interests:</p> <ul style="list-style-type: none"> • Current or former Medicaid beneficiaries, • Paid or unpaid caregivers of people enrolled in Medicaid • Family members of Medicaid beneficiaries”
<p><i>N/A - new language proposed</i></p>	<p>“No more than 15% of the MAC members (i.e., three (3) members) shall be represented by the Managed Care Plans (MCPs), limited to:</p> <ul style="list-style-type: none"> • One (1) member representing all three of the DC Healthy Families Plans. The representative will rotate annually between all DC Healthy Family Plans, with the remaining plans serving as public ex officio members of the MAC. • One (1) representative from the contracted health care plan provider for the District of Columbia’s Child and Adolescent Supplemental Security Income Program (CASSIP), • One (1) representative from the Dual-Eligible Special Needs Plan.”



Proposed New MAC Voting Member Composition



The proposed MAC structure will include 21 Voting Members.

- ▶ Six (6) Beneficiary Advisory Committee (BAC) Members
- ▶ Five (5) State or local consumer advocacy groups or other community-based organizations that represent the interests of or provide direct service to Medicaid beneficiaries
- ▶ Seven (7) Provider members
- ▶ Three (3) Managed Care Plan Members
 - One (1) from contracted CASSIP plan
 - One (1) from contracted DSNP plan
 - One (1) from contracted Healthy Families Program plans – rotating annually

In this proposed structure, the MAC meets the 25% BAC member threshold requirement, includes the required managed care representatives, and ensures that the combined voting power of BAC members and organizations that represent the interests of Medicaid beneficiaries sits at greater than 50%



Proposed Changes to Align MAC Structure with New Regulatory Requirements (Continued)



Current Language	Proposed Language
<p>Initial appointments to the MCAC will be for terms as follows:</p> <ul style="list-style-type: none"> • Five (5) members appointed to one-year terms; • Five (5) members appointed to two-year terms; • Five (5) members appointed to three-year terms. 	<p>Appointments to the MAC will be conducted as follows:</p> <p>Three (3) seats added for MCP voting members to the MAC as described in Section 5.5 at the beginning of Fiscal Year 2027.</p> <p>Three additional (3) seats added at the beginning of Fiscal Year 2027,</p> <p>Initial appointments for new members to the MAC will be for terms between one- and three-years at the discretion of the Director to ensure an equal number of openings each successive year</p>
<p>“The MCAC shall meet quarterly at a minimum (according to the District of Columbia’s fiscal year, meaning the 12-month period ending on September 30 of that year, having begun on October 1 of the previous calendar year), unless otherwise determined by the MCAC, at a location and time determined by the Executive Committee. Meetings shall be run by rules established by the Executive Committee.”</p>	<p>Addition of: “Meetings will be held using a rotating formal of attendance options, which include in-person and hybrid (in-person and virtual) meetings.”</p>
<p>“DHCF shall make financial arrangements, if necessary, to make possible the participation of beneficiaries [CFR 42-431.12(f)5].”</p>	<p>“DHCF shall make financial arrangements, if necessary, to facilitate Medicaid beneficiary engagement in the MAC, including providing financial support to current or former Medicaid beneficiaries and people with direct experience supporting Medicaid beneficiaries (family members and paid or unpaid caregivers of people enrolled in Medicaid) [CFR 42-431.12(h)].”</p>
<p>“The MCAC or any committee may prepare a majority report to the Department which reflects the wishes of as many of its members as possible. The opinions of members who disagree with a MCAC position in a majority report may prepare minority reports. The MCAC Liaison may be called upon to assist MCAC members in preparing both majority and minority reports.”</p>	<p>“The MAC must submit an annual report to be posted publicly, which reflects the wishes of as many of its members as possible and will be reviewed by DHCF. This report must describe the activities, topics discussed, and recommendations from both the MAC and BAC, as well as state Medicaid program responses to recommended actions.</p> <p>DHCF will review and post each annual report on the DHCF website within 30 days of submission. The first annual report must be finalized by July 9th, 2026, and annually thereafter. DHCF must provide MAC members with a final review of the report.</p> <p>The MAC or any subcommittee may prepare a majority report to the Department which reflects the wishes of as many of its members as possible. The opinions of members who disagree with a MAC position in a majority report may prepare minority reports. The MAC Liaison may be called upon to assist MAC members in preparing both majority and minority reports.”</p>



Proposed Changes That Include Administrative Updates



Current Language	Proposed Language
<p>“Each MCAC member shall sign a conflict of interest disclosure form that discloses all material facts relating to any actual or potential conflicts of interest on occasions during their term that include, but are not limited to, the following:</p> <p>Initially, upon joining the MCAC;</p> <p>Annually thereafter;</p> <p>Prior to any new business transactions with actual or potential conflict of interest; and</p> <p>Immediately upon becoming aware of an actual or potential conflict of interest.”</p>	<p>“Each voting MAC member, Chair and Vice-Chair shall sign a conflict-of-interest disclosure form that discloses all material facts relating to any actual or potential conflicts of interest on occasions during their term that include, but are not limited to, the following:</p> <p>Initially, upon joining the MAC;</p> <p>Prior to any new business transactions with actual or potential conflict of interest; and</p> <p>Immediately upon becoming aware of an actual or potential conflict of interest.”</p>
<p>“The MCAC shall have a three person Executive Committee. The Executive Committee shall be composed of the Chairperson, Vice Chairperson, and a member at large. The Chairperson, in consultation with the Vice Chairperson, shall appoint a member at large to serve on the Executive Committee for the duration of the term. The Executive Committee shall meet between meetings of the MCAC as necessary and shall assist the Chairperson in carrying out the day to day functions and responsibilities of the MCAC.”</p>	<p>“The MAC shall have a three-person Executive Committee. The Executive Committee shall be composed of the Chairperson, Vice Chairperson, and the Medicaid Director. The Executive Committee shall meet between meetings of the MAC as necessary and shall assist the Chairperson in carrying out the day to day functions and responsibilities of the MAC.”</p>



MCAC Member Discussion



- ▶ Subcommittee chair representation on executive committee
- ▶ “Individuals legally responsible for a Medicaid beneficiary”
- ▶ **Other feedback/ considerations?**
 - XXX



Voting Process Reminder



- 1. A member makes a motion:** A Member formally proposes that the MCAC take a certain action
 - *After being recognized by the chair, any member can raise a motion*
- 2. Another member seconds the motion**
- 3. The chair states the question:** The Chair restates the motion, officially placing it before the committee
- 4. Members debate the motion**
- 5. The chair puts the question to a vote**



BAC and Subcommittee Updates and Report Out

Health-System Redesign (HSR)

Access

(New) Long-Term Care (LTC)

Beneficiary Advisory Committee (BAC)



HSR Subcommittee Recommendations



The HSR Subcommittee Recommendations Presented at the December MCAC Focus on two Key Cross-Cutting Areas



- ▶ Whereas the recommendations adopted by the MCAC at the July 2025 meeting were organized by service domain (housing, reentry, nutrition), these recommendations encompass all three domains and coordination across domains.

- ▶ **Screening, Referral, and Technology**
 - Prioritize Patient-Centered Care and Minimize Administrative Burden through Key Policy Principles
 - Adopt a “No Wrong Door” Approach with Flexible Screening Frequency
 - Leverage Existing Technology Infrastructure for HRSN Screening, Closed-Loop Referrals, and Data Sharing
 - Ensure Robust Technology System Capabilities for Screening and Referrals
 - Establish Clear Goals and Strategy for Screening and Referral & Clear, Consistent Eligibility Criteria for HRSN Services with Structured Accountability Mechanisms

- ▶ **Care Coordination and Workforce**
 - Create a Hub or Centralized Structure to Support HRSN Service Administration, Care Integration and Coordination, Quality Improvement, and Other Identified Roles
 - Utilize Opportunity for Role Clarity and Structurally Supporting the Relationships that Drive Connection to Care and Outcomes
 - Implement Necessary Policy and Regulatory Changes to Facilitate Appropriate Service Provision, Billing and Reimbursement by Community Health Workers



Voting Process Reminder



- 1. A member makes a motion:** A Member formally proposes that the MCAC take a certain action
 - *After being recognized by the chair, any member can raise a motion*
- 2. Another member seconds the motion**
- 3. The chair states the question:** The Chair restates the motion, officially placing it before the committee
- 4. Members debate the motion**
- 5. The chair puts the question to a vote**



The Reestablished MCAC Long-Term Services and Supports (LTSS) Subcommittee will Begin Meeting in March

- ▶ The LTSS subcommittee will discuss and inform issues that impact the delivery of high-quality long-term care to Medicaid beneficiaries in the District. The first meeting of the LTSS Subcommittee will take place in late March.
- ▶ The subcommittee is open to all interested individuals. We encourage you to fill out this survey if you are interested in joining (also sent via email prior to the MCAC meeting), which includes questions on preferred meeting times, topics of interest, and contact information

***Note** - For those of you who already reached out, we have you on the list to receive the invite, but encourage you to fill out the survey with topic suggestions and time preferences*

- ▶ The LTSS Subcommittee will be led by an MCAC member chair, and a non-member co-chair:
 - **Rajan Thomas**, Health Management Inc. (*MCAC ex-officio member*)
 - **Lisa Harfoot**, Lisner-Louise-Dickson-Hurt Home
- ▶ You can reach out to Katrice Jefferson-Pope (katrice.jefferson-pope@dc.gov) or dhcfMACandBAC@dc.gov with any questions



The Beneficiary Advisory Committee (BAC) Has Begun to Meet to Share Input on the Medicaid Program in the District

- ▶ The Beneficiary Advisory Committee (BAC) held its inaugural meeting on February 19, 2026, and will meet quarterly for the remainder of the Fiscal year
- ▶ The BAC represents a wide array of individuals connected to the Medicaid program, all eager to provide feedback and engage in opportunities to strengthen the Medicaid program to support District residents. At the meeting, BAC members:
 - Shared their own and community perspectives on elements of the Medicaid program,
 - Suggested opportunities for clarity
 - Worked with DHCF staff to develop a structure and prioritize topics for the year



Public Announcements



Get Involved and Make Sure You're Getting Updates



The next meeting will be April 22, 2026 - we look forward to seeing you all there!

As a reminder, our April meeting will be focused on the Dhcf FY27 Budget.

If you (or other community members and partners) are not already receiving MCAC meeting invites, you can email the newly established dhcfMACandBAC@dc.gov and we will add you to the list.

If you are already receiving MCAC invites and emails, no action is needed.