



GOVERNMENT OF THE DISTRICT OF COLUMBIA
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Department of Health Care Finance Informational Bulletin

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SUBJECT: Program Updates:
Nursing Facility Census Submissions and Optional State Assessment Validation; Medicaid LTSS-EPD Waiver Provider Enrollment Process Updates; Clinical Case Management System (CCMS) Redesign/Refresh.

This Information Bulletin offers an essential update on a modification to the Nursing Facility (NF) Census submission process and the Optional State Assessment (OSA) submission and validation process. It outlines the cadence and process required for submission of monthly census reports by NFs to the Department of Health Care Finance (DHCF) and ensures the timely and compliant transmission of OSAs. This bulletin also offers updates on several key enhancements to the provider enrollment process, as well as updates on the recently awarded contract for the District's LTSS CCMS-DC Care Connect redesign.

NF Census Submissions

NF census data that includes daily resident counts, payor mix and demographics is critical to monitoring compliance with federally and state required Minimum Data Set (MDS)/OSA schedules. Proper census tracking ensures that every admission, discharge and death is recorded with a corresponding MDS/OSA and heavily influences case-mix scores used to calculate reimbursement. Missing or inaccurate census data can lead to late or missed assessments and are considered compliance failures.

What is changing?

Effective March 1, 2026, CRISP Nursing Facility census reporting will sunset.

Phase 1: All Medicaid-certified NFs in the District of Columbia will be required to submit a census report by the 5th business day of the next month that reflects the daily status (admissions, discharges, activity summary) of all the residents at the NF during the previous month (e.g. by the 5th of April, submit a report that reflects your census for each of the 31 days in March) via this census submission [link](#). This report must include the resident's first and last name, social security number, date of birth, primary, secondary and tertiary payor, when applicable, the resident's admission date, readmission, discharge date if applicable, and if the resident has Level II PASRR evaluation.

Phase 2: All out-of-District Medicaid-certified NFs will be required to submit a census report at a later date to be announced in the coming months. Additionally, updated reimbursement guidelines for out-of-District NFs in Virginia and other States will be provided.

Optional State Assessments Submissions and Billing

OSA submissions can follow several pathways.

- a. **Match Found:** an OSA is submitted correctly and the person for whom an OSA was submitted is found on the Medicaid roster. In this case the OSA is filed in the DC Care Connect (DCCC). No further action is needed by the NF and billing may proceed.
- b. **Match Not Found- Complete or Partial:** an OSA is submitted correctly and the person for whom an OSA was submitted is not found on the Medicaid roster. NFs should check the facilities' Export/clientNotFound folder on the SFTP site to identify individuals who have failed the member match. Mismatches can result from social security numbers, first names, last names and/or dates of birth discrepancies. NFs that expect to bill DC Medicaid are expected to resolve the match issues and re-submit a corrected OSA file. If resident match is not obtained after re-submission, create a ticket with FEI's Help Desk by phone at 833-635-0276, by email at DCCCHelpDesk@feisystems.com.
- c. **Match Not Found- Complete or Partial:** an OSA is submitted correctly and the person for whom an OSA was submitted is not found on the Medicaid roster. If the person is not found in the facility's SFTP file, this message may be a result of not having Medicaid eligibility approval/ Medicaid enrollment is in progress. To receive reimbursement, NFs can opt to:
 - i. Re-upload the OSA file once Medicaid eligibility and match have been confirmed to receive reimbursement commensurate with resident's RUG score or
 - ii. Submit for reimbursement using the RUG-IV default code, AAA00. This option is only available for Eligible Medicaid NF residents when assessments are delayed and the NF intends to bill Medicaid in the interim. NFs are expected to follow the established AAA00 guidelines if this option is used.
- d. **Match Not Found- Complete:** an OSA is submitted correctly and the person for whom an OSA was submitted is not found on the Medicaid roster. If the person is not found in the facility's SFTP file, this message may be a result of not having Medicaid eligibility and being affiliated to a non-Medicaid payer. NFs that expect to bill a non-Medicaid payer, will follow their respective billing process to those entities. No FEI tickets are needed here. This subset of assessments should not be resubmitted and NFs should work with their respective vendor systems to close them.

Stakeholder Collaboration

Effective coordination among Long-Term Care (LTC) stakeholders remains a top priority to ensure consistency in assessment processes, streamlined program operations, and efficient information sharing. To achieve this, the LTCA will continue to foster collaboration with a diverse group of stakeholders, Nursing Facilities, Hospitals, the Department of Health, the Department of Behavior Health, and the Department of Disability Services (DDS).

Long-Term Care Services and Supports: Provider Enrollment Process updates (Effective 3/1/26)

The updated provider enrollment framework makes several key enhancements, including an update to the Provider Enrollment Policy and Procedures, a revised updated Financial Viability Assessment by DHCF-ORRFA, and a structured pre- and post-enrollment site visit process for all EPD waiver providers- both prospective and existing, conducted by DHCF's Provider Enrollment vendor, Maximus. Additionally, updates will be reflected on the LTCA Provider Enrollment webpage to ensure transparency and accessibility.

These changes are designed to ensure uniformity in the screening process through a standardized review approach and to strengthen the desk review elements, ensuring that all reviews of applications are substantive and aligned with Local and Federal requirements.

Step 1: Expression of Interest

Prospective providers should begin by reviewing the Medicaid and EPD Waiver Program Overview. If, after reviewing the information, you remain interested, use the provided [TA & T Link](#) to register for the mandatory information session.

Upon registration, you will receive a confirmation email with the session schedule and details. Attendance is required, as the session provides essential guidance on program requirements and next steps. After participating, prospective providers may submit a formal Letter of Intent (LOI) based on the information learned, followed by completing the full application process as outlined during the session.

Step 2: Mandatory Prospective Provider Information Session

All prospective providers must attend a formal information session coordinated by LTCA. These sessions are held quarterly on an ad hoc basis when necessary. Requests for ad hoc sessions must include a documented exigent or reason and receive prior approval from DHCF/LTCA leadership.

Session Content Includes:

- Overview of the Department of Health Care Finance (DHCF) mission.
- DHCF's commitment to federal assurances and performance goals for administering home and community-based waiver services.
- Review of program details, current trends, and service needs.
- Comprehensive explanation of the provider enrollment process.
- Opportunity for participants to ask questions and receive technical assistance.

Participation of Key Personnel:

Prospective providers should ensure that key personnel, such as the administrator, owner(s), and quality assurance director, attend the session.

Step 3: Submit a Letter of Intent (LOI)

After successfully attending the mandatory information session, prospective providers must submit a formal LOI to LTCA using the [LOI link](#) within 10 business days. The LOI must include:

- Agency name with proof of incorporation in the District of Columbia.
- Primary contact information (mailing address, business email, and phone number).
- Brief description of services provided.
- Statement of readiness to deliver the services for which the application will be submitted.
- Confirmation of participation in the mandatory information session.

The LOI must demonstrate understanding of the relationship between Medicaid State Plan services and EPD Waiver services relevant to the requested service type.

LTCA Response:

- Within 10 business days of receiving the LOI, LTCA will respond via email to either request corrections or acknowledge receipt of a complete LOI. The response will include next steps and resources such as enrollment process overviews and application checklists.

Step 4: Submit Application via Provider Data Management System (PDMS)

After attending the information session and submitting the LOI:

- Prospective providers have 90 days to submit the application through the Provider Data Management System (PDMS) at www.dcpdms.com.
- DHCF's enrollment vendor will conduct an initial review to ensure all required documents are included before forwarding the application to DHCF.
- Note:
 - The formal review process begins only after a complete application packet has been submitted through PDMS.
 - Informal inquiries via email or phone will not be accepted. The mandatory information session is designed to provide comprehensive guidance, including Instructional materials, self-help resources, checklists and tools to assist prospective providers in completing their application.
 - All questions or requests for support outside the mandatory information session must be submitted through the designated formal channels:
 - LTCA Question Board: For general inquiries
 - Technical Assistance & Training (TA&T) Portal: For training or technical assistance requests, limited to items not covered during the mandatory information session

PDMS Communication: All application-related review correspondence, including application decisions, inquiries, and updates, will be available within the provider's electronic application file in PDMS.

CCMS- DC Care Connect System Redesign/Refresh

The District has initiated a major modernization effort to redesign and refresh its Clinical Case Management System (CCMS), known as DC Care Connect, which supports care coordination and service delivery for Long-Term Services and

Supports (LTSS) programs. This initiative reflects the District's commitment to improving efficiency, interoperability, and person-centered care for Medicaid beneficiaries.

Under a contract effective February 1, 2026, the District has engaged **Carahsoft Technologies Corporation, in partnership with FEI Systems**, to lead the Design, Development, and Implementation (DDI) of the new CCMS platform over a 12-month period. The project will deliver a state-of-the-art, commercial off-the-shelf (COTS) solution designed to streamline operations, reduce administrative burden, and enhance data accuracy across integrated systems.

Key Objectives

- **Modern Platform Deployment:** Implement a modular, flexible CCMS solution capable of supporting future enhancements and additional functionality.
- **Improved Care Coordination:** Enable holistic care management that strengthens communication among providers, agencies, and beneficiaries throughout the LTSS continuum.
- **System Interoperability:** Develop automated interfaces and ensure seamless integration with critical District systems, including MMIS, DCAS, Health Information Exchange (HIE), and Medicaid Data Warehouse (MDW).
- **Operational Efficiency:** Reduce manual data entry errors, enable real-time updates, and improve reporting capabilities for better decision-making and compliance.

Expected Outcomes

- A modern, reliable system supported by FEI Systems with ongoing updates and maintenance.
- Enhanced person-centered service delivery, leading to improved health outcomes and sustainable LTSS operations.
- Seamless data sharing across agencies and providers, giving caseworkers a complete, real-time view of each participant.

Project Phases

Following the Kickoff Meeting on February 10, 2026, the project will advance through the following phases:

- Initiation and Planning
- Configuration and Analysis
- User Acceptance Testing (UAT)
- End User Training
- CMS Operational Readiness Review (ORR)
- Go Live

Stakeholder Collaboration

Routine communication will be provided to stakeholders at each milestone phase, including progress updates, readiness assessments, and training schedules. Post-go live, a feedback process will ensure continuous improvement and user support.

Helpful links:

- [Nursing Facility Census Submission](#)
- [LTCA Technical Assistance and Training Registration](#)
- [Provider Enrollment Letter of Intent Form](#)
- [LTCA-relevant forms](#), for information about other required program-related forms

Additional reminders and resources:

- These Informational Bulletins are being archived on DHCF's website under the Long Term Care Administration tab: <https://dhcf.dc.gov/publication/informational-bulletins-ltc-providers>