OFFICE OF THE
INSPECTOR GENERAL
DISTRICT OF COLUMBIA GOVERNMENT

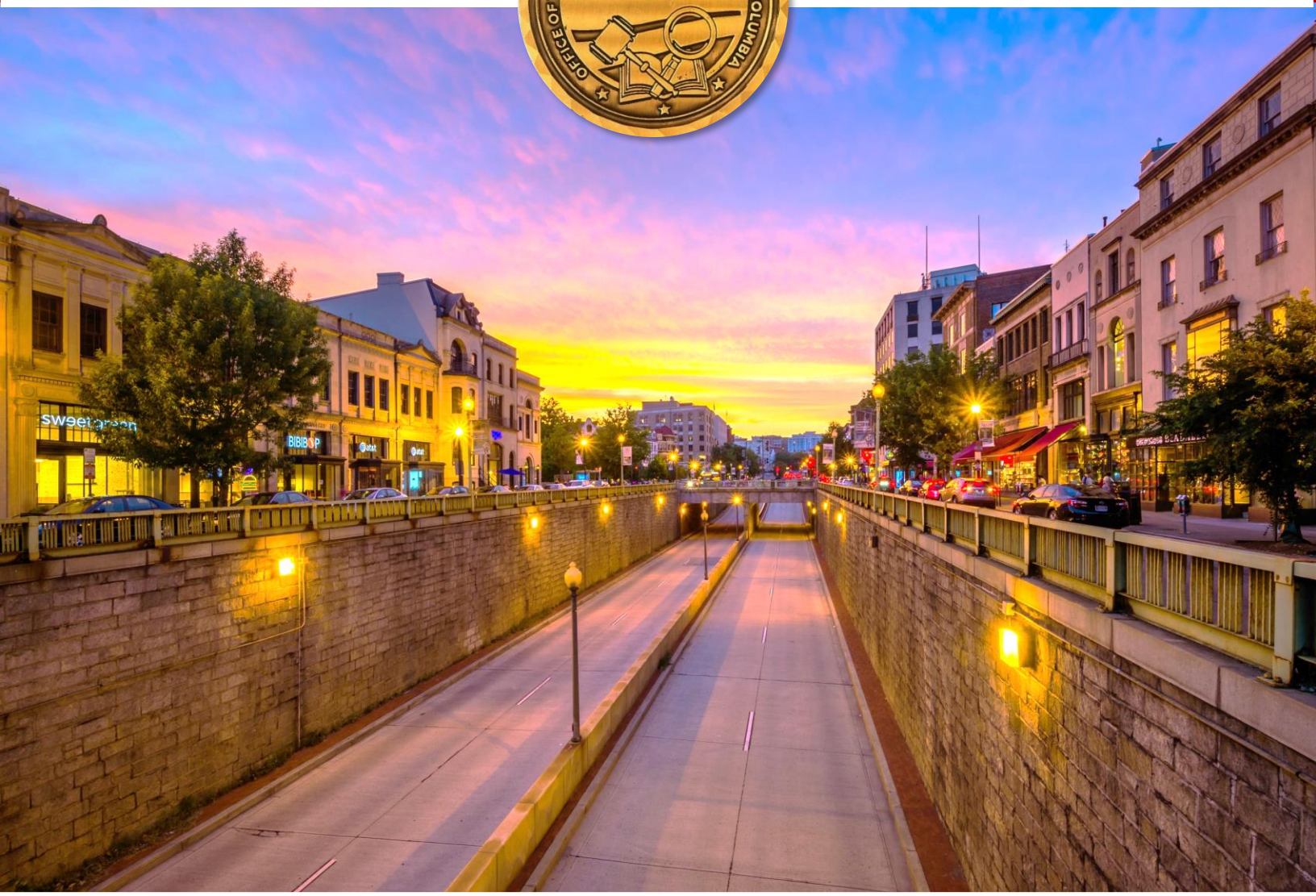
AUDIT REPORT

Medicaid Eligibility Determinations Audit

The District Completed Required Medicaid Eligibility Renewals During the Unwinding Period But Could Improve Internal Controls

OIG No. 24-1-04JA

July 28, 2025



DANIEL W. LUCAS
INSPECTOR GENERAL

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MEMORANDUM

To: Wayne Turnage, M.P.A.
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From: Daniel W. Lucas
Inspector General

Date: July 28, 2025

Subject: **Medicaid Eligibility Determinations Audit | OIG No. 24-1-04JA**

This memorandum transmits our audit report on the District's Medicaid Eligibility Determinations. We conducted this audit in accordance with generally accepted government auditing standards (GAGAS). Our audit objectives were to: (1) review internal controls over Medicaid eligibility; and (2) evaluate compliance with federal program requirements. The audit was included in our *Fiscal Year 2024 Audit and Inspection Plan*.

Both agencies provided written responses to our recommendations. DHS committed to implementing corrective actions for all six recommendations directed to them, including establishing procedures for termination notices, enhancing supervisory review processes, and updating record retention policies. DHCF committed to implementing corrective actions through their Commanding Case Closure Initiative, including refresher training and enhanced supervisory review processes. All eight recommendations are considered open and resolved, pending verification of implementation.

We appreciate the cooperation and courtesy extended to our staff during this audit. If you have any questions about this report, please contact me or Dr. Slemo Warigon, Assistant Inspector General for Audits, at slemo.warigon@dc.gov.

EXECUTIVE SUMMARY

Medicaid Eligibility Determinations Audit

Summary

In March 2020, Congress enacted the Families First Coronavirus Response Act in response to the COVID-19 public health emergency, which required states to ensure most individuals were continuously enrolled for Medicaid. During the COVID-19 public health emergency, continuous Medicaid coverage led to a 20 percent enrollment increase, with the Department of Health Care Finance (DHCF) reporting more than 300,000 individuals enrolled in the District's Medicaid Program.

The Consolidated Appropriations Act of 2023 ended the continuous enrollment of Medicaid coverage. As a result, and through guidance from the Centers for Medicare and Medicaid Services (CMS), the Department of Human Services (DHS) had to resume recertification procedures and conduct eligibility renewals for all individuals enrolled in Medicaid.

The Office of the Inspector General (OIG) identified this audit engagement due to its vulnerability to corruption, fraud, waste, abuse, and mismanagement, hence its inclusion on the OIG High Risk List.

Objectives

For this engagement, our objectives were to: (1) review internal controls over Medicaid eligibility; and (2) evaluate compliance with federal program requirements.

Findings

Through this audit, we made the following findings:

1. DHCF successfully met CMS' requirements for developing an unwinding operational plan.
2. DHCF submitted baseline and twelve monthly reports to CMS timely, as required.
3. DHS did not always send termination notices to Medicaid beneficiaries.
4. DHS did not always maintain required supporting documentation.
5. DHS did not always provide denial notices to ineligible applicants.
6. The District's eligibility system of record did not consistently reflect correct or accurate eligibility status.

Recommendations

We made six recommendations to DHS and two recommendations to DHCF. We recommend establishing clear internal control procedures and quality assurance measures to ensure termination notices are consistently generated and aligned with federal regulations. We recommend developing a procedure to ensure adequate supervisory review and accurate documentation of eligibility decisions in the District of Columbia Access System. Additionally, we recommend updating policies and procedures to enhance monitoring, documentation, and error mitigation for manual processes.

Management Response

DHS committed to implementing corrective actions for six recommendations, and DHCF committed to implementing corrective measures for two recommendations. All eight recommendations are considered open and resolved, pending verification of implementation.

Medicaid Eligibility Determinations Audit

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INTRODUCTION

Objectives

The objectives of this audit were to: (1) review internal controls over Medicaid eligibility; and (2) evaluate compliance with federal program requirements.

See Appendix 3 for our audit scope and methodology.

Background

Medicaid Program Overview

Medicaid is a joint federal-state program that finances healthcare coverage for low-income and medically disadvantaged populations, including individuals with disabilities. It encompasses a range of services such as medical consultations, hospital care, prescription medications, mental health support, transportation, and various other healthcare provisions.

Medicaid operates through state Medicaid agencies, with states paying providers of medical services directly or through the use of managed care plans.[1] For Medicaid purposes, the District of Columbia is treated as a state and has the same responsibilities and requirements.[2] As such, the District operates its own Medicaid program, receives federal matching funds, and is subject to the same federal requirements and oversight as any state.

The Department of Health Care Finance (DHCF) is the District's State Medicaid agency. DHCF administers the Medicaid program and is responsible for determining the types and extent of services that beneficiaries may receive. DHCF delegates its responsibility for making Medicaid eligibility determinations to the Economic Security Administration (ESA), a division of the DC Department of Human Services (DHS).

Medicaid eligibility in the District is determined based on specific information, including income, household size, age, disability status, and other factors. Applicants must be US citizens or qualified immigrants and are typically required to provide

[1] OFF. OF MGMT. & BUDGET, EXEC. OFF. OF THE PRESIDENT, COMPLIANCE SUPPLEMENT, 2 C.F.R. PART 200, APP XI, 4-93.778-1 (May 2024), https://www.fac.gov/assets/compliance/2024-Compliance-Supplement.pdf.
[2] Per Social Security Act § 1902(e)(53)(F)(v)(I), "The term 'State' means 1 of the 50 States or the District of Columbia."

documentation of income, residency, and other personal details to determine eligibility.

The DC Access System (DCAS) is the integrated system used to determine eligibility for various health and human services for the District. DCAS integrates with federal and local databases, such as the Federal Data Services Hub, to verify applicant information, including income, citizenship, and Social Security data. Eligibility determinations are conducted in alignment with federal and District regulations, along with agency policies and procedures. The system also facilitates annual renewals and helps case workers in documenting eligibility decisions.

Continuous Coverage Requirements

On January 31, 2020, the Health and Human Services Secretary declared that a public health emergency (PHE) existed due to the spread of the coronavirus disease 2019 (COVID-19). As a result, Congress enacted the Families First Coronavirus Response Act (FFCRA), which authorized an approximately 6.2 percent increase in federal funding for Medicaid programs as long as states continuously maintained participants' Medicaid eligibility throughout the PHE.[3]

This continuous coverage provision prohibited states from terminating Medicaid benefits for most enrollees during the PHE, even when changes in circumstances would normally make them ineligible. The provision was designed to ensure that vulnerable populations maintained access to healthcare services during the pandemic without the risk of losing coverage due to administrative hurdles or economic disruptions. However, these temporary policies paused regular eligibility reviews, causing a backlog of eligibility determinations that needed to be addressed once the continuous coverage requirement ended.

The Consolidated Appropriations Act of 2023 (CAA) set March 31, 2023, as the definitive end date for the continuous coverage of Medicaid requirement of the FFCRA.[4] The CAA created a two-phased approach for states to return to normal Medicaid eligibility operations. This process of transitioning back to regular Medicaid eligibility determination procedures after the continuous coverage period is referred to as "unwinding." The unwinding process required states to systematically work through the backlog while ensuring eligible individuals maintained their healthcare coverage.

[3] Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020).
[4] Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459 (2022).

Unwinding Process Requirements

In March 2022, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official Letter No. 22-001, announcing that states must initiate eligibility renewals for all individuals enrolled in Medicaid within 12 months of the start of the state's unwinding period.[5] Furthermore, states were required to complete these renewals within 14 months of the unwinding period's commencement.

CMS guidance established key requirements for states during the unwinding process, including:

- development of an Unwinding Operational Plan outlining the state's approach to resuming normal eligibility operations;
- implementation of strategies to minimize inappropriate coverage loss, including updated contact information processes;
- establishment of prioritization frameworks for processing renewals; and
- submission of monthly data reports on renewal progress and outcomes.

Additionally, the CAA required states to report their progress on eligibility and enrollment actions such as reviews, redeterminations, and disenrollments and mandated that CMS make this information publicly available.[6] These measures were aimed at ensuring a smooth transition and preventing unnecessary loss of health coverage.

District Of Columbia's Medicaid Unwinding Efforts

During the PHE, the District of Columbia experienced a significant increase in Medicaid enrollment, growing by 20 percent to over 300,000 enrollees.[7] This surge was due to the continuous coverage provisions that suspended annual eligibility redeterminations to ensure uninterrupted access to healthcare. At the end of the PHE, the District resumed Medicaid renewals on April 1, 2023, and resumed annual eligibility redetermination.

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[5] Letter from Daniel Tsai, Acting Deputy Administrator and Director, Department of Health & Human Services, Centers for Medicare & Medicaid Services to State Health Official, Executive Summary (SHO# 22-001) (Mar. 3, 2022) (on file with the OIG).
[6] Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459 (2022).
[7] Department of Health Care Finance, "Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #28 Medicaid Renewal Community Meeting" (PowerPoint presentation, Washington, DC, May 22, 2024), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Community%20Meeting%20052224.pdf.

By March 2024, the District started all Medicaid renewals and reached an 80 percent renewal rate.[8] The District's 80 percent renewal rate demonstrated significant progress in returning to normal eligibility operations while ensuring eligible individuals maintained coverage.

AUDIT RESULTS

Our audit of Medicaid eligibility determinations, including the unwinding of continuous Medicaid coverage, revealed areas of strength and areas for improvement. We found that DHCF and DHS showed notable strengths in planning and reporting during the unwinding process, successfully meeting CMS requirements for operational planning and timely submission of monthly progress reports. These accomplishments reflect the agencies' commitment to compliance, transparency, and accountability during a complex transition period.

Despite these successes, we found instances of internal control deficiencies that require attention. Our audit found inconsistent issuance of termination and denial notices to beneficiaries, inadequate documentation retention practices, and inaccuracies in DCAS. These weaknesses may negatively affect beneficiaries' access to healthcare coverage and their awareness of appeal rights.

Addressing these issues could significantly enhance the integrity, transparency, and compliance of Medicaid program administration in the District of Columbia. Ensuring accurate eligibility determinations and proper notification processes will help build public trust, reduce the risk of legal challenges, and improve access to healthcare for eligible residents. Furthermore, resolving systemic internal control deficiencies could prevent future errors, improve operational efficiency, and better align the program with federal standards. The following findings provide detailed information on both the strengths we observed and the areas requiring improvement.

Finding 1: DHCF Successfully Met CMS' Requirements for Developing an Unwinding Operational Plan

On December 22, 2020, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official Letter #20-004, which directed states to develop and document a comprehensive plan to restore routine operations in their Medicaid programs following the suspension of certain processes during the COVID-19 PHE.[9]

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[8] Department of Health Care Finance, "Restarting Medicaid Renewals," slide 4.
[9] Letter from Ann Marie Costello, Acting Deputy Administrator and Director, Department of Health & Human Services, Centers for Medicare & Medicaid Services to State Health Official, Section VI (SHO# 20-004) (Dec. 22, 2020) (on file with the OIG).

In response, DHCF released its *Operational Plan for Unwinding Continuous Coverage and the COVID-19 Public Health Emergency* (Unwinding Plan) in March 2023.[10] The Unwinding Plan established clear objectives and internal control activities to align with federal requirements to mitigate risks associated with the return to routine operations.

Key strengths of the DHCF's Unwinding Plan include:

- **Eligibility Operations Under the Continuous Cover Requirement:** DHCF created strategies to prevent unnecessary coverage loss for Medicaid beneficiaries during the transition period, focusing on seamless continuity of care.
- **Federal Eligibility-Related Flexibilities During Renewals:** DHCF introduced measures to expedite eligibility determinations and renewals, ensuring prompt and accurate processing of cases.
- **Outreach Campaign:** DHCF implemented robust outreach initiatives to inform Medicaid beneficiaries, healthcare providers, and community organizations about changes to policies and processes during the unwinding period.
- **Risk Mitigation and Compliance Monitoring:** DHCF designed comprehensive internal control activities to address potential risks, such as coverage gaps or compliance lapses, ensuring adherence to CMS guidelines.

By proactively addressing federal requirements and emphasizing planning, communication, and operational efficiency, DHCF demonstrated its commitment to protecting Medicaid beneficiaries and supporting program integrity during the unwinding period.

Finding 2: DHCF Timely Submitted Required Baseline and Monthly Reports to CMS

The CAA, along with State Health Official Letters No. 20-004 (December 22, 2020)[11] and No. 22-001 (March 2022),[12] outlines specific reporting requirements for states during the unwinding period following the COVID-19 PHE. States were mandated to submit monthly reports to CMS on eligibility redeterminations, application processing times, and disposition of Medicaid renewals. These reports were required

[10] Operational Plan for Unwinding Continuous Coverage and the COVID-19 Public Health Emergency.
[11] *Supra* note 6.
[12] *Supra* note 3.

to show compliance with federal timelines, ensure transparency, and provide CMS with data to monitor state performance.

DHCF consistently met the requirement for timely monthly reporting throughout the 14-month unwinding period. DHCF established effective processes and procedures to ensure the collection, validation, and submission of the required data to CMS. These measures were critical in maintaining compliance with federal regulations and demonstrated DHCF's commitment to transparency and accountability during this transition.

As a result, DHCF ensured that beneficiaries received proper benefits while mitigating risks of erroneous disenrollments. Additionally, DHCF's effective reporting processes facilitated continued transparency and strengthened the integrity of the Medicaid unwinding process.

Finding 3: DHS Did Not Always Send Medicaid Beneficiaries Termination Notices

Title 29 DCMR § 9501.31 requires DHCF to provide written notice of Medicaid enrollment termination at least 15 calendar days prior to termination.[13] Additionally, the DCMR mandates eligibility determinations for other Insurance Affordability Programs (IAPs) for applicants or beneficiaries found ineligible for Medicaid.[14] Furthermore, 29 DCMR § 9508 outlines beneficiaries' rights to notice and a fair hearing.

We found that DHS did not issue termination notices to three out of five (60 percent) of the Medicaid beneficiaries in our sample, violating the requirement to notify individuals at least fifteen days before termination.[15] This occurred because DHS lacks a formal procedure to ensure termination notices are generated and sent to beneficiaries when cases are closed manually. The DCAS system automatically generates termination notices during regular case closures, but this automation is bypassed during manual closures. Without a standardized procedure to address this system limitation, there is no consistent mechanism to ensure beneficiaries receive required notifications when their cases are manually closed.

As a result, beneficiaries may be unaware of their Medicaid coverage loss, their right to appeal, or their eligibility for alternative programs. This can lead to gaps in health coverage, delayed medical care, and unmet health needs. Additionally, these notification failures risk undermining public trust in the Medicaid program,

[13] 29 DCMR § 9501.31.
[14] 29 DCMR § 9501.32.
[15] To understand our sampling methodology, please refer to Appendix 3.

increasing appeals and disputes, and imposing unnecessary administrative costs on taxpayers.

Recommendation 1 (DHS)
We recommend that the DHS Director: Establish and implement clear procedures to generate and issue termination notices to beneficiaries when Medicaid cases are closed manually.
Management Feedback: DHS agrees with this finding and acknowledges the need to reinforce manual case closure procedures to ensure timely and accurate notification is provided to beneficiaries. DHS will work with DHCF to implement a Commanding Case Closure Initiative that will include reinforcing procedures and training (both in person and on demand) for manual case closures. This initiative is expected to be completed by the end of FY26 and will provide case workers with mandatory and on demand refresher training and job aids covering manual case closure reasons. Additionally, DHS will leverage the Medical Coverage Termination report from MicroStrategy to track the timeliness and accuracy of the manual closures processes.
Our Notes: We consider this recommendation open and resolved, pending verification.

Recommendation 2 (DHS)
We recommend that the DHS Director: Establish a formal process to detect and track manual closures of terminated cases.
Management Feedback: DHS agrees with this finding and acknowledges the need to reinforce internal controls to monitor the timeliness and accuracy of these case closure procedures by leveraging the existing monthly Medical Coverage Termination report. Supervisors will review these reports on a monthly basis to identify any incomplete or invalid closures and will make corrections and provide additional training to staff as needed.
Our Notes: We consider this recommendation open and resolved, pending verification.

Finding 4: DHS Did Not Always Maintain Required Supporting Documentation

Title 42 CFR § 431.17, requires Medicaid agencies to maintain individual records for each applicant and beneficiary that include all information provided in the initial application.[16] These records must be kept for the duration of the applicant's or beneficiary's active case and for a minimum of three years thereafter.[17] Additionally, ESA Policy mandates that all case documents needed to determine eligibility must be kept for as long as the case remains open.[18]

Our testing procedures revealed documentation retention deficiencies at DHS. We found that for the newly eligible beneficiaries we examined, DHS did not keep the required supporting documentation in two out of six cases (33 percent). For renewal-eligible beneficiaries, DHS did not keep required supporting documentation in 12 out of 43 cases (28 percent). In all of these instances, the documentation should have been kept either because the cases remained active or fell within the three-year retention period required by federal regulations. This pattern of missing documentation shows that the DHS' current record retention practices do not align with ESA's program policy manual and federal regulations.

[16] 42 CFR § 431.17(b)(1)(i).
[17] 42 CFR § 431.17(c)(1).
[18] GOV'T OF THE DISTRICT OF COLUMBIA, DEP'T OF HUMAN SERVICES, ESA POLICY MANUAL, PART 8, CHAPTER 1 (undated).

The failure to keep proper documentation undermines confidence in DHS' ability to ensure accurate eligibility determinations and program integrity. Moreover, inadequate documentation retention can hinder oversight, audits, and corrective actions needed to address potential compliance issues.

Recommendation 3 (DHS)
We recommend that the DHS Director: Review its record retention policies and procedures to ensure alignment with ESA's program policy manual and applicable federal requirements (42 CFR § 431.17).
Management Feedback: DHS disagrees with this finding. The cited federal requirements (42 CFR § 431.17) were revised in 2023 to require states to maintain eligibility records for the period that the beneficiary's case is active plus three years and the deadline for compliance is in 2026. The previous rule deferred to states to set their own record retention schedule, and in 2019, DHS adopted a record retention schedule of three years. DHS adhered to the prior record retention requirements and those requirements did not mandate retention of records prior to 2016. While DHS does not agree with this finding, DHS will be revising its record retention policy to be compliant with the new federal regulations prior to the compliance deadline in 2026.
Our Notes: DHS disagrees with our finding, arguing that the updated federal regulation does not apply retroactively and that they complied with the previous requirements. However, we maintain that the cases we examined should have been retained under the existing three-year retention requirement, as our audit covered FY 2024, which falls within the minimum retention period required by federal regulation. While we disagree with DHS's interpretation of the requirements, we acknowledge that DHS has committed to updating their record retention policy to comply with current federal regulations prior to the 2026 deadline. We consider this recommendation open and resolved, pending verification.

Finding 5: DHS Did Not Always Provide Denial Notices to Ineligible Applicants

To ensure transparency, accountability, and fairness, federal and District regulations require notifying applicants when Medicaid applications are denied. Title 29 DCMR § 9508.1 mandates that individuals applying for Medicaid through DHS be informed of

their right to a fair hearing when their Medicaid application is denied.[19] Additionally, 29 DCMR § 9501.32 requires DHS to promptly provide ineligible Medicaid applicants with information about potential eligibility for other IAPs, along with details about their right to appeal the determination.[20]

Our testing revealed that DHS did not consistently follow these notification requirements. In three of the 17 cases (18 percent) where applicants were denied Medicaid eligibility, DHS did not provide the required denial notices. These notices should have included information about eligibility for other programs and the applicant's right to appeal. Further, we found that one applicant should have been approved for Medicaid but was denied eligibility in error.

We found that these notification deficiencies occurred due to procedural gaps in DHS' processes for generating and sending denial notices, combined with insufficient management oversight of the denial notification process. Current procedures do not ensure that when caseworkers determine an applicant is ineligible for Medicaid, the required denial notices are consistently created and sent. Management oversight mechanisms, such as supervisory reviews or quality checks, did not effectively identify or address these missing notifications. Additionally, documentation in the DCAS system was inconsistent, with case narratives often lacking sufficient detail to explain ineligibility determinations. This deficiency prevents applicants from receiving denial notices with adequate explanations of why they were found ineligible, making it difficult for them to understand the basis for the decision and determine whether to exercise their appeal rights. Without effective supervisory internal controls to verify that required notices are sent with proper explanations, applicants may be unable to mount effective appeals of potentially erroneous decisions.

When denial notices are not issued, applicants lose the ability to contest potentially erroneous decisions. The lack of notification to applicants could result in eligible individuals being wrongfully excluded from vital healthcare coverage. Further, the agency's failure to issue these notices undermines public confidence in the fairness and transparency of the Medicaid program.

[19] 29 DCMR § 9508.
[20] 29 DCMR § 9501.32.

Recommendation 4 (DHS)
We recommend that the DHS Director: Develop and implement a procedure to ensure adequate supervisory review of Medicaid applications when Medicaid applicants are determined ineligible.
Management Feedback: DHS agrees with this finding and has identified an alternative solution that will address this finding. DHS acknowledges that there is a need to reinstate supervisory review of ineligible Medicaid applications, which had been paused during the COVID-19 Public Health Emergency. As part of the Commanding Case Closure Initiative, DHS and DHCF will reinforce procedures and trainings for documenting eligibility determination decisions on the case record, including case narratives. DHS will also reinstate the supervisory review of ineligible Medicaid applications to ensure that the case record has an appropriate explanation for the determination of ineligibility. These efforts will be completed by the end of FY26.
Our Notes: We consider this recommendation open and resolved, pending verification.

Recommendation 5 (DHS)
We recommend that the DHS Director: Establish a formal mechanism to ensure the DCAS timely and accurately reflects eligibility determinations when Medicaid applicants are determined ineligible.
Management Feedback: DHS agrees with this finding and will work with DHCF to automate the creation and mailing of Medicaid denial notices for all situations (instead of a subset of situations as designed). This enhancement will be prioritized on the development roadmap once a solution is designed.
Our Notes: We consider this recommendation open and resolved, pending verification.

Recommendation 6 (DHS)
We recommend that the DHS Director: Develop and implement procedures to ensure case workers add case narratives in DCAS to accurately explain why Medicaid applicants are determined ineligible.
Management Feedback: DHS agrees with this finding and recognizes the need to develop case narrative standards when beneficiaries are determined to be ineligible or when processing an administrative action to correct eligibility with no intention to deny or terminate the beneficiary. Concurrently, DHS will work with DHCF to automate the creation and mailing of Medicaid denial notices. This enhancement will be prioritized on the development roadmap once a solution is designed.
Our Notes: We consider this recommendation open and resolved, pending verification.

Finding 6: DCAS Did Not Consistently Reflect Correct or Accurate Eligibility Status

Federal standards require information systems to keep accurate and reliable data. According to GAO's *Standards for Internal Control in the Federal Government* (GAO Green Book), management must design information systems and internal controls that ensure data completeness, accuracy, and validity. These standards help agencies achieve operational effectiveness, carry out objectives, and respond to risks.[21]

Our testing revealed that DHS staff did not consistently maintain accurate eligibility status information in DCAS. Our review of 47 active cases found seven beneficiaries (15 percent) were incorrectly listed as active in DCAS despite having been determined to be ineligible for Medicaid benefits. This discrepancy occurred because caseworkers did not properly update DCAS after determining ineligibility. The manual update process lacked sufficient internal control and verification steps, creating a disconnect between actual eligibility determinations and information recorded in the system.

The underlying causes of these deficiencies include:

[21] GAO Green Book §§ 11.01, 11.03, and 11.09.

- DHS did not have clear procedures or effective oversight to ensure timely and accurate updates to DCAS, including missing automated checks to spot inconsistencies, inefficient workflows for processing updates, and limited system tools to flag issues, leading to delays and errors.

- DHS policies and procedures lack effective internal controls to detect errors in manual updates within the eligibility system, including inadequate monitoring processes to identify and address mistakes promptly.

These conditions expose the District to significant risks, including potential improper payments, inaccurate reporting, and regulatory noncompliance. Such risks undermine the integrity of the Medicaid program and could result in financial losses, sanctions, or fines for the District government. Furthermore, they jeopardize the effectiveness and fairness of the Medicaid program by not ensuring eligibility determinations are processed accurately and efficiently.

Recommendation 7 (DHCF)
We recommend that the DHCF Director: Develop and implement effective internal control procedures for systematic monitoring of manual updates in DCAS.
Management Feedback: DHCF disagrees with this recommendation. DCAS system categorization of "Active" simply indicates that a public assistance application has been initiated. Notwithstanding, as part of the Commanding Case Closure Initiative, DHCF will provide refresher training to staff on the appropriate procedures for proper case closure and will incorporate a check for cases with an active status but no eligibility in the supervisory review process. Estimated Completion Date: End of Fiscal Year 2026.
Our Notes: While DHCF disagrees with the recommendation, they have committed to implementing corrective actions that address the intent of our recommendation. However, we maintain that an "Active" status in DCAS should accurately reflect actual eligibility determinations, as inaccurate system data can lead to improper payments and compliance issues. We consider this recommendation open and resolved, pending verification.

Recommendation 8 (DHCF)
We recommend that the DHCF Director: Update policies and procedures to define specific internal controls for prompt detection and remediation of errors in manual processes.
Management Feedback: DHCF disagrees with this finding but will implement the same corrective actions described in Recommendation 7, including refresher training on proper case closure procedures and incorporating checks for cases with active status but no eligibility in the supervisory review process. Estimated Completion Date: End of Fiscal Year 2026.
Our Notes: While DHCF disagrees with the finding, they have committed to implementing corrective actions that address the intent of our recommendation. We consider this recommendation open and resolved, pending verification.

CONCLUSION

DHCF successfully met federal requirements for unwinding continuous Medicaid coverage after the Covid-19 Public Health Emergency. DHCF developed a comprehensive Unwinding Operational Plan and submitted all required baseline and monthly reports to CMS on time. These accomplishments show the agency's commitment to transparency, accountability, and adherence to federal guidelines during this complex transition affecting over 300,000 Medicaid beneficiaries.

While DHCF effectively managed the planning and reporting aspects of the unwinding process, we found several internal control weaknesses that require attention. Specifically, DHS did not consistently provide the required termination and denial notices to beneficiaries and did not maintain complete documentation. Additionally, DHCF needs to strengthen its internal controls over the accuracy of data in DCAS. These deficiencies could potentially impact beneficiaries' access to healthcare, their awareness of appeal rights, and the overall integrity of the District's Medicaid program.

Our eight recommendations focus on strengthening procedural controls, improving documentation practices, enhancing system accuracy, and implementing effective quality assurance mechanisms. Implementing these recommendations will not only improve operational efficiency and regulatory compliance but will also better serve District residents by ensuring eligible individuals retain access to vital healthcare services while managing program resources.

APPENDIX 1. FINDINGS

Table of Findings

No.	Finding
1	DHCF Successfully Met CMS' Requirements for Developing an Unwinding Operational Plan
2	DHCF Timely Submitted Required Baseline and Monthly Reports to CMS
3	DHS Did Not Always Send Medicaid Beneficiaries Termination Notices
4	DHS Did Not Always Maintain Required Supporting Documentation
5	DHS Did Not Always Provide Denial Notices to Ineligible Applicants
6	DCAS Did Not Consistently Reflect Correct or Accurate Eligibility Status

APPENDIX 2. RECOMMENDATIONS

Table of Recommendations

Agency	No.	Recommendation	Status	Action Required	Finding
DHS	**1**	Establish and implement clear procedures to generate and issue termination notices to beneficiaries when Medicaid cases are closed manually.	**Open**	Tracking implementation	3
DHS	**2**	Establish a formal process to detect and track manual closures of terminated cases.	**Open**	Tracking implementation	3
DHS	**3**	Review its record retention policies and procedures to ensure alignment with ESA's program policy manual and applicable federal requirements (42 CFR § 431.17).	**Open**	Tracking implementation	4
DHS	**4**	Develop and implement a procedure to ensure adequate supervisory review of Medicaid applications when Medicaid applicants are determined ineligible.	**Open**	Tracking implementation	5
DHS	**5**	Establish a formal mechanism to ensure the DCAS timely and accurately reflects eligibility determinations when Medicaid applicants are determined ineligible.	**Open**	Tracking implementation	5
DHS	**6**	Develop and implement procedures to ensure case workers add case narratives in DCAS to **accurately explain why Medicaid applicants are determined ineligible.**	**Open**	Tracking implementation	5
DHCF	**7**	Develop and implement effective internal control procedures for systematic monitoring of manual updates in DCAS.	**Open**	Tracking implementation	6
DHCF	**8**	Update policies and procedures to define specific internal controls for prompt detection and remediation of errors in manual processes.	**Open**	Tracking implementation	6

APPENDIX 3. SCOPE & METHODOLOGY

Scope

The scope of this audit was DHCF's and DHS' internal controls over Medicaid eligibility determinations during the Public Health Emergency and the unwinding of continuous Medicaid coverage from April 1, 2023, to June 30, 2024.

Methodology

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Document Review

We obtained, reviewed, and analyzed relevant laws, rules, regulations, policies, and procedures related to Medicaid eligibility and the unwinding of continuous Medicaid coverage. This included federal guidance from CMS, District regulations, and agency-specific operational documents.

Interviews and Site Visits

We interviewed DHCF and DHS officials to gain an understanding of the Medicaid renewal process after the end of the Public Health Emergency. Additionally, we conducted site visits at DHS service centers, where we interviewed and conducted walkthroughs with Social Service Representatives to gain an understanding of Medicaid applications and renewals processing.

System Access and Data Reliability Assessment

We met with DHCF officials to understand DCAS and Document Imaging Management System and received training to access and use these systems. We conducted data reliability testing and walkthroughs to ensure the validity and integrity of the data used for our analysis. We worked with OIG data scientists to analyze DHCF and DHS data sets identifying more than 300,000 beneficiaries whose Medicaid eligibility had to be redetermined.

Sample Testing and Analysis

We selected 30 samples during the survey phase to assess Medicaid eligibility determinations, identifying instances where proof of Medicaid eligibility or continued Medicaid eligibility was not clearly documented or where supporting evidence for determinations was unavailable.

We selected 45 additional samples during the verification phase. We tested initial Medicaid eligibility, proper Medicaid denial determinations, and proper Medicaid terminations. We reviewed eligibility documentation associated with all samples.

We developed findings and recommendations based on available evidence, continuing to follow up and assess documentation received from DHCF and DHS to reach our conclusions and recommendations.

Sampling Design and Selection

Sampling Frame

The sampling frame for this audit consists of all Medicaid beneficiaries across five strata. The strata are:

- Eligible Stratum: individuals determined eligible for Medicaid (10,150);
- Terminated Stratum: individuals whose Medicaid coverage was terminated (9,184);
- Denials Stratum: individuals denied Medicaid coverage (1,449);
- Renewal Stratum: individuals undergoing Medicaid renewal (304,742); and
- Overlapping Stratum: individuals appearing in multiple strata (451).

Table 1. Breakdown of Sample Strata

No.	Population description	Distinct Medicaid ID Count	Count without Overlap
1	Eligible Stratum	10,601	10,150
2	Terminated Stratum	9,635	9,184
3	Denials Stratum	1,449	1,449
4	Renewal Stratum	305,193	304,742
5	Overlapping Stratum	-	451
Total		**326,878**	**325,976**

Sample Unit

The sample unit in this audit was an individual Medicaid beneficiary.

Sample Design

We employed a stratified sampling approach, dividing the Medicaid beneficiary population into five distinct strata based on the applicants' statuses. Given the population's characteristics where the eligibility requirements vary across different

programs, a non-generalizable probability approach was employed, meaning the results may not be projected to the entire population.

Sample Size

The total sample size was determined using an attribute sample size calculator with the following parameters:

- Precision rate: 15 percent
- Error rate: 50 percent
- Confidence level: 98 percent

Based on these parameters, the initial sample size was calculated to be 60 beneficiaries. The team allocated 60 samples across the five strata based on the stratum's characteristics and size. To ensure a more robust assessment of denials, we selected an additional 15 samples from the Denials stratum, bringing the total number of denials tested to 17 and the overall sample size to 75.

The allocation of samples was as follows:

No.	Stratum	Count by Strata	Total Samples (Survey + Verification)
1	Renewal Stratum	304,742	43
2	Eligible Stratum	10,150	6
3	Terminations Stratum	9,184	5
4	Overlapping Stratum	451	4
5	Denials stratum	1,449	17
Total		**325,976**	**75**

Method for Selecting Samples:

We used systematic sampling implemented through an Automated Sampling tool. The tool selected samples based on sample intervals determined by dividing the population by the required number of samples. This approach maintained randomness and avoided bias in the sample selection process.

APPENDIX 4. DHS MANAGEMENT RESPONSE

DC | DEPARTMENT of HUMAN SERVICES

July 16, 2025

Daniel W. Lucas, Inspector General
Office of the Inspector General
100 M Street SE, Suite 1000
Washington, DC 20003

Dear Inspector General Lucas,

By this letter, I am providing written responses from the Department of Human Services (DHS) to the findings addressed to DHS in the *Draft OIG Report: Medicaid Eligibility Determinations Audit* (OIG No. 24-1-04JA). The Department of Health Care Finance (DHCF) will be providing written responses to the DHCF findings under separate cover.

Finding 3: DHS Did Not Always Send Medicaid Beneficiaries Termination Notices

Recommendation 1 (DHS): We recommend that the DHS Director establish and implement clear procedures to generate and issue termination notices to beneficiaries when Medicaid cases are closed manually.

Recommendation 2 (DHS): We recommend that the DHS Director establish a formal process to detect and track manual closures of terminated cases.

Response: DHS agrees with this finding and acknowledges the need to reinforce manual case closure procedures to ensure timely and accurate notification is provided to beneficiaries. DHS also acknowledges the need to reinforce internal controls to monitor the timeliness and accuracy of these case closure procedures by leveraging the existing monthly Medical Coverage Termination report.

Action Plan: DHS will work with DHCF to implement a Commanding Case Closure Initiative that will include reinforcing procedures and trainings (both in person and on demand) for manual case closures. This initiative is expected to be completed by the end of FY26 and it will provide caseworkers with mandatory and on demand refresher trainings and job aids covering the following manual case closure reasons:

- Voluntary withdrawal requests
- No longer part of the household
- Out of state notification/attestation with no forwarding address
- Administrative actions taken to correct eligibility with no intent to deny or terminate coverage

Additionally, DHS will leverage the Medical Coverage Termination report from MicroStrategy to track the timeliness and accuracy of the manual closures processes. Supervisors will review

these reports on a monthly basis to identify any incomplete or invalid closures and will make corrections and provide additional training to staff as needed.

Finding 4: DHS Did Not Always Maintain Required Supporting Documentation

Recommendation 3 (DHS): We recommend that the DHS Director review its record retention policies and procedures to ensure alignment with ESA's program policy manual and applicable federal requirements (42 CFR § 431.17).

Response: DHS disagrees with this finding. The cited federal requirements (42 CFR § 431.17) were revised in 2023 to require states to maintain eligibility records for the period that the beneficiary's case is active plus three years and the deadline for compliance is in 2026. The previous rule deferred to states to set their own record retention schedule, and in 2019, DHS adopted a record retention schedule of three years. DHS adhered to the prior record retention requirements and those requirements did not mandate retention of records prior to 2016.

Action Plan: While DHS does not agree with this finding, DHS will be revising its record retention policy to be compliant with the new federal regulations prior to the compliance deadline in 2026.

Finding 5: DHS Did Not Always Provide Denial Notices to Ineligible Applicants

Recommendation 4 (DHS): We recommend that the DHS Director develop and implement a procedure to ensure adequate supervisory review of Medicaid applications when Medicaid applicants are determined ineligible.

Recommendation 5 (DHS): We recommend that the DHS Director establish a formal mechanism to ensure DCAS timely and accurately reflects eligibility determinations when Medicaid applicants are determined ineligible.

Recommendation 6 (DHS): We recommend that the DHS Director develop and implement procedures to ensure case workers add case narratives in DCAS to accurately explain why Medicaid applicants are determined ineligible.

Response: DHS agrees with this finding and has identified an alternative solution that will address this finding. DHS acknowledges that there is a need to reinstate supervisory review of ineligible Medicaid applications, which had been paused during the COVID-19 Public Health Emergency. DHS also recognizes the need to develop case narrative standards when beneficiaries are determined to be ineligible or when processing an administrative action to correct eligibility with no intention to deny or terminate the beneficiary. Concurrently, DHS will work with DHCF to automate the creation and mailing of Medicaid denial notices for all situations (instead of a subset of situations as designed).

Action Plan: As part of the Commanding Case Closure Initiative, DHS and DHCF will reinforce procedures and trainings for documenting eligibility determination decisions on the case record, including case narratives. DHS will also reinstate the supervisory review of ineligible Medicaid

applications to ensure that the case record has an appropriate explanation for the determination of ineligibility. These efforts will be completed by the end of FY26. DHS will also be working with DHCF to automate the creation and mailing of Medicaid denial notices. This enhancement will be prioritized on the development roadmap once a solution is designed.

We appreciate the opportunity to review and provide feedback on the draft issue brief. If you have any questions about this response, please reach out to Christa Phillips, DHS Chief Accountability Officer, at 202-200-7669.

Regards,

A. D. Rachel Pierre
Interim Director, Department of Human Services

APPENDIX 5. DHCF MANAGEMENT RESPONSE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

To: Daniel W. Lucas, D.C. Inspector General

From: Melisa Byrd, D.C. State Medicaid Director, Deputy Agency Director
D.C. Department of Health Care Finance

Date: July 16, 2025

Re: Draft OIG Report: Medicaid Eligibility Audit (OIG No. 24-1-04JA)

This memorandum responds to the DC OIG's Draft Audit Report on the District's Medicaid Eligibility Determinations. The Draft Report contains six findings, each directed at either the D.C. Department of Human Services (DHS), or the D.C. Department of Health Care Finance (DHCF). Finding 6 was addressed to DHCF, the response to which is stated below.

Finding 6: DCAS Did Not Consistently Reflect Correct or Accurate Eligibility Status

In 7 out of 47 cases, the DC OIG found that the DCAS System did not consistently reflect accurate eligibility status. The DC OIG recommends that the DHCF Director develop and implement effective internal control procedures for systematic monitoring of manual updates in DCAS. DHCF disagrees with this finding. DCAS system categorization of "Active" simply indicates that a public assistance application has been initiated. Notwithstanding, as part of the Commanding Case Closure Initiative, DHCF will provide refresher training to staff on the appropriate procedures for proper case closure, and will incorporate a check for cases with an active status but no eligibility in the supervisory review process.

Estimated Completion Date: End of Fiscal Year 2026

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